



Medical Case Management (Including Treatment Adherence Services) Service Standard

Texas Department of State Health Services, HIV Care Services Group — [HIV/STD Program](#)

Subcategories	Service Units
Intake—Medical Case Management	Per 15 minutes
Medical Case Management (Including Treatment Adherence Services)	Per 15 minutes
Medical Case Management Recertification	Per 15 minutes
Plan Reevaluation	Per 15 minutes
Service Coordination and Medical Follow-up	Per 15 minutes
Treatment Adherence Counseling	Per 15 minutes

Health Resources and Services Administration (HRSA) Description:

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided 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, and any other forms of communication).

In addition to providing the medically oriented activities 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, the Texas State Pharmacy Assistance Program, 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 the objective of improving health care outcomes, whereas Non-Medical Case Management services (NMCM) have the objective of providing guidance and assistance in improving access to needed services. Agencies should report client visits to ensure readiness for, and adherence to, complex HIV treatments as MCM or Outpatient/Ambulatory Health Services (OAHS). Agencies should report treatment adherence services provided during a MCM visit in the MCM service category and services provided during an OAHS visit under the OAHS service category.

Clients may be enrolled in both MCM and NMCM simultaneously only in situations where the two services are required to meet all client needs. Agencies that provide both services should evaluate clients who are dually enrolled to ensure that simultaneous case management is necessary and does not constitute either a duplication of services or an undue burden on clients. Documentation in client charts should demonstrate that the services being provided are distinct and necessary.

Agencies should report referrals for health care and support services provided during a case management visit in the appropriate service category (i.e., MCM or NMCM). If a client who is enrolled in MCM receives referral services that are not provided during a case management visit or by the client's medical case manager, agencies should report these under Referral for Health Care and Support Services (RHCS), provided the service standards for RHCS are met. Recipients should take steps to ensure services are not billed in duplicate across different service categories.

Limitations:

Medical Case Management is a service based on need and is not appropriate or necessary for every client accessing services. MCM is designed to serve only individuals who have complex needs related to their ability to access and maintain HIV medical care. Agencies should not use MCM as the only access point for medical care and other agency services. Clients who do not need MCM services to access and maintain medical care should not be enrolled in MCM services. Agencies should graduate clients when they are able to maintain their medical care or have needs that can be adequately addressed under other support categories, such as NMCM or RHCS. However, some clients may have an ongoing need for MCM, due to

mental illness, behavioral or developmental disorders, or other issues that result in a continual need for assistance to improve or maintain health outcomes.

Services:

Core components of MCM services are:

1. **Coordination of Medical Care:** Scheduling appointments for treatments and referrals including labs, screenings, medical specialist appointments, mental health treatment, oral health care, and substance use treatment.
2. **Follow-up of Medical Treatments:** Includes accompanying clients to medical appointments; or calling, emailing, texting, or writing letters to clients with respect to various treatments to ensure appointments were kept or rescheduled as needed. Additionally, follow-up to ensure clients have appropriate documentation, transportation, and understanding of procedures.
3. **Treatment Adherence:** The provision of counseling or special programs to ensure adherence to HIV treatments to achieve and maintain viral suppression.

Key activities include:

- Initial assessment of case management 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 review of utilization of services

Universal Standards:

Service providers for Medical Case Management must follow [HRSA and DSHS Universal Standards](#) 1-63 and 120-134.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
<p>Initial Comprehensive Assessment: Case managers must complete the initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services. The assessment must include, at a minimum:</p> <ul style="list-style-type: none">• Client health history, health status, and health-related needs• Substance use disorder screen, using a valid and reliable tool• Mental health screen, using a valid and reliable tool• Risk assessment• Medication adherence screening• Client strengths and resources• Other agencies that serve the client and their household• Progress notes from assessment session(s) <p>Screening tools for substance use, mental health, risk assessment, and medication adherence can be found on the Texas DSHS Case Management website.</p> <p>Case management staff should re-administer screening tools, such as a substance use disorder screen or a mental health screen, if there is concern about changes to the client's status. If the client exits and then re-enters MCM, the case manager should complete the comprehensive assessment again in its entirety. Otherwise, the comprehensive assessment is only required at the time of entry to services, and not annually thereafter.</p>	<ol style="list-style-type: none">1. Percentage of clients that have a completed initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services. The assessment must include:<ol style="list-style-type: none">1a: Valid and reliable substance use disorder screening1b: Valid and reliable mental health screening1c: Risk assessment1d: Medication adherence screening tool

<p>Acuity Level and Client Contact: Case managers should assess client acuity using an approved acuity scoring tool at the time of the initial comprehensive assessment.</p> <p>Staff should review acuity levels every 3 months at a minimum, to ensure the acuity is still appropriate for the client's needs. Case managers should document the review even if no change is made to the client's acuity. Each interaction with a client has the potential to change acuity scores in specific categories, and staff should document any changes in a client's acuity. The frequency of contact between case management staff and the client should be appropriate for the client's level of acuity.</p> <p>Staff providing MCM services have the discretion to determine whether a client needs a higher frequency of contact or to remain in MCM services despite a low score on the acuity tool. The case management staff should document any additional information that is relevant to their assessment of the client's true acuity, such as additional needs not captured by the tool.</p>	<ol style="list-style-type: none"> 2. Percentage of clients with an acuity assessment that includes: <ol style="list-style-type: none"> 2a. Acuity level assessed using an approved acuity tool at the time of initial comprehensive assessment 2b. Acuity level reviewed every 3 months, at a minimum, using an approved acuity tool 2c. Frequency of contact by staff matches current acuity level
<p>Care Planning: The client and the staff providing MCM services will actively work together to develop and implement the medical case management care plan. Care plans must include at a minimum:</p> <ul style="list-style-type: none"> • Problem statement based on the client's need • One to three current goals • Interventions (such as tasks, referrals, or service deliveries) • Individuals responsible for the activity (such as the staff providing MCM services, the client, other team members, the client's family, or another support person) 	<ol style="list-style-type: none"> 3. Percentage of clients with a care plan that contains all of the following: <ol style="list-style-type: none"> 3a: Problem statement or need 3b: Goal(s) 3c: Intervention (tasks, referral, service delivery) 3d: Responsible party for the activity 3e: Timeframe for completion 4. Percentage of clients with care plans that have been updated at least every 6 months.

<ul style="list-style-type: none"> • Anticipated time for the completion of each intervention <p>Regular case notes should describe the progress toward meeting care plan goals. Case managers should update the plan with outcomes of interventions and revise or amend the plan in response to changes in the client’s life circumstances or goals. Staff should update tasks, referrals, and services as they are identified or completed, and not at set intervals.</p> <p>Case managers must update care plans at least every 6 months, with documentation that all required elements (problem statement, goals, interventions, responsible party, and timeframe) have been reviewed and, if appropriate, revised.</p>	<p>5. Percentage of client records with case notes that document the progress towards meeting goal(s) identified in the care plan.</p>
<p>Education: MCM staff should provide education to clients to ensure an understanding of key areas of health and HIV treatment. Education is an ongoing process that case managers should begin at the initiation of MCM services and repeat at least annually. Staff should ensure the education is appropriate to the client’s age, level of education, and existing knowledge and health literacy. Education must include the following:</p> <ul style="list-style-type: none"> • The HIV disease process • Medication adherence and the goals of antiretroviral therapy • Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable • Nutrition • Oral health 	<p>6. Percentage of clients with documentation of education provided, to include the following:</p> <p>6a: The HIV disease process</p> <p>6b: Medication adherence and goals of antiretroviral therapy</p> <p>6c: Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable</p> <p>6d: Nutrition</p> <p>6e: Oral health</p>

<p>Viral Suppression and Treatment Adherence: An assessment of treatment adherence support needs and client education should begin as soon as the client accesses MCM services and should continue until the client is discharged from MCM services. Services should involve an individually tailored adherence intervention program, and staff providing MCM should continuously reinforce the importance of treatment adherence.</p> <p>If clients miss appointments for medical care, case managers should contact clients to follow up. Staff should discuss barriers to appointment attendance and collaborate with clients to address these barriers.</p> <p>Staff should address the following as part of a comprehensive treatment adherence program:</p> <ul style="list-style-type: none"> • The client’s current level of medication and treatment adherence. • Attendance at appointments for core medical services and understanding of the importance of regular attendance at medical and non-medical appointments. • Potential adverse side effects associated with HIV treatment, and the impact on functioning and adherence. • Knowledge of HIV medications, their role in achieving positive health outcomes, and techniques to manage side effects. • Client relationships with family, friends, or community support systems, which may either promote or hinder client adherence to treatment protocols. 	<ol style="list-style-type: none"> 7. Percentage of clients who were provided treatment counseling, as indicated. 8. Percentage of charts with documentation of follow-up after any missed medical appointments, including identified barriers to appointment attendance and efforts to address barriers.
---	---

<p>Referral and Follow-Up: Staff providing MCM services will work with the client to determine barriers to referrals and facilitate access to referrals. When a client presents with a need for referral, case management staff will initiate the referral within three business days.</p> <p>When clients are referred for services elsewhere, case notes should include documentation of whether the appointment was attended and the outcome of the referral. For clients who decline a referral, the case notes should also document this declination. The care plan may address challenges to completing the referral and any case management interventions.</p>	<ol style="list-style-type: none"> 9. Percentage of clients with documentation that referrals were initiated within three business days of an identified need. 10. Percentage of clients with referrals that have documentation of follow-up to the referral, including appointment attended and the result of the referral.
<p>Case Closure and Graduation: Clients who are no longer engaged in active medical case management services should have their cases closed with a case closure summary documented in the client's chart. This should include both a brief narrative progress note and a formal case closure and graduation summary. The case management supervisor should review and sign all closed cases.</p> <p>Staff must notify clients of plans for case closure and provide written documentation explaining the reason for closure or graduation and the process to be followed if the client elects to appeal the case closure or graduation from service. At the time of case closure, case management staff should also provide clients with contact information including the process for re-establishment of MCM services.</p> <p>A client is "out of care" if three attempts to contact the client (via phone, e-mail, or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter), as</p>	<ol style="list-style-type: none"> 11. Percentage of closed cases with discharge documentation including: <ol style="list-style-type: none"> 11a. Formal case closure or graduation summary that documents the reason for case closure. 11b. Supervisor signature and approval. 11c. Client notification, including the provision of written documentation explaining the reason for case closure or graduation. 11d. Client was given information on appealing case closure and the process to re-establish MCM in the future.

<p>permitted by client authorization when trying to re-engage a client. Case closure proceedings should be initiated by the agency 30 days following the third attempt at contact.</p> <p>Common reasons for case closure include:</p> <ul style="list-style-type: none"> • Client is referred to another medical case management program • Client relocates outside of the service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client does not engage in service despite at least three attempts to engage client within a 30 consecutive day time period. • Client is or will be incarcerated for more than 6 months in a correctional facility • Provider initiated termination due to behavioral violations, per agency's policy and procedures • Client's death <p>Graduation criteria:</p> <ul style="list-style-type: none"> • Client completed medical case management goals • Client is no longer in need of medical case management services 	
--	--

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). [Ryan White HIV/AIDS Program \(RWHAP\) National Monitoring Standards for RWHAP Part A Recipients](#). Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). [Ryan White HIV/AIDS Program \(RWHAP\) National Monitoring Standards for RWHAP Part B Recipients](#). Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. [Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds](#). Health Resources & Services Administration, October 22, 2018.