Medical Case Management (Including Treatment Adherence Services) Service Standard

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, 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 (NMCM) 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 MCM or Outpatient/Ambulatory Health Services (OAHS). Treatment adherence services provided during an MCM visit should be reported in the MCM service category whereas treatment adherence services provided during an OAHS visit should be reported under the OAHS category.

Referrals for health care and support services provided during a case management visit (medical and nonmedical) should be reported in the appropriate case management 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, these services can be reported 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 only serve individuals who have complex needs related to their ability to access and maintain HIV medical care. MCM should not be used 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. Clients should be graduated 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.

Clients can only receive one category of case management service (MCM or NMCM) at one time. However, clients that were previously enrolled in MCM can be discharged and enrolled in NMCM services if they experience a decline in acuity.

Services:

Staff providing MCM services act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan and assisting in the coordination and follow-up of the client's medical care between multiple providers. The goals of this service are 1) the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the staff providing Medical Case Management services; 2) to address needs for concrete services such as health care, public benefits and assistance, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system; and 3) client-specific advocacy and/or review of utilization of services provided and needed by the client.

Core components of MCM services are:

1. **Coordination of Medical Care:** Scheduling appointments for various treatments and referrals including labs, screenings, medical specialist appointments, mental health, oral health care, and substance use treatment.
2. **Follow-up of Medical Treatments:** Includes either accompanying clients to medical appointments, 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 also includes ensuring clients have appropriate documentation, transportation, and understanding of procedures. MCM staff must also encourage and enable open dialogue with medical healthcare professionals.
3. **Treatment Adherence:** The provision of counseling or special programs to ensure readiness for, and adherence to, HIV treatments, in order 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/or review of utilization of services

Universal Standards:

Service providers for Medical Case Management must follow HRSA/DSHS Universal Standards 1-46 and 104-119.

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.

<table>
<tr><th>Standard</th><th>Measure</th></tr>
<tr><td>Initial Comprehensive Assessment: The initial comprehensive assessment must be completed within 30 calendar days of the first appointment to access MCM services and must include, at a minimum:
Client health history, health status, and health-related needs
Substance use disorder screen, using a valid and reliable tool such as SAMISS
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)
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 comprehensive assessment should be completed again in its entirety. Otherwise, the comprehensive assessment is only required to be completed at the time of entry to services, and not annually thereafter.</td><td>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:
1a: Valid and reliable substance use disorder screening, such as SAMISS
1b: Valid and reliable mental health screening
1c: Risk assessment
1d: Medication adherence screening tool</td></tr>
<tr><td>Acuity Level and Client Contact: Clients should have an</td><td>2. Percentage of clients who had their acuity level</td></tr>
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acuity level assessed using an approved acuity scoring tool at the time of the initial comprehensive assessment. Acuity levels should be reviewed every 3 months at a minimum, to ensure the acuity is still appropriate for the client's needs. The review should be documented 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 any changes in a client's acuity should be documented. The frequency of contact between case management staff and the client should be appropriate for the client's level of acuity. 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 or high concern for the client falling out of care.	assessed using an approved acuity tool at the time of the initial comprehensive assessment. 3. Percentage of clients whose acuity level was reviewed every 3 months, at a minimum, using an approved acuity tool. 4. Percentage of clients whose frequency of contact by staff matches their current acuity level.
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: • 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)	5. Percentage of clients with a care plan that contains all of the following: 5a: Problem statement/need 5b: Goal(s) 5c: Intervention (tasks, referral, service delivery) 5d: Responsible party for the activity 5e: Timeframe for completion 6. Percentage of clients with care plans that have been updated at least every 6 months. 7. Percentage of client records with case notes that document the progress towards meeting goal(s)

• Anticipated time for the completion of each intervention Regular case notes should describe the progress toward meeting care plan goals. The care plan should be updated with outcomes of interventions and revised or amended in response to changes in the client's life circumstances or goals. Tasks, referrals, and services should be updated as they are identified or completed, and not at set intervals. Care plans must be updated at least every 6 months, with documentation that all required elements (problem statement/need, goals, interventions, responsible party, and timeframe) have been reviewed and, if appropriate, revised.	identified in the care plan.
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 should begin at the initiation of MCM services and should be repeated at least annually. The education provided should be appropriate to the client's age, level of education, and existing knowledge and health literacy. Clients should be given education on the following: • 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	8. Percentage of clients with documentation of education provided, to include the following: 8a: The HIV disease process 8b: Medication adherence and goals of antiretroviral therapy 8c: Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable 8d: Nutrition 8e: Oral health
Viral Suppression/Treatment Adherence: An assessment of treatment adherence support needs and client	9. Percentage of clients who were provided treatment counseling, as indicated.

education should begin as soon as the client accesses MCM services and should continue as long as the client continues to access MCM services. Services should involve an individually tailored adherence intervention program, and staff providing MCM should continuously reinforce the importance of treatment adherence. The following areas should be addressed as part of a comprehensive treatment adherence program: • 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, and/or community support systems, which may either promote or hinder client adherence to treatment protocols.	10. Percentage of clients who did not have a medical visit in the last 6 months of the measurement year, according to the documentation in the medical case management record. *(HRSA HAB measure – DSHS language clarification)* 11. Percentage of clients who had at least one medical visit in each 6-month period of the 24-month measurement period, with a minimum of 60 days between medical visits. *(HRSA HAB measure – DSHS language clarification)* 12. Percentage of clients with an HIV viral load less than 200 copies/mL at the last test during the measurement year. *(HRSA HAB measure – DSHS language clarification)*
Referral and Follow-Up: Staff providing MCM services will work with the client to determine barriers to referrals and facilitate access to referrals. 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	13. Percentage of clients with documentation that referrals were initiated immediately. 14. Percentage of clients with documentation that referrals were declined by the client, as applicable. 15. Percentage of clients with referrals that have documentation of follow-up to the referral, including appointment attended and the result of the referral.

this declination. The care plan may address challenges to completing the referral and any interventions conducted by the case management team.	
Case Closure/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/graduation summary. All closed cases should be reviewed and signed by the case management supervisor. Clients must be notified of plans for case closure and provided written documentation explaining the reason for closure/graduation and the process to be followed if the client elects to appeal the case closure/graduation from service. At the time of case closure, clients should also be provided with contact information to reestablish MCM services and information on the process for re-establishment. A client is considered to be "out of care" if three attempts to contact the client (via phone, e-mail, and/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 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. Common reasons for case closure include: • Client is referred to another medical case management program • Client relocates outside of the service area	16. Percentage of closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary). 17. Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). 18. Percentage of clients that are notified (through face-to-face meeting, telephone conversation, or letter) of plans for MCM case closure. 19. Percentage of clients with written documentation provided to the client explaining the reason(s) for case closure/graduation and the process to be followed if the client elects to appeal the case closure/graduation from service. 20. Percentage of clients who are provided with contact information and the process for re-establishment in MCM at the time of case closure.

• Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client is/will be incarcerated for more than 6 months in a correctional facility • Provider initiated termination due to behavioral violations, per agency's policy and/or procedures • Client's death Graduation criteria: • Client completed medical case management goals • Client is no longer in need of medical case management services • Client needs are able to be addressed through non-medical case management and the client has been referred to these services Note: Staff should not inactivate clients in Take Charge Texas (TCT) at the time of case closure or graduation, unless the case is being closed due to a deceased client.	

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 2022.

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 2022.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.