Las Vegas Transitional Grant Area
Planning Council

Medical Case Management (including treatment adherence) Standards of Care

Originated	**Ratified**
March 2011	November 2012

1. HRSA Service Definition

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems. Medical case management may also include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic reevaluation and adaptation of the care plan, at least every 6 months, as necessary during the enrollment of the client.

Benefits and Entitlement Counseling
Funds awarded under the Ryan White HIV/AIDS Program may be used to refer or assist eligible clients to obtain 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, and other State or local health care and supportive services.
Such benefits/entitlement counseling and referral activities may be provided as a component of three allowable Ryan White HIV/AIDS Program support service categories: "Medical Case Management," "Case Management (Non Medical)" and/or "Referral for Health Care/Supportive Services."

1.2 Key Definitions

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the staff providing these services.

As used herein, the term:

Grantee: Ryan White Part A Las Vegas TGA-Clark County Social Services.

Client: includes the terms “patient” and “consumer”.

Provider: includes the terms “service provider”; “agency”; “organization” and “subgrantee”.

2. Service Goals and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Medical Case Management (including treatment adherence) Service Goal:

To provide coordinated HIV services that improves the quality of health for clients in the Las Vegas TGA

2.2 Las Vegas Transitional Grant Area (TGA) Medical Case Management (including treatment adherence) Service Objectives:

1. Continue to provide to clients, currently in medical case management, an assessment of the client’s individual HIV specific and non-specific needs, a comprehensive client-centered service plan including referrals to outpatient/ambulatory medical care, supportive services, any other referrals required to meet the clients HIV health needs, and management and review of comprehensive service plan.
2. Increase MSM, IDU and MSM/IDU enrollment in medical case management by 5% by targeting identified population through out of care program and needs assessments.

3. Key Services

1. One appointment with a medical case manager (face to face or phone)
2. Ryan White funded clients will have a medical case management visit every 6 months.
3. Ryan White funded clients will work with their case manager to create or update their care plan at a minimum of every 6 months.

4. Eligibility

4.1 Part A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re-assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re-assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household
5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

4.2 Medical Case Management (including treatment adherence)

The following eligibility is for any client determined eligible for Part A services but must also meet the criteria specific for this service category.

Clients are to be referred to Medical Case Management (including treatment adherence) program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline evaluation

5.1 Client Intake and Initial Assessment

Intake is a time to gather registration information, assess the clients overall health status and unmet needs, provide necessary referrals for care, and provide basic information about case management and other HIV services. It is also a pivotal moment for establishment of trust and

confidence in the care system. Each client will receive an initial comprehensive assessment utilizing the standardized Ryan White Part A assessment forms. Part A eligible clients referred from another agency must receive contact from the receiving agency within 5 business days and an appointment within thirty days of referral.

5.2 Case Management Reassessment

Case management is to be an ongoing management process, not simply an initial or occasional assessment and referral. The purpose of the reassessment process is to ensure continued progress in meeting consumer needs while identifying any new emerging needs or problems.

5.3 Follow-up and Monitoring

Follow-up and monitoring contacts need not all be face-to-face, telephone contacts are adequate. However, the client must be seen face-to-face at a minimum of every six months for a full reassessment and a redetermination of eligibility. Each follow-up contact should include, at a minimum, discussion of the client's progress on their ISP and goals outlined therein, current needs and necessary referrals, and the clients overall health and wellbeing.

5.4 Discharge Planning

Unplanned discharge from case management services may affect the client's ability to receive and stay compliant with medical care. Therefore it is mandatory that at least three attempts be made over no more than a three month period to contact the clients who appear to be lost to follow-up (those who haven't had an appointment with the agency for a period of twelve months or more in moderate services or three months or more in intensive services). Clients who cannot be located after three attempts shall receive a formal letter by mail explaining their reason for discharge. A client may be discharged from case management services for any of the following conditions:

- The client is deceased.
- The client has become ineligible for services (e.g., due to relocation outside the TGA or fails to meet other eligibility criteria).
- The client no longer demonstrates need for case management due to their own ability to effectively advocate for their needs.
- The client chooses to terminate services.
- The client's needs would be better served by another agency.
- The client is being discharged from the correctional facility at which they are receiving jail case management services.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client cannot be located after documented three attempts for a period of no less than three months.

- The client is transitioning into another level of case management services within the Part A system. In this case to ensure a smooth transition, relevant intake documents maybe forwarded to the new service provider and case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained.

6. Clients Rights and Confidentiality:

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.

2. The provider will provide assurances and a method for protection of client rights in the process of care provision.

3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.

4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.

5. Respect, confidentiality and equal access to all clients will be assured.

7. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.

2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.

3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

8. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

9. Access, Care Coordination and Provider Continuity

- ❖ All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.
- ❖ Providers will document the following regarding access to and continuity of care:
  - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).
  - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.
  - Procedures for providing feedback to referring providers when a client is referred from another provider.
  - For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

10. Fees

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.

11. Licensing, Knowledge, Skills and Experience

Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered

services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services.

Any staff that is considered "other health care staff" positions will need prior approval by the grantee regarding the qualifications of these positions to ensure compliance with the approved program model as well as within the scope of allowable credentials approved by HRSA.

12. Program Data and Reporting

Program data for each Ryan White Part A funded program will be collected and reported through CAREWare, the Ryan White client level data collection system. This data will be used to monitor program progress as well as clinical outcomes. This data should also be reflected in each of the client's individual client charts.

13. Quality Assurance and Service Measures

13.1 Quality Management and Assurance

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.
2. The provider organization will provide for methods to monitor services areas in need of improvement.
3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

13.2 Service Indicators and Measures

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. Through our Quality Management Program, all measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. Agency Compliance Measures and Client Level Outcomes will be tracked and reported by agency and TGA wide, the Overall Program Performance Measures will be tracked and reported as TGA wide only. The intent is that agency compliance with Standards of Care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each

agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Medical Case Management services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

14. Clinical Standards

The Client Level Outcome Measures are a reflection of a client's progress as they access Medical Case management. The following Client Level Outcome Measure and percentage goal will be assessed annually for each of the three primary levels of medical case management:

14.1 Intensive Medical Case Management-Medical

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care (HRSA HAB Measure)

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Undetectable Viral Load

- 50% of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs during the measurement period to final labs during the measurement period. (Please note that clients in Intensive Medical Case Management-Medical services are generally entering the care system and therefore not receiving any HIV/AIDS medication, consequently they will most likely not have an undetectable viral load.)

Most Recent Viral Load Undetectable

- 50% of clients with at least one viral load within the measurement year will be considered undetectable (<50). (Please note that clients in Intensive Medical Case Management-Medical services are generally entering the care system and therefore not receiving any HIV/AIDS medication, consequently they will most likely not have any improvements in their viral load.)

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

14.2 Intensive Medical Case Management-Social

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care (HRSA HAB Measure)

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Undetectable Viral Load

- 50% of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs during the measurement period to final labs during the measurement period.

Most Recent Viral Load Undetectable

- 50% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

Medication Adherence

- 80% of clients will indicate missing less than 2 doses of their prescribed HIV/AIDS medication within the last 30 days of their most recent Medical Case Management appointment.

14.3 Medical Case Management

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care (HRSA HAB Measure)

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Undetectable Viral Load

- 75% of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs during the measurement period to final labs during the measurement period.

Most Recent Viral Load Undetectable

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Medical Case Management (including treatment adherence) services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

16. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

17. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

18. Appendices

Not Applicable.