MEDICAL CASE MANAGEMENT

(Approved by Planning Council 7/27/15)

I. DEFINITION/ OVERVIEW

Medical Case Management provides a range of client–centered services linking clients with health care, psychosocial, and other services that improve overall health. An essential component of Medical Case Management includes the coordination and follow-up of medical treatment, as well as treatment adherence counseling. The primary goal of Medical Case Management is to work with the primary care provider to assist a client to maintain and improve health status, which is reflected in a client's health indicators (CD4, viral load, acuity). Client empowerment and monitoring of service utilization (including medical appointment adherence) and health indicators are crucial elements of the service.

Enrollment in Medical Case Management may not be permanent; a client's level of need may change over time and require a different level of service to fit their present circumstances. Ongoing and frequent assessment by a medical case manager and a medical case management supervisor should occur to ensure clients receive the appropriate level of care. Routine assessment tools and acuity scales must be used consistently by all Medical Case Management providers, as mandated by the Office of Health Policy (OHP). [Copies of tools can be obtained from OHP.]

Case management providers should implement a consistent method of assigning caseloads based on the unique composition of PLWHA within the EMA. A caseload of 1:35 clients is considered optimal but other factors may impede this goal. Limiting caseloads below 60 is encouraged.

II. SERVICES

Key activities include: (1) completion of comprehensive assessment of service needs, (2) development of a comprehensive, individualized care plan, (3) coordination of services required to implement the plan (service linkage), (4) client monitoring to assess the efficacy of the plan, and (5) periodic re–evaluation and adaptation of the plan as necessary over the duration of the client's case (reassessment), (6) case closure or transfer as appropriate. Activities should also include multi-disciplinary care coordination and client-specific advocacy. Medical case managers are expected to review health status indicators, service utilization, and treatment adherence.

Medical case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the Medical Case Management service provider.

III. ELIGIBILITY

Eligibility for medical case management services is explained under the Universal Standards for All Ryan White Part A Services Eligibility section.

Criteria for case assignment to Medical Case Management is based on a variety of factors (including but not limited to: acuity scores, poor health status as demonstrated by high viral load or low CD4 counts, acute opportunistic infection, or multiple needs). Assignment to Medical Case

Management is determined by the criteria established by the Office of Health Policy (OHP). [A copy of the policy can be obtained from OHP.]

IV. SECTIONS

Note: Universal Standards apply to all service categories. This additional service specific standard contains the following sections:

→ Personnel	→ Assessment/Reassessment	→ Ongoing Assessments	→ Discharge/Transition
→ Enrollment in Part A Services	→ Individual Care Plan	→ General Standards	

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualifications**	
1.11	**Minimum qualifications**. All medical case managers will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are: • A currently licensed social worker (RSW, CSW, LMSW, LCSW) from a program accredited by the Council on Social Work Education; OR • A currently licensed nurse (RN or LPN) in Louisiana; OR • A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation; AND one (1) year of post-degree experience in direct service to HIV target population; OR • A bachelor's in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in item C of this part; AND one (1) year of post-degree experience in direct service to HIV target population.	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.12	**Minimum supervisory qualifications**: A medical case management supervisor must meet the *minimum* qualifications for education and experience listed below: A. A currently licensed social worker (RSW, CSW, LMSW, LCSW) from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing case management services; OR	Personnel files/resumes/applications for employment reflect requisite experience and education.

#	Standard	Measure
	B. A currently licensed nurse (RN or LPN) in Louisiana and two (2) years of paid post degree experience in providing case management services; OR C. A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two (2) years of paid post degree experience in providing case management services; OR D. A bachelor's in liberal arts or general studies with concentration of at least 16 hours in one of the fields listed above and two (2) years of paid post degree experience in providing case management services.	
1.2	**Supervision**	
1.21	**Minimum components of medical case management supervision**. A. Each Medical Case Management service provider must have and implement a written plan for supervision of all medical case management staff. B. Supervisors must review a 10 percent sample of each medical case manager's case records each quarter for compliance with these standards, and quality and timeliness of service delivery with special attention to Comprehensive assessments, Reassessments, Care Plans, tracking of appointments and health outcomes, transition planning and timely referral completion. Areas for improvement should be notated and shared with the medical case manager. C. Medical case managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	A. Service provider has written plan for supervision of all medical case management staff. B. Service provider will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews; the file contains medical case manager signature indicating notification of areas for improvement. C. Personnel files contain annual performance evaluations.
1.22	Each supervisor must maintain a file on each medical case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the medical case manager must include, at a minimum: • Date, and content of the supervisory sessions • Results of the supervisory case review addressing, at a minimum, completeness and	a. Documentation of supervision provided b. Supervisors' files on each medical case manager reflect ongoing supervision, supervisory sessions and case review as described above.

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	accuracy of records, compliance with standards and effectiveness of service.	
1.23	Service provider must maintain linkage with a medical provider (nurse, nurse equivalent, or higher) to provide consultation for medically complex client cases. Agencies are preferred to employ or contract with a nurse.	Service provider must maintain a written consultation plan indicating the method by which routine consultation by a medical provider (nurse, nurse equivalent, or higher) takes place. The written plan should specify the purpose of consultation, the required frequency of consultation, and the minimum essential components of consultation. All consultative sessions should be documented in the client record. Evidence of job description and/or contract with a Louisiana registered nurse with a bachelor's degree in nursing, with experience in HIV and one year of paid experience as a registered nurse in a public health or human service field. Also, a written consultation plan shall be kept on file outlining how nurse will help develop comprehensive care plans for medically complex individuals, as well as offer trainings for medical case managers and general staff.
1.3	**Orientation – See Universal Standards for Tier X Staff**	
1.4	**Training – See Universal Standards for Tier X Staff**	
2.0	**ENROLLMENT IN PART A SERVICES**	
2.1	**The objectives of the enrollment process are to:** ➢ Inform the client of: • all Ryan White Part A funded services available AND • all Ryan White Part A funded medical case management agencies in the New Orleans EMA AND	N/A

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	• what client can expect if s/he enrolls in medical case management services; ➢ Establish and/or verify client eligibility for services; ➢ Collect required state/federal client data for reporting purposes; and ➢ Complete a full Client Eligibility Review and Verification Form (CERV).	
2.2	All funded Medical Case Management agencies must be able to: ➢ Provide enrollment on a walk-in basis; ➢ Schedule an appointment at the client's convenience; ➢ Refer the client to another agency in the event of a waiting list or any capacity constraints prohibiting an agency from serving a client immediately.	Service Provider policy and procedures reflect the availability of walk-in services. Documented referral kept on file at the agency.
2.3	The presentation to the client of information regarding the Ryan White Part A service delivery system will include: A. Confidentiality, release of information, and HIPAA privacy notification as appropriate B. Statement of Consumer Rights and Responsibilities C. Service Provider grievance/complaint procedures	Documented in client's file.
2.4	Financial resources and insurance status shall be documented for all clients and payment shall be sought from any and all third party payers before using Ryan White Part A funds. Documentation of a discussion with each client regarding various options for payment shall be noted in client charts.	A. Documented CERV on file with client signature verifying discussion regarding application for Medicaid/SSI or other benefits resources and will document the dates of these activities. B. A supervisory review will assure that medical case managers are discussing options for alternative payment with each client on a quarterly basis.
3.0	**ASSESSMENT/REASSESSMENT**	
3.1	**The objectives of the assessment/reassessment process are to:** ➢ Establish whether client demonstrates need to enroll in medical case management services offered by the provider agency; ➢ Gather, on an on-going basis, appropriate client information in order to determine client	N/A

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	needs; and ➢ Reassess eligibility verification at least every six (6) months or as required by change in client status, utilizing assessment tools as mandated by OHP. ➢ Conduct a comprehensive reassessment at least annually and to re-inform the client of: • all Ryan White Part A funded services available, AND • all Ryan White Part A funded medical case management agencies in the New Orleans EMA. • Client Rights and Responsibilities and Agency Grievance Policy	
3.2	**Initial Assessment** Within three (3) working days of enrollment, a comprehensive assessment of needs shall be completed to evaluate the client's needs, including, but not limited to the following: • Medical history and current health/primary care status • Available support systems • Substance abuse history and status • Emotional/mental health history and status • Available financial resources (including insurance status) with emphasis on securing 3rd-party insurance coverage, public benefits, and other resources. • Availability of food, shelter, and transportation • Need for legal assistance	Documented in client's file.
3.3	After completion of an initial comprehensive assessment of the client, results shall be reviewed and analyzed by a medical case management supervisor and/or multi-disciplinary team to determine appropriate level of case management services. Clients who are newly diagnosed or new to HIV care should be assigned to medical case management, unless justifiable documented circumstances dictate otherwise.	Client chart contains documentation of review by supervisor or multi-disciplinary team.
3.4	A medical case manager will be assigned within ten (10) working days of completion of enrollment. Immediate needs of eligible clients will be addressed appropriately with the available resources, within one business day of enrollment into services.	All contacts and attempted contacts must be documented in client's file.
3.5	Providers must demonstrate adequate linkages with Ryan White and non-Ryan White agencies to ensure timely coordination and referral to services to meet the client's needs.	Documented by memorandum of understanding and provider policies
4.0	**INDIVIDUAL CARE PLAN**	

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4.1	**The objectives of the Individual Care Plan (ICP) process are to:** ➢ Create an action plan to support improved client health and wellbeing made up of goals and measurable objectives prepared with the participation of the client. ➢ Utilize information gathered during comprehensive assessments of clients in order to develop goals and objectives supporting client empowerment, self-efficacy and improvement in health outcomes. ➢ Utilize assessment tools to monitor and reevaluate the individual care plan. ➢ Review and revise the care plan in a way that supports the client's progress in achieving health-related goals.	N/A
4.2	An individual care plan, and any other assessment tools as required by OHP, will be completed within thirty (30) days following assignment to a medical case manager.	Documented in client's file.
4.3	The Individual Care Plan (ICP) will be a written, comprehensive plan consisting of goals and measurable objectives. The ICP must be prepared with client participation with the primary objective to achieve HIV treatment adherence. The ICP should be holistic in nature, identify barriers to overall wellbeing and stabilization and seek to resolve identified barriers (i.e., housing, substance abuse, self-efficacy etc.) Plans should include: A. Description of identified barriers • Resources available to meet each need • Nature and level of service need • Time frames within which services are to be provided • Who will provide the services • Short and long term goals for resolving each barrier • Documentation of outcomes for each goal	➢ Documentation shall include client's medically focused wellness needs and attempts to address identified barriers (including timeframe and names of providers involved). ➢ Implementation of the individual care plan will be documented through: i. Periodic follow-up and progress notes on each need identified ii. Periodic follow-up with each provider iii. Contact with client every 30-60 days depending on client's level of need, and in connection with monitoring client's progress, including revising of care plan iv. Re-evaluate and develop, as needed, new care plan every 6 months, which will be signed and dated by medical case manager.
5.0	**ONGOING ASSESSMENTS**	

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5.1	**The objectives of ongoing assessments are to:** ➢ Assist case managers in tracking client health outcomes and medical treatment adherence by utilizing tools to both inform development of and monitor progress of individual care plans. ➢ Determine the client's acuity level as needed. ➢ Track client health outcomes and medical appointment attendance.	N/A
5.2	Medical case managers will utilize tools as mandated by OHP to track client status. When appropriate, information collected from ongoing assessments should be reflected in updates to individual care plans.	Documented in client's file.
6.0	**GENERAL STANDARDS**	
6.1	Each service provider providing medical case management services shall have an outreach program and/or working linkages in place designed to reach the population eligible for services and to target individuals with HIV/AIDS requiring multiple interventions, such as disproportionately affected and emerging populations.	• Written outreach plan and publicity/educational materials with evidence/record of distribution in targeted areas such as points of entry into the continuum of care (i.e., substance abuse services, homeless shelters); or • Linkage agreements and documented referrals from linked Service Providers.
6.2	Face to face contact will be made and repeated at least quarterly; home visits are preferable, if client permits.	Documented in client's file.
6.3	Contact with client attempted every 30-60 days depending on level of need.	Documented in client's file.
6.4	Medical Case Managers will refer clients for necessary services within 10 business days. Medical Case Managers will follow-up on the outcomes of referrals made.	Documented in client's file.
6.5	Medical Case Manager will review documentation of monitoring client's current immunological parameters (for example, CD4 count, and HIV viral load) and appointment adherence at least quarterly.	Documentation of review of current immunological data in client's file

#	Standard	Measure
6.6	A **full-time Medical Case Manager** may manage a maximum caseload of 60 clients.	Job descriptions reflect maximum caseloads as described above.
6.7	A **Medical Case Management Supervisor** may supervise eight (8) full-time medical case managers or a combination of full-time medical case managers and other professional-level human services staff.	Caseloads are monitored to ensure that the maximum allowable standard is not exceeded.
6.8	In the event a funded agency is unable to adequately communicate in the client's preferred language, it is then the agency's responsibility to refer the client to an agency with the appropriate language capacity. If no such agency exists, interpretative services will be provided at no cost to the client.	Service Provider maintains updated documentation of staff's language capabilities, including the names and job titles of the specific staff with those skills. A list will be provided to OHP and updated as needed.
7.0	**DISCHARGE/TRANSITION**	
7.1	**The objectives of discharge/transition are to:** ➢ Ensure a smooth transition for a client no longer needing Medical Case Management services at the provider agency; ➢ Accurately track and document clients receiving case management services; and ➢ Assist service providers to appropriately monitor caseload.	N/A
7.2	A client may be discharged from medical case management services through a systematic process that includes a discharge/case closure summary in the client's record. Discharge/case closure summary will include a reason for the discharge and a transition plan to other services or other service provider. If client does not agree with the reason for discharge, s/he should be informed of the service provider's grievance procedure. A client may be discharged from case management services for the following reasons: a. if client no longer meets Ryan White eligibility standards; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency personnel or other clients at risk; d. if client moves out of the service area; if possible an attempt should be made to connect client to services in the new service area; e. if after repeated and documented attempts, a medical case manager is unable to reach a client for a minimum of three (3) months and maximum of six (6) months. Ideally case managers should check in with their clients every 30-60 days depending on need. After a maximum of six (6) months, the program should discharge client from medical case	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)

#	Standard	Measure
	management services or transfer a client as appropriate; f. death	
7.3	In all cases, medical case managers shall ensure that, to the greatest extent possible, clients who leave Medical Case Management are linked with appropriate services to meet their needs and are prepared for the transition. In the case a client changes agencies based on a recommendation in the best interest of their health, a medical case manager should inform the client of any changes in medication delivery/access and insurance coverage they may expect.	Documentation in client's record indicating referrals or transition plan to Non-medical Case Management or other service provider(s).