RYAN WHITE PART A (RWPA) HIV/AIDS PROGRAM
LAS VEGAS TRANSITIONAL GRANT AREA (TGA)

MEDICAL CASE MANAGEMENT — *SERVICE STANDARDS*

Drafted by Part A Recipient Office	Approved by Part A Planning Council
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I. Service Description (Per PCN 16-02)

Medical Case Management 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).

Key activities include:

- Initial assessment of 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 six 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.

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:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category 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 Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

II. Service Goals and Objectives

The Ryan White Part A medical case management program will coordinate medical and support services that enable clients of RWPA to navigate complex health and human service systems to successfully access and adhere to medical treatment, resulting in increased sustained self-sufficiency and improved health outcomes and quality of life.

The **GOALS** of RWPA medical case management program are to:

- Develop a resource and referral network of medical, healthcare and supportive services.
- Identify client needs and eligibility through a client-centered assessment process.
- Educate clients about HIV disease processes, treatment adherence, chronic disease management and service availability.
- In collaboration with the client, develop a plan to help overcome the barriers to accessing medical care.
- Empower clients to navigate the healthcare system to the best of their ability.
- Advocate for client access to medical and supportive services.
- Provide culturally competent services.
- Promote chronic disease self-management training and skills building.

III. Case Management Model

The RWPA case management model provides MCM and NMCM services as part of an HIV Case Management team that recognizes the need for three distinct tiers of expertise:

Tier 1: Navigation Services:
Tier 2: Community Based Case Management
Tier 3: Clinical-Based Case Management

IV. Currently Funded Activities

A. Initial Assessment
B. Reassessment
C. Individualized Care Planning

D. Linkage, Referral & Related Activity
E. Client Monitoring
F. Benefits Counseling
G. Treatment Adherence Counseling
H. Discharge Planning

V. Service Delivery

STANDARD	Documentation
1. Staff Requirements	
MCM services must be provided by medically credentialed individuals or other healthcare staff who are part of the clinical care team. Minimum qualifications apply as follows: **Tier 1:** Certified Community Health Worker, Level I. **Tier 2:** Certified Community Health Worder, Level II, and/or Certified Peer Recovery Support Specialist and/or a bachelor's degree or above in human service or medical related field. **Tier 3:** Licensed Clinical Staff (i.e., LPN, RN, BSN, MSN, LCSW, LMSW, PharmD etc.)	A copy of current qualifying certificates, degrees and/or licenses must be on file in the provider's personnel records.
2. Service Delivery	
2.1. Initial Assessment Comprehensive assessment of individual needs to determine the need for any medical, educational, social, or other services. Case Management assessments will include an evidenced-based screening tool to be conducted on clients during intake and on an annual basis to determine referrals into substance abuse, mental health services, or other services.	2.1 Copies of screening tool utilized for the determination of the client assessed needs will be uploaded to CAREWare.
2.2. Reassessment Comprehensive reassessment of individual needs to determine change in status to continue determining the need for any additional medical, educational, social, or other services. A reassessment should be completed no sooner than six months after the previous assessment.	2.2. Changes to the Client Assessment will be uploaded into CAREWare and noted in the Clients file.
2.3. Individualized Care Planning Development of a specific care plan based on the information collected through the assessment individualized for the client which; • specifies goals and actions that will be established to address services needed; • identify activities ensuring active participation of the individual and others in developing goals; and • identifies a course of action to respond to the needs of the individual.	2.3. The client's Individualized Care Plan will be uploaded into their CAREWare file. Any revisions will be noted in CAREWare.

Periodic revision of the care plan should be completed every three months, ensuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the changing needs of the individual.	
2.4. Linkage, Referral and Related Activities Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.	2.4. Staff must document any and all efforts to work with client and provide services, such that progress notes and service entries match in CAREWare.
2.5. Client Monitoring The case manager should engage in continuous contacts to assess the client's response to the care plan. This can be in collaboration with the client, family or caregiver, or providers of services. The case manager should be in contact with the client to be aware of any changes in the client's medical condition, service needs, or life events. In accordance with the client's Care Plan, or at a minimum once quarterly.	2.5. Staff must document any and all efforts to work with client and provide services, such that progress notes and service entries match in CAREWare.
2.6. Benefits Counseling Benefits counseling refers to the assistance and coordination to eligible clients to obtain access to other public and private programs for which they may be eligible.	2.6 Staff must document any and all efforts to work with client and provide services, such that progress notes and service entries match in CAREWare.
2.7. Treatment Adherence Counseling Contacts made under Treatment Adherence Counseling are specifically to advise clients via telephone, digital, in-person, etc. about the importance of adherence to medication treatments, primary and specialty doctor visits, and laboratory visits. Treatment Adherence Counseling is to be done by and with the Medical Case Manager or Case Management Team in a non-outpatient setting.	2.7 Staff must document any and all contact with client and provide services, such that progress notes and service entries match in CAREWare.
2.8. Discharge Planning When a client has reached their stated goals and no longer need higher tier services or additional tier services.	2.8. Any contact with the client will be noted in CAREWare.

VI. Minors Seeking Services

Minors (under 18 years old) may receive services. Those seeking services without parental consent will be determined on a case-by-case basis with the approval of Ryan White Program Administrators.