

Standards of Care

MARCH 2011



Medical Case Management

STANDARDS OF CARE

The purpose of the Ryan White Part A Standards of Care and performance measures is to ensure that a uniformity of service exists in the Las Vegas Transitional Grant Area (TGA) as such that the consumers of services receive the same quality of service regardless of where the service is rendered. These standards align with current Public Health Services (PHS) Guidelines and the Health Resources and Services Administration's standards and performance measures for service delivery to ensure the highest quality of service.

APPLICATION OF STANDARDS

These standards apply to any agency receiving Part A funds to provide services as contracted for that time period. If any agency is unable to meet a particular standard, the agency must document why the standard was unable to be met and explain the steps underway to meet the standards. All standards and measures will be reviewed by Part A Grantee staff annually as designated.

I. Definition of Service

Health Resources and Services Administration (HRSA)

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 are 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, telephone, and any other forms of communication.

II. Goals of Service

To enhance independence, self sufficiency and increase quality of life for individuals living with HIV/AIDS through actively assisting clients in reducing barriers to care while promoting adherence to medical care and facilitating access to community support services to further enhance and sustain the clients overall health.

III. Service Objectives

- 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.

- 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.

IV. Levels of Medical Case Management

Three levels of case management have been developed within the Medical Case Management service category; Intensive Medical Case Management-Medical and Intensive Medical Case Management-Social and Medical Case Management. Basic non-Medical Case Management falls within its own service category and consequently has its own standard of care.

The levels are distinguished as follows:

Intensive Medical Case Management-Medical (Nursing)	Intensive Medical Case Management-Social (Social Work)
<p>Intensive Medical Case Management is to be provided by a Master's/Bachelor's level Registered Nurse (RN) or RN with a minimum of 2 years of case management experience and should be provided for a period not to exceed six months. Clients must fall within one or more of the following categories to receive Intensive Medical Case Management services:</p> <ol style="list-style-type: none"> 1. High Acuity clients-31 points or higher on the approved Ryan White Part A Client Acuity Scale scoring in Life Area #2 and/or #3 in the areas of Medical Needs, Educational Issues, or Adherence History. 2. Client must be a new diagnosis (< 1 year) entering the care system or re-entering the care system after being out of care (no medical visits with a provider with prescribing privileges for 12 months or more). 3. Client must be pregnant (in this case Intensive Medical Case Management Services may exceed six months). 4. Client must be 18 years old or younger (in this case Intensive Medical Case Management Services may exceed six months). <p>Once the client is considered medically stable they should be transitioned into the appropriate level of case management based upon their acuity score and overall assessment or referred to an outside source if they qualify. Clients found to be in need of Intensive Medical Case Management for longer than a six month period are subject to all reassessment provisions as found in the reassessment section.</p> <p>Episodic clients not in need of re-admittance to the Intensive Medical Case Management Program should receive minimal immediate assistance in addition to a</p>	<p>Moderate Medical Case Management must be provided by a professional with a Master's/Bachelor's level education in a Human Services field or a Master's/Bachelors level education in a non-Human Services field with a minimum of two years Case Management experience. Moderate Medical Case Management has no definite time constraints. However, clients should be encouraged and educated on how to self-manage their HIV/AIDS care to ultimately transition into self-managed care. Clients must fall within one or more of the following categories to receive Moderate Medical Case Management:</p> <ol style="list-style-type: none"> 1. Moderate Acuity clients-16 to 30 points on the approved Ryan White Part A Client Acuity Scale scoring in Life Area #2 and/or #3 in the categories of Cultural Issues, Educational Issues, Social Support/Family Issues, or Finances. 2. Homeless clients 3. Problematic substance use/abuse (observed or reported) 4. Problematic mental health issues (observed or reported) 5. Perceived/acknowledged difficulty navigating the service system(s). 6. No Nevada Identification 7. Frequent EFA (Emergency Financial Assistance) requests (more than 2 in 6 months) 8. Pregnant women 9. Single parent 10. In hospital/other institution 11. Unstable CD-4 and/or viral load. 12. Client is referred from Intensive Medical Case Management and is transitioning to a Moderate Case Management level 13. Client is referred from non-Medical Case Management and is in need of Moderate Case Management services

referral to the appropriate party/agency to contact for future assistance.

14. Client is a new diagnosis (< 1 year) entering the care system or re-entering the care system after being out of care (no medical visits with a provider with prescribing privileges for 12 months or more) and doesn't require Intensive Medical Case Management services.

Medical Case Management

Medical Case Management should be provided to those clients with an acuity score of 15 or less needing follow-up or assistance with their Medical Care needs. If the client is medically stable they should be referred to non-Medical Case Management.

V. 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.

1. Agency Compliance Measures

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.

2. Client Level Outcome Measures

The Client Level Outcome Measures are a reflection of our client's progress as they access Medical Case Management services. The following Client Level Outcome Measures will be assessed annually according to the client's level of case management, they are as follows with their respective percentage goals:

Intensive Medical Case Management-Medical	Intensive Medical Case Management-Social
<p>In Medical Care</p> <ul style="list-style-type: none"> ○ 75% of clients that are in medical care (at least one medical visit per measurement period). <p>Maintained Adherence to Medical Care (HRSA HAB Measure)</p> <ul style="list-style-type: none"> ○ 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). 	<p>In Medical Care</p> <ul style="list-style-type: none"> ○ 75% of clients that are in medical care (at least one medical visit per measurement period). <p>Maintained Adherence to Medical Care (HRSA HAB Measure)</p> <ul style="list-style-type: none"> ○ 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).

<p>Stabilized CD4</p> <ul style="list-style-type: none"> ○ 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. <p>Most Recent CD4 Stable</p> <ul style="list-style-type: none"> ○ 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable ($CD4 \geq 200$). <p>Undetectable Viral Load</p> <ul style="list-style-type: none"> ○ 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.) <p>Most Recent Viral Load Undetectable</p> <ul style="list-style-type: none"> ○ 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.) <p>Decreased Client Acuity</p> <ul style="list-style-type: none"> ○ 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. 	<p>Stabilized CD4</p> <ul style="list-style-type: none"> ○ 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. <p>Most Recent CD4 Stable</p> <ul style="list-style-type: none"> ○ 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable ($CD4 \geq 200$). <p>Undetectable Viral Load</p> <ul style="list-style-type: none"> ○ 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. <p>Most Recent Viral Load Undetectable</p> <ul style="list-style-type: none"> ○ 50% of clients with at least one viral load within the measurement year will be considered undetectable (< 50). <p>Decreased Client Acuity</p> <ul style="list-style-type: none"> ○ 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. <p>Medication Adherence</p> <ul style="list-style-type: none"> ○ 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.
---	---

Medical Case Management

<p>In Medical Care</p> <ul style="list-style-type: none"> ○ 75% of clients that are in medical care (at least one medical visit per measurement period). <p>Maintained Adherence to Medical Care (HRSA HAB Measure)</p> <ul style="list-style-type: none"> ○ 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). <p>Stabilized CD4</p> <ul style="list-style-type: none"> ○ 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. <p>Most Recent CD4 Stable</p>
--

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

Undetectable Viral Load

75% of clients will have a viral load that remained undetectable or decreased to \leq 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.

3. Overall Program Performance Measures

Overall Program Performance Measures illustrate how accessible Medical Case Management services are in our TGA in addition to how they are perceived by the client for not only the HIV/AIDS population but the minority population as well. These measures and respective goals are as follows:

MAI Measure-Service Utilization among Minority Populations

- 75% of minority clients (excluding only non-Hispanic White Male clients age 25+) will access Medical Case Management Services at least once during the measurement period. (Minority AIDS Initiative Measure)

Received Medical Case Management Services

- 85% of clients who access medical care through Ryan White Part A will also access Medical Case Management services.

Increase Medical Case Management Service Utilization

- 75% of clients in the Ryan White Part A system of care will have at least one Medical Case Management service visit within the measurement period.

Client Satisfaction

- 75% of clients will report being very satisfied or satisfied with the services they received from community case managers and social workers for their HIV/AIDS status over the last 12 months.

Received the Care and Services Needed

- 65% of clients will report that their case manager helped them get the services they need.

Received Needed Referrals

- 65% of clients will report getting the referrals they were in need of.

Understanding Case Management Care Plan

- 65% of clients will report that their case manager helped them understand their case management care plan.

Improved Psychosocial Status

- 65% of clients will report that their case manager helped them improve the problems, feelings, or situations they discussed.

Importance of Medical Care

- 65% of clients will report that their case manager talked to them about their HIV medical care and the importance of keeping their doctors appointments.

Importance of Taking Medication as Prescribed

- 65% of clients will report that their case manager talked to them about their HIV medication and the importance of taking their medication as prescribed by their doctor.

VI. Service Standards

A. STAFFING REQUIREMENTS

1. Caseloads

Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently. Case loads should be established based upon intensity of needs of clients and program managers should conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties.

The following is provided as a guideline for appropriate case levels:

Intensive Medical Case Management-Medical Standards	Intensive Medical Case Management-Medical Agency Compliance Indicators
<ul style="list-style-type: none">✓ Case Load 20-30<ul style="list-style-type: none">• High-31 points or higher• Scoring in level 2 or 3	Assigned to a Case Manager <ul style="list-style-type: none">○ 100% of clients will be assigned to a Case Manager upon intake.
Intensive Medical Case Management-Social Standards	Intensive Medical Case Management-Social Agency Compliance Indicators
<ul style="list-style-type: none">✓ Case Load 30-60<ul style="list-style-type: none">• Moderate-16-30 points• Scoring in level 2 or 3	Assigned to a Case Manager <ul style="list-style-type: none">○ 100% of clients will be assigned to a Case Manager upon intake.
Medical Case Management Standards	Medical Case Management Agency Compliance Indicators
<ul style="list-style-type: none">✓ Case Load 81-100<ul style="list-style-type: none">• Low-15 points or less• Scoring in level 0-1	Assigned Case Manager <ul style="list-style-type: none">○ 100% of clients will be assigned to a Case Manager upon intake.

2. Case Manager Transition

Changes in client-Case Manager assignment should be minimized to maintain continuity of care. Clients should be able to see the same Case Manager over time as this arrangement develops trust. However, the program should also be willing to change client-Case Manager assignments if a client expresses his/her wishes to do so based on negative experience or lack of trust.

B. MEDICAL CASE MANAGEMENT SERVICE ACTIVITIES

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.

The following must be completed during the initial assessment or as indicated:

Intensive Medical Case Management-Medical Standards	Intensive Medical Case Management-Medical Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ A client registration form (either Part A or equivalent is acceptable) ✓ Client Acuity (copy of original is acceptable) ✓ Nurse Assessment-Medical History ✓ Individual Service Plan (ISP) Development 	<p>Initial Acuity</p> <ul style="list-style-type: none"> ○ 95% of clients entering Intensive Medical Case Management-Medical will have a client acuity performed and documented on intake or within their first three appointments. <p>Nursing Assessment</p> <ul style="list-style-type: none"> ○ 95% of clients entering Intensive Medical Case Management-Medical will have a client acuity performed and documented on intake or within their first three appointments. <p>Client Care Plan or Individual Service Plan</p> <ul style="list-style-type: none"> ○ 95% of clients entering Intensive Medical Case Management-Medical will have a client care plan or individual service plan performed and documented on intake or within their first three appointments.
Intensive Medical Case Management-Social Standards	Intensive Medical Case Management-Social Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ Ryan White Part A Client Registration Form <ul style="list-style-type: none"> ○ Case Management Screening Tool <ul style="list-style-type: none"> • HIV/AIDS Medical Appointment Adherence Screening • HIV/AIDS Medication Adherence Screening • HIV/AIDS Nutritional Assessment • CAGE Substance/Alcohol Screening • Evaluation of Mental Health Disorders Screening ✓ Client Acuity ✓ Individual Service Plan (ISP) Development 	<p>Complete Ryan White Part A Client Registration Form</p> <ul style="list-style-type: none"> ○ 100% of newly enrolled clients during the measurement period will have a Ryan White Part A Client Registration Form documented in the client chart on intake. <p>(The following seven indicators are round on the Medical Case Management Screening Tool)</p> <p>Medical Appointment Adherence Screening on Intake</p> <ul style="list-style-type: none"> ○ 85% of clients will have an HIV/AIDS Medical Appointment Adherence Screening documented on intake. <p>HIV/AIDS Medication Adherence Screening on Intake</p> <ul style="list-style-type: none"> ○ 85% of clients will have an HIV/AIDS Medication Adherence Screening documented on intake.

Nutritional Assessment on Intake

- 85% of clients will have a Nutritional Assessment documented on intake

Substance Abuse Screening on intake

- 85% of clients will have a CAGE Substance/Alcohol Abuse Screening documented on intake.

Substance Abuse Referral

- 75% of clients scoring within appropriate levels will receive a referral for Substance Abuse services.

Mental Health Screening on Intake

- 85% of clients will have a Evaluation of Mental Health Disorders Screening documented on intake.

Mental Health Referral

- 75% of clients scoring within appropriate levels will receive a referral for Mental Health services.

Complete Client Acuity Form

- 100% of newly enrolled clients during the measurement period will have an Acuity Form documented in the client chart on intake.

Client Care Plan or Individual Service Plan

- 100% of newly enrolled clients during the measurement period will have a Client Care Plan or Individual Service Plan documented in the client chart on intake.

Current Labs

- 85% of clients will have current labs (dated no more than 12 months from current date of service) documented on intake.

Medical Case Management Standards

- ✓ Ryan White Part A Client Registration Form
- ✓ Client Acuity
- ✓ Individual Service Plan (ISP) Development

Medical Case Management Agency Compliance Indicators

Complete Ryan White Part A Client Registration Form

- 100% of newly enrolled clients during the measurement period will have a Ryan White Part A Client Registration Form documented in the client chart on intake.

Complete Client Acuity Form

- 100% of newly enrolled clients during the measurement period will have an Acuity Form

	<p>documented in the client chart on intake.</p> <p>Client Care Plan or Individual Service Plan</p> <ul style="list-style-type: none"> ○ 100% of newly enrolled clients during the measurement period will have a Client Care Plan or Individual Service Plan documented in the client chart on intake. <p>Current Labs</p> <ul style="list-style-type: none"> ○ 85% of clients will have current labs (dated no more than 12 months from current date of service) documented on intake.
--	--

Additionally, all clients will be provided, and sign if necessary, the following:

- ✓ A Statement of Consumer Rights
- ✓ Sanction policy and/or Zero Tolerance Information
- ✓ Explanation of the grievance policy
- ✓ Notice of Privacy Practices for each individual agency
- ✓ Booklet of information regarding community resources (compiled by the Part A Grantee or another reputable source)

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.

The following must be completed during each reassessment at a minimum of the indicated intervals:

Intensive Medical Case Management-Medical Standards	Intensive Medical Case Management-Medical Agency Compliance Indicators
<p>Intensive Medical Case Management clients should be reassessed at a minimum of every two months but may occur more often if necessary. These interactions should be face-to-face, only under extraordinary circumstances should reassessments occur via telephone. Each two month reassessment should, at a minimum, include the following:</p> <p style="text-align: center;">Intensive Medical Case Management (Every 2 Months)</p> <ul style="list-style-type: none"> ✓ Intensive Medical Case Management Client Encounter Form ✓ Update Individual Service Plan ✓ Current Labs (dated no more than 12 months from the current date of service) <p>Intensive Medical Case Management clients will also receive a comprehensive six month reassessment to assess their progress and continued need for Medical Case Management. At the six month point the Intensive Medical Case Manager will either transition the client into</p>	<p>Updated Case Management Care Plan (HRSA HAB Measure)</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated care plan or individual service plan (ISP) documented at least twice each at least three months apart within the measurement period. <p>Updated Labs</p> <ul style="list-style-type: none"> ○ 85% of clients (still in Intensive Medical Case Management services at the six month mark) will have updated labs documented in the client chart. <p>Transitioned Within Six Months of Initial Contact</p> <ul style="list-style-type: none"> ○ 85% of clients in Intensive Medical Case Management-Medical will be transitioned into another level of care or program within six months of initial contact (excluding those 18 years old or younger or those that are pregnant).

<p>Moderate Medical Case Management through the Part A system or refer the client to other community resources they are eligible for. Each six month reassessment should, at a minimum, include the following:</p> <p style="text-align: center;">Intensive Medical Case Management (6 Month Reassessment)</p> <ul style="list-style-type: none"> ✓ Intensive Medical Case Management Client Encounter Form ✓ Client Acuity ✓ Assess and Update Individual Service Plan ✓ Current Labs (dated no more than 12 months from the current date of service) <p>If the client is found to need Intensive Medical Case Management beyond a six month period from admission into the Intensive Medical Case Management Program (and doesn't fall within the allotted exceptions), an acceptable explanation and verification of Part A eligibility must be provided in the CAREWare custom tab no more than two business days from the determination.</p> <p>The client will need to continue on an every two month reassessment in addition to the six month reassessment procedure listed above.</p>	<p>Justification of Continued Intensive Medical Case Management Services</p> <ul style="list-style-type: none"> ○ 100% of clients found to be in need of Intensive Medical Case Management services beyond the six month mark (and don't fall within the allotted exceptions), an acceptable explanation and verification of Part A eligibility must be provided in the CAREWare custom tab no more than two business days from the determination.
<p style="text-align: center;">Intensive Medical Case Management-Social</p>	<p style="text-align: center;">Intensive Medical Case Management-Social Agency Compliance Indicators</p>
<p>Moderate Medical Case Management clients should be reassessed at a minimum of every six months, however this may occur more often if necessary. These interactions should be face-to-face and coincide with the client's redetermination of eligibility for Part A services. Each six month reassessment should, at a minimum, include the following:</p> <p style="text-align: center;">Moderate Medical Case Management (Every 6 Months)</p> <ul style="list-style-type: none"> ✓ Ryan White Part A Client Reassessment Form <ul style="list-style-type: none"> ○ Case Management Screening Tool <ul style="list-style-type: none"> • HIV/AIDS Medical Appointment Adherence Screening • HIV/AIDS Medication Adherence Screening • HIV/AIDS Nutritional Assessment • CAGE Substance/Alcohol Screening • Evaluation of Mental Health Disorders Screening ✓ Client Acuity ✓ Update Individual Service Plan (ISP) ✓ Current Labs (dated no more than 6 months from the current date of service) 	<p>Complete Reassessment Every Six Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have a completed reassessment form documented twice each at least three months apart within the 12 month measurement period. <p>Medical Appointment Adherence Screening Every Six Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have an HIV/AIDS Medical Appointment Adherence Screening documented twice each at least three months apart within the 12 month measurement period. <p>HIV/AIDS Medication Adherence Screening Every Six Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have an HIV/AIDS Medication Adherence Screening documented twice each at least three months apart within the 12 month measurement period. <p>Nutritional Assessment Every Six Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have a Nutritional Assessment documented twice each at least three months apart within the 12 month measurement period.

	<p>Substance Abuse Screening Every Six Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have a CAGE Substance/Alcohol Abuse Screening documented twice each at least three months apart within the 12 month measurement period. <p>Substance Abuse Referral</p> <ul style="list-style-type: none"> ○ 75% of clients scoring within appropriate levels will receive a referral for Substance Abuse services. <p>Mental Health Screening</p> <ul style="list-style-type: none"> ○ 85% of clients will have a Evaluation of Mental Health Disorders Screening documented twice each at least three months apart within the 12 month measurement period. <p>Mental Health Referral</p> <ul style="list-style-type: none"> ○ 75% of clients scoring within appropriate levels will receive a referral for Mental Health services. <p>Updated Client Acuity</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated client acuity documented at least twice each at least three months apart within the 12 month measurement period. <p>Updated ISP (HRSA HAB Measure)</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated ISP documented at least twice each at least three months apart within the 12 month measurement period. <p>Current Labs</p> <ul style="list-style-type: none"> ○ 85% of clients will have current labs (dated no more than 12 months from current date of service) documented within the measurement period.
Medical Case Management Standards	Medical Case Management Agency Compliance Indicators
<p>Medical Case Management clients should be reassessed at a minimum of every six months, however this may occur more often if necessary. These interactions should be face-to-face and coincide with the client’s redetermination of eligibility for Part A services. Each six month reassessment should, at a minimum, include the following:</p> <ul style="list-style-type: none"> ✓ Ryan White Part A Client Reassessment Form ✓ Client Acuity 	<p>Client Reassessment</p> <ul style="list-style-type: none"> ○ 85% of clients will have a completed reassessment form documented twice each at least three months apart within the 12 month measurement period. <p>Updated Client Acuity</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated client acuity documented at least twice each at least three

<ul style="list-style-type: none"> ✓ Update Individual Service Plan (ISP) 	<p>months apart within the 12 month measurement period.</p> <p>Updated ISP (HRSA HAB Measure)</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated ISP documented at least twice each at least three months apart within the 12 month measurement period. <p>Current Labs</p> <ul style="list-style-type: none"> ○ 85% of clients will have current labs (dated no more than 12 months from current date of service) documented within the measurement period.
--	--

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 re-determination 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.

The following must be completed during each follow-up at a minimum of the indicated intervals:

Intensive Medical Case Management-Medical Standards	Intensive Medical Case Management-Medical Agency Compliance Indicators
<p>Minimum contact frequency for clients receiving Intensive Medical Case Management is once per month.</p> <ul style="list-style-type: none"> ✓ Case notes must be documented in client chart or CAREWare. 	<p>Follow-up Every Month</p> <ul style="list-style-type: none"> ○ 85% of clients will have a follow-up documented by a client encounter form or in CAREWare at least once per month while the client is in Medical Case Management-Medical services.
Intensive Medical Case Management-Social Standards	Intensive Medical Case Management-Social Agency Compliance Indicators
<p>Minimum contact frequency for clients receiving Moderate Medical Case Management is every two months.</p> <ul style="list-style-type: none"> ✓ Case notes must be documented in client chart or CAREWare. 	<p>Follow-up Every Two Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have a follow-up documented in client chart or CAREWare every two months.
Medical Case Management Standards	Medical Case Management Agency Compliance Indicators
<p>Minimum contact frequency for clients receiving Medical Case Management is every three months.</p> <ul style="list-style-type: none"> ✓ Non-Medical Case Management Encounter Form or other approved method of tracking follow-up contacts. 	<p>Client Follow-Up Every Three Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have a follow-up documented by a Medical Case Management client encounter form (or other approved method such as case notes) at least twice per year in between each period of reassessment.

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.

All clients exiting case management services from an agency must have the following documentation in their chart or CAREWare within two days of termination of service:

Intensive and Moderate Medical Case Management Standards	Intensive and Moderate Medical Case Management Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ Discharge summary in the clients chart/case notes/CAREWare explaining: <ul style="list-style-type: none"> • Reason for discharge • That at least three attempts were made over a period of three months to contact the client if they have been lost to follow-up 	<p>Discharge Summary</p> <ul style="list-style-type: none"> ○ 90% of clients discharged from case management will have a discharge summary documented in the client chart or in CAREWare. <p>Final Acuity Score at Discharge</p> <ul style="list-style-type: none"> ○ 90% of clients will have an updated acuity score documented in their chart at the time of discharge.
Intensive Medical Case Management-Social Standards	Intensive Medical Case Management-Social Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ Discharge summary in the clients chart/case notes/CAREWare explaining: <ul style="list-style-type: none"> • Reason for discharge • That at least three attempts were made over a period of three months to contact the client if they have been lost to follow-up 	<p>Discharge Summary</p> <ul style="list-style-type: none"> ○ 90% of clients discharged from case management will have a discharge summary documented in the client chart or in CAREWare. <p>Final Acuity Score at Discharge</p> <ul style="list-style-type: none"> ○ 90% of clients will have an updated acuity score

	documented in their chart at the time of discharge.
Medical Case Management Standards	Medical Case Management Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ Discharge summary in the clients chart/case notes/CAREWare explaining: <ul style="list-style-type: none"> • Reason for discharge • That at least three attempts were made over a period of three months to contact the client if they have been lost to follow-up 	<p>Discharge Summary</p> <ul style="list-style-type: none"> ○ 90% of clients discharged from case management will have a discharge summary documented in the client chart or in CAREWare. <p>Final Acuity Score at Discharge</p> <ul style="list-style-type: none"> ○ 90% of clients will have an updated acuity score documented in their chart at the time of discharge.

5. Documentation Tools and Minimum Requirements

Most of the forms utilized for Intensive Medical Case Management and Moderate Medical Case Management are the same but some differ as listed below:

RYAN WHITE PART A CLIENT REGISTRATION FORM

The Ryan White Part A Client Registration Form must be filled out on intake for all clients, whether they are new to the system of care or re-entering (haven't had an appointment for a period of 12 months or more). Information collected on this form will provide a portion of the eligibility requirements in addition to all data required in CAREWare.

Completed information on this must include, at a minimum, the following:

- Demographics
- HIV/AIDS Status and Medical Information
- Emergency Contact Information
- Living Status and Relationship Information
- Employment and Income Information
- Current Service Needs
- Case Managers and Client Signature
- Case Notes

CLIENT ACUITY

The client acuity scale is a tool that is used to measure the intensity and severity of a client's condition. This can be useful in guiding the Case Manager's assessment, client progress, and can help identify serious problems that need attention. Points range from 1 (non-critical) to 4 (very critical). All clients should receive a client acuity assessment on intake and at a minimum of every six months at the client's reassessment. Referrals for appropriate levels of case management should be made accordingly.

Client acuity level guidelines provide a basic framework for the level of case management needed, they are as follows:

Level of Case Management	General Case Load	Client Acuity Level	Minimum Reassessment Frequency	Minimum Contact Frequency
Basic(Medical/non-Medical)	81-100	Low 15 points or less Scoring level 0-1 Only	6 months	3 months
Intensive (Social)	30-60	Moderate 15-39 points Scoring level 1 & 2	6 months	2 months
Intensive (Medical)	20-30	High 31 points or higher Scoring level 2 & 3	2 months	1 month

Acuity assessments must be filled out completed for each life area and an overall score documented on the acuity assessment in order for it to be considered complete.

INDIVIDUAL SERVICE PLAN (ISP)

The Case Manager shall develop an Individual Service Plan (ISP) for each client. Care planning begins at admission to case management services and is based upon initial or reassessment. Once the client's needs have been assessed, Case Managers, with assistance from the client, shall prioritize care, support needs, and identify activities to address them.

This individualized plan provides a guide for both the client and the Case Manager on how to address the client's needs in a manner that promotes self-sufficiency of the client. Discernment is required on the part of the Case Managers to provide enough support to assist clients in meeting their needs, while fostering the clients' ability and responsibility for self-care. This requires an approach that is heavier in initial support, which includes a transition over time to increased client responsibility. Good communication regarding roles and expectations is essential from the beginning of the client-Case Manager relationship. While the ISP must be developed in collaboration with the client, other members of the support team (i.e. family, medical providers) if appropriate may participate if they are able to take into account his/her priorities and perception of needs.

The ISP must be completed at time of appointment to ensure it is discussed with the client in addition to the client receiving a copy. Additionally, a copy must be retained in the client's file. A Ryan White Part A Individual Service Plan form must be used and shall contain, at a minimum, the following:

- ✓ The needs and goals for the client (this may include referrals to other organizations/programs/services)
- ✓ Concrete actions that need to be taken to address them
- ✓ The timeframes for each action
- ✓ The responsible parties for each activity
- ✓ Contact information for the Case Manager
- ✓ Signature of both parties (Case Manager and client)
 - By the client signing the ISP they are indicating that they agree to the terms and that they received a copy of their ISP

Case Managers shall have a mechanism in place for checking on ISP progress that coincides with timing of activities on the plan. For example, if the ISP indicates that the client will apply for the ADAP program by May 1st, then the Case Manager shall have a mechanism for follow-up on that activity with the client. The ISP should also be considered a dynamic tool. It should be updated as needs are addressed or identified. At a minimum, the ISP needs to be updated once every two months for Intensive Medical Case Management clients and once every six months for Moderate Medical Case Management clients.

CURRENT LABS

All client charts require a copy of their most recent labs dated no more than twelve months from the current date of service. It is the client's responsibility to provide current labs every six months and the Case Manager's responsibility to ensure clients are receiving the necessary medical care and follow-up including monitoring of their CD4 and viral load at a minimum of every six months.

Intensive Medical Case Management Forms	Moderate Medical Case Management Forms
<p>CASE MANAGEMENT CLIENT ENCOUNTER FORM The date, method of contact, changes in; CD4, viral load, medication, mental status, substance abuse issues, social issues, in addition to notes related to the conversation must be documented in the clients chart utilizing the Client Encounter form. This should be completed at each client encounter, a minimum of once per month for all Intensive Medical Case Management clients.</p>	<p style="text-align: center;">SCREENINGS</p> <p>The following screenings must be completed at least every six months for all Moderate Medical Case Management clients and referrals provided as necessary, this includes the minimum of the following:</p> <ul style="list-style-type: none"> ○ HIV/AIDS Medical Appointment Adherence Screening <ul style="list-style-type: none"> ● Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment). ○ HIV/AIDS Medication Adherence Screening ○ Nutritional Assessment ○ CAGE Substance/Alcohol Abuse Screening <ul style="list-style-type: none"> ● CAGE is a Self report screening instrument that is well suited for use in busy medical settings where there is limited time for patient interviews. It uses 4 straight forward yes/no questions that clinicians can easily remember. ● CAGE can be self-administered or conducted by a clinician. Proven utility for use in routine health screening of adults and adolescents over the age of 16. The screen may identify individuals with alcohol problems that may have been otherwise missed. ● If the client answered "yes" to any of the substance abuse screening questions providing a referral for substance abuse treatment is strongly encouraged. ○ Evaluation of Mental Health Disorders Screening <ul style="list-style-type: none"> ● These questions were taken from the Primary Care Evaluation of Mental Disorders screening tool. ● If the client answered "yes" to any of the mental health disorders screening questions providing a referral for mental health treatment or counseling is strongly encouraged.
<p>CASE MANAGEMENT NURSE ASSESSMENT-MEDICAL HISTORY This assessment should include a full assessment of the client's current health including vitals, activities of daily living, services requested, general history, medical history, opportunistic infections, gynecological, oral, nutritional, mental health, substance abuse and/or addictions, medication adherence, medication side effects and barriers to medication. This must be completed upon intake for all Intensive Medical Case Management clients.</p>	