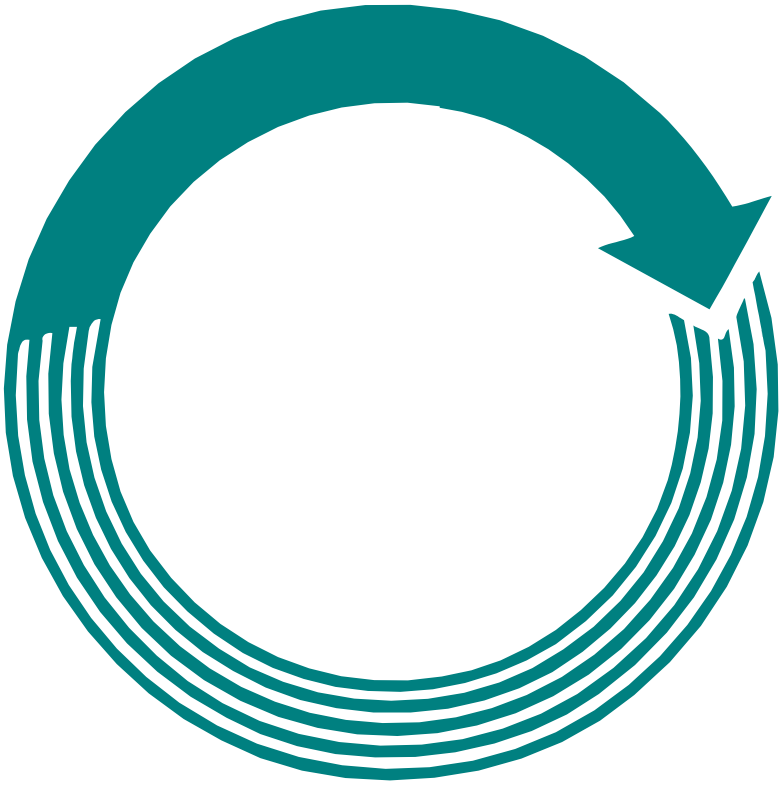
Ryan White Part A Quality Management



Medical Case Management Service Delivery Model 2014

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Ryan White Part A
HIVPC Approved 5/22/14

Ryan White Part A Quality Management

Medical Case Management
Service Delivery Model

Definition:

A range of client-centered services that link clients with health care, psychosocial, and other services including benefits/ entitlement, counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The coordination and follow-up of medical treatments is 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's 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 re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. In addition, Peer Education Counseling is coupled with Medical Case Management to offer clients individual therapeutic support services by an individual who may be the same age, gender, and HIV status as the client. This person will have had experienced and resolved the same type of problems as the client. The peer counselor will assist the client with the implementation of the case plan goals and objectives, which may include a recommended therapeutic regimen, medication adherence, compliance with medical procedures and self-care. The Peer Education Counselor will also conduct medical case management services including face-to-face, phone contact, home visits, medical eligibility screenings, educating new client regarding HIV and accompanying client(s) to initial appointments for medical care and other support services.

OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

Client Outcomes	Outcome Indicators	Inputs	Strategies	Data Source (Only one required for each strategy.)
1. Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care *NOTE: Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	1.1. 80% of clients achieve POC goals related to Outpatient/ Ambulatory Medical Care services by designated target dates 1.2. 80% of clients are retained in Outpatient/ Ambulatory Medical Care	Funding Clients Staff Facilities Supplies	1.1.1. Collaborate with client to assess client medical needs. 1.1.2. Develop POC goals that reflect client's medical needs. 1.1.3. Develop obtainable target dates. 1.2.1. Assist client in making medical appointments as needed. 1.2.2. Follow-up to ensure client attended medical appointments. 1.2.3. Educate clients on the importance of attending medical appointments.	1.1.1.1. Progress Notes 1.1.1.2. Action Plan 1.1.2.1. Progress Notes 1.1.2.2. Action Plan 1.1.3.1. Progress Notes 1.1.3.2. Action Plan 1.2.1.1. Needs Assessment 1.2.1.2. Client appointment record 1.2.1.3. Action Plan 1.2.2.1. Client appointment record 1.2.2.2. Action Plan 1.2.3.1. Progress Notes 1.2.3.2. Action Plan

STANDARDS FOR SERVICE DELIVERY

Standard	Indicator	Data Source
1. Each client receives an assessment.	1.1. 100% of client records will have a completed Needs Assessment.	1.1.1. Needs Assessment 1.1.2. Designated HIV MIS System
2. Each client will be assessed to determine if he/she currently receives primary medical care.	2.1. 100% of client records will have documented client's primary medical care status in the Needs Assessment.	2.1.1. Needs Assessment 2.1.2. Designated HIV MIS System
3. Each client's viral load and CD4 will be collected.	3.1. 100% of client viral loads and CD4 will be requested at least semi-annually with the intent of collecting data.	3.1.1. Client Chart 3.1.2. Lab Report 3.1.3 Designated HIV MIS System
4. Each client's viral load and CD4 will be tracked to observe trends.	4.1. 100% of the collected client viral loads and CD4 will be recorded at least semi-annually.	4.1.1. Client Chart 4.1.2. Lab Report 4.1.3 Designated HIV MIS System
5. Each client will be assessed for barriers to access care, treatment adherence, adherence to medications, and culturally specific needs.	5.1. 100% of client Needs Assessment will have documented the barriers to access primary medical care, adherence to treatment, adherence to medications and culturally specific needs as agreed with client.	5.1.1. Action Plan 5.1.2. Needs Assessment 5.1.3. Designated HIV MIS System
6. An individual Action Plan will be developed in agreement with the client.	6.1. 100% of Action Plan will have client and/or caregiver's signature.	6.1.1. Action Plan 6.1.2. Designated HIV MIS System
7. The Action Plan will be based on identified needs and will address client's cultural needs.	7.1. 100% of Action Plan will address client needs identified in Needs Assessment.	7.1.1. Action Plan 7.1.2. Designated HIV MIS System

8. Each client will be assisted to develop time frames for the resolution of barriers to care identified in the Needs Assessment.	8.1. 100% of Action Plan documented the interventions to resolve the barriers to care. 8.2. 100% of Action Plan documented achieves dates. 8.3. 100% of Client Progress Notes document assistance.	8.1.1. Action Plan 8.1.2. Client Progress Notes 8.1.3. Designated HIV MIS System
9. Each client will be assisted to establish expected outcomes based on the Action Plan.	9.1. 100% of Action Plan document expected outcomes. 9.2. 100% of Progress Notes document assistance.	9.1.1. Target dates in Action Plan 9.2.1. Progress Notes

Standard	Indicator	Data Source
10. Each client will be assisted to remain in primary medical care and adhere to treatment.	10.1. 100% of Client Progress Notes document attempted assistance. 10.2. 100% of Client Action Plans outline barriers to retention to medical care.	10.1.1. Action Plan 10.1.2. Client Progress Notes 10.1.3. Designated HIV MIS System
11. Each client receiving medical case management for at least 6 months during the measurement year will have two or more medical visits.	11.1. 95% of clients receiving medical case management for at least 6 months during the measurement year will have two or more medical visits.	11.1.1. Client Progress Notes 11.1.2. Documented Provider Visit 11.1.3. Designated HIV MIS System
12. Each client receiving medical case management for at least 6 months will have their medical case management Action Plan updated two or more times in the measurement year.	12.1. 95 % of clients receiving medical case management for at least 6 months will have their medical case management Action Plan updated two or more times in the measurement year.	12.1.1. Client Progress Notes 12.1.2. Action Plan 12.1.3. Designated HIV MIS System
13. Each client will be assessed for prescribed HAART therapy when CD4 count is below 500.	13.1. 100% of clients are assessed for HAART prescription.	13.1.1. Needs Assessment 13.1.2. Client Progress Notes 13.1.3. Designated HIV MIS System
14. Each client will be assessed for other medication use.	14.1. 100% of clients are assessed for medication~~s~~ adherence.	14.1.1. Needs Assessment 14.1.2. Client Progress Notes 14.1.3. Designated HIV MIS System
15. Conduct multi-disciplinary case staffing for appropriate clients, defined as clients identified with a decrease in CD4, increase in viral load and/or missed appointments.	15.1. 100% of clients identified with a decrease in CD4, increase in viral load and/or missed appointments will be assessed for a multi-disciplinary case staffing.	15.1.1. Action Plan 15.1.2. Client Chart
16. Upon a face-to-face discharge medical case managers will review community resources with client.	16.1. 100% of clients' files will document a review of community resources to access upon discharge.	16.1.1. Progress Notes

17. Upon termination of active medical case management services, a client case is closed and contains a closure summary documenting the case disposition and an exit interview with Medical Case Manager & Medical Case Management Supervisor.	17.1. 100% of closed cases include documentation stating the reason for closure and a closure summary. 17.2. 100% of case closure summaries are signed off by a Medical Case Management Supervisor. 17.3. 100% of Exit Interviews document client discharge	17.1.1. Case closure summary 17.1.2. Progress Notes 17.1.3. Action Plan 17.2.1. Case closure summary 17.2.2. Progress Notes 17.2.3. Action Plan 17.3.1. Case closure summary
18. Progress notes and all program and service related documentation must be entered in Designated HIV MIS System within 3 business days of client contact.	18.1. 100% of progress notes will be written within 3 business days of client contact.	18.1.1. Progress Notes 18.1.2. Designated HIV MIS System
19. Each client will receive a return call within 1 business day of client's voice message requesting a return call.	19.1. 80% of clients will receive a return call within 1 business day of client's voice message requesting a return call.	19.1.1. Telephone Log 19.1.2. Progress Log

PROTOCOLS

The Medical Case Management and Peer Counseling Protocol identifies the specific ways to implement the Medical Case Management and Peer Counseling Standards and processes inherent to medical case management and peer counseling services. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, HAB HIV Medical Case Management Performance Measures, etc.).

Eligibility Verification
The medical case manager shall verify client's eligibility is established by reviewing the certification in the designated HIV MIS System. MCM (or other authorized individual such as Peer Educator), shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System. MCM (or designee) will review client's eligibility for all funding streams and services for which client may qualify. MCM's will follow-up with referrals as appropriate. The purpose of the assessment is to ensure 1) client's access to all services client may be eligible for and 2) the status of Ryan White as payer of last resort.

Needs Assessment
The medical case manager shall assess client needs by completing all sections of the Needs Assessment document and/or designated HIV MIS System. The medical case manager shall complete the Needs Assessment within three (3) sessions from the time of initial visit.

Additionally, client's progression of HIV will be indicated under *HIV Disease Progression* in the Needs Assessment in designated HIV MIS System.

Action Plan

Individualized Plan of Care (POC)
The medical case manager in conjunction with the client shall complete an individualized Action Plan that incorporates the specific needs of the client. Action Plan includes the needs that can be met in the time frame agreed with the client. The medical case manager completes the Action Plan the same day the Needs Assessment is completed.

Time frames
The medical case manager shall assist the client to set client driven, realistic time frames to resolve the barriers for access to primary medical care identified in the Needs Assessment. Time frames shall be documented in the *Target Date* field in the Action Plan.

Addressing Cultural Needs
The medical case manager shall ensure client cultural needs are addressed in Action Plan by including those agreed with the client in the Action Plan.

Addressing Client Needs
The medical case manager shall use the Needs Assessment data in the development of the Action Plan. The medical case manager, in conjunction with the client, shall prioritize the client needs to be addressed in the Action Plan.

Resolutions to Barriers
The medical case manager shall assist the client in determining appropriate strategies to resolve barriers to access primary medical care. The resolutions shall be client driven. The strategies shall

be documented in the column *Interventions*.

Goals

As a member of the clinical care team, the medical case manager shall assist the client to define both medical and social service goals for the needs identified in the Action Plan. The expected results/benefits shall be documented in the Action Plan. The medical case manager shall document the specific assistance provided to the client in the Progress Notes.

In making sure that the client meets their objectives and defined case plan goals in their action plans the peer counselor will document efforts to assist the client by documenting with a progress note in the client record.

Client Participation

The medical case manager shall ensure client participation in the development of the Action Plan. The client's signature on the Action Plan shall evidence the client participation in agreements stated in the Action Plan.

Once barriers are addressed and goals are achieved, case management is no longer needed and client should be discharged from services.

Referral Process

Purpose

To standardize the process used to provide clients with information, and referrals when appropriate, within the Ryan White system of care and to other third party providers.

Procedure

Referring medical case manager shall assess client needs by completing a Needs Assessment. The analysis of the Needs Assessment shall assist the medical case manager in determining the referrals needed.

An Action Plan shall be developed by the referring medical case manager based on the identified needs. Referrals shall be documented in the Action Plan and the Progress Notes.

Referring medical case manager or peer counselor shall provide client with information of available services. This shall be documented in Progress Notes.

Referring medical case manager or peer counselor shall follow-up and document the results of the referral in the Progress Notes.

Status of Referral

Referring medical case manager, peer and provider that receives the referral shall communicate to update each other on the status of the referral.

No Show

Referring medical case manager or peer counselor shall contact "no show" clients to assess potential barriers and/or conditions leading to "no show".

Referring medical case manager or peer counselor and client shall determine future steps to resolve the situations that triggered the "no show".

Referring medical case manager or peer counselor shall establish coordination with the agency that received the initial referral to re-activate it after client consents.

Medical case manager or peer counselor shall document all client follow-up (phone calls, mail, face-to-face and/or electronic communication) on Progress Notes as soon as information is collected.

Medical case manager or peer counselor shall access outreach services if client remains unreachable after 6 months of not showing for outpatient/ambulatory medical care or medical case management appointments.

Access to Primary Medical Care

The medical case manager or peer counselor shall assist the client to get primary medical care, if he/she is not in care, using information provided in the Needs Assessment. The medical case manager or peer counselor shall discuss with the client the reasons for accessing primary medical care and with client participation determine how the medical case manager can help him/her access primary medical care. The medical case manager or peer counselor shall discuss with the client what needs to happen so he/she can start primary medical care. The medical case manager or peer counselor shall coordinate a primary medical care appointment for consenting client within 2 weeks of client contact with medical case manager.

The medical case manager or peer counselor shall detail the assistance provided in the Progress Notes including any coordination conducted to get the client in primary medical care.

Retention in Primary Medical Care

The medical case manager or peer counselor shall assist client to remain in primary medical care. The medical case manager or peer counselor shall assess possible barriers to continue in primary medical care and assist in their removal.

The medical case manager or peer counselor shall detail the assistance provided in the Progress Notes. The medical case manager or peer counselor shall document any coordination conducted to assist client to remain in primary medical care.

Adherence to Treatment

The medical case manager or peer counselor shall assist the client to adhere to treatment using information provided in the discussion of retention in primary medical care documented in the Progress Notes. The medical case manager or peer counselor shall discuss with the client the reasons for not adhering to medical treatment and with the client participation determine how the medical case manager can help to have him/her to adhere. The medical case manager or peer counselor shall discuss with the client strategies to improve adherence treatment. The medical case manager or peer counselor shall detail the assistance provided in the Progress Notes. The medical case manager or peer counselor shall document any coordination conducted to assist client to adhere to treatment.

Medical Case Management and Peer Counselor Monitoring

The medical case manager and peer counselor will collect, plot, analyze and monitor and review with client his/her CD4 and viral loads at a minimum biannually. Each client will be assessed to determine whether multidisciplinary case staffing is warranted upon receipt and analysis of lab results. The peer counselor will provide clients with services such as face-to-face, phone contact, home visits, and medial eligibility screenings.

Follow-up

Schedule of Client Follow-up

The medical case manager or peer counselor shall provide follow-up based on the client Action Plan. The medical case manager and peer counselor shall follow-up the progress of the Action Plan and adherence to treatment and medications. The medical case manager and peer counselor shall document the follow-up in the Progress Notes, including phone calls, mail, face-to-face and/or electronic communication. Checking lab reports (trending viral loads and CD-4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. The medical case manager and the peer counselor shall take every possible interaction with the client as a window of opportunity to assess and/or reinforce access, retention and adherence to treatment.

Documentation

The medical case manager and the peer counselor shall document within three business days any coordination and/or intervention with the client and/or on behalf of the client. The Progress Notes make up the major source of documentation.

Reassessment

The medical case manager shall conduct: a) continuous client monitoring to assess the efficacy of the Action Plan and b) Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary. The medical case manager shall document the reassessment in the Progress Notes. The medical case manager shall revise and update the Action Plan at reassessment.

If the client chooses to receive services from a different provider, the medical case manager shall ask if the client desires to have the record transferred once he/she has selected another provider. The medical case manager shall document the reasons for client's refusal of services. If the client does not express a reason, the medical case manager shall document this.

Continuous Quality Improvement

Medical case management shall conduct chart reviews at least quarterly to ensure appropriate documentation of all services, including referrals, follow-up and reassessment.

Responsibilities of Medical Case Managers

Ryan White Part A medical case managers shall provide services to clients as indicated below:

Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
Complete Needs Assessment
Complete POC
Monitor service delivery and client adherence to POC
Follow-up POC
Re-assess Needs Assessment and POC
Promote medical adherence, including medication
Facilitate access to primary medical care, medications, home health care, specialty care
Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
Coordinate medical referrals
Monitor referral status
Coordinate medical care needs
Ensure all non-Ryan White Part A medical clients' verified Viral Loads, CD4 counts are available and entered into designated HIV MIS system

Refer to disease management programs non-adherent clients
Identify, refer, follow-up social support service needs identified in the POC
Coordinate client care with all appropriate parties
Document all interventions
Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)

Responsibilities of Peer Counselors
Ryan White Part A peer counselors shall provide services to clients as indicated below:

Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
Monitor service delivery and client adherence to POC
Follow-up POC
Promote medical adherence, including medication
Facilitate access to primary medical care, medications, home health care, and specialty care
Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
Coordinate medical referrals
Monitor referral status
Coordinate medical care needs
Refer to disease management programs non-adherent clients
Identify, refer, follow-up social support service needs identified in the POC
Coordinate client care with all appropriate parties
Document all interventions
Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)
Assist Medical Case Manager in care coordination

Payer of last resort
An applicant may not be eligible for services from Ryan White Part A Program if the applicant is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White may be utilized for HIV related services only when no other source of payment exists.

An applicant cannot be receiving services or be eligible to participate in local, state, or federal programs where the same type service is provided or available. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state, or federal programs, or pending determination of eligibility from other local, state or federal programs. Ryan White Part A services is the payer of last resort. All community resources should be explored with clients prior to obtaining and receiving Ryan White Part A services.

Professional Requirements and Training

Peer Counselor

Education Requirements:
High School Diploma or Equivalent

Requirement: Must be a consumer of services and have at least one-year's experience in the HIV/AIDS service delivery system.

Other experience that would be helpful to assist consumers:
- Knowledge of community resources and support groups
- Knowledge of target population
- Knowledge of HIV disease and treatment

Skills:
- Written documentation
- Adherence assessment and reinforcement
- Time management

Additional requirement based on the type of setting and/or project:
- Knowledge of substance abuse
- Knowledge of women's health
- Knowledge of medical issues

Training of the Medical Case Manager:
- HIV Basic Training
- Annual HIV Update

Additional requirement:
- Mandatory Case Management Seminars and/or training sessions required by Grantee
- Cultural and linguistic competence

Medical Case Manager

Education Requirements:

Earned Bachelor or graduate degree from an accredited institution with a major in either social work, nursing or social services field with a minimum of one year medical case management experience.

Other Requirements:
- Knowledge of community resources
- Knowledge of target population
- Knowledge of HIV disease and treatment
- Cultural and linguistic competence
- Experience in care coordination

Skills:
- Client assessment
- Written documentation
- Adherence assessment and reinforcement
- Time management

Additional requirement based on the type of setting and/or project:
- Knowledge of substance abuse
- Knowledge of women's health
- Knowledge of medical issues

Training of the Medical Case Manager:

HIV Basic Training
Annual HIV Update
Medical Case Manager must have a minimum of 8 hours of training annually on medically-related topics

Medical Case Management Supervisors

In addition to the case manager requirements:

Master's degree from an accredited institution in health/human services preferred or Bachelors with a minimum of 3 years case management experience
A minimum of one year supervisory experience in a health or social services setting
Knowledge of program goals, outcomes, indicators, protocols, quality improvement evaluation, staff training and development
Experience with chart review
Experience with assessment of staff performance

Training:

Updates on management issues and/or skills
Other appropriate to the position
Medical Case Manager must have a minimum of 8 hours of training annually on medically-related topics

MULTI-DISCIPLINARY CASE STAFFING FORM

Collaborative staffing required? Yes No

Provide client URN#

Date of staffing

State reason for staffing
(i.e.: client not adherent with medical appointments or medication regimens, client at risk to fall out of care (substance use relapse, mental health issue, etc.), client medical condition not improving (CD4 counts, viral loads, etc.), client dropped out of care (no labs in past 6 months), or any situation detrimental to client remaining in care or adhering to care and medications)

Client medical provider information:
Medical funding source: RW Part A, Medicaid, Medicare, other:
Physician name:
Physician agency:
Physician address:

Pharmacy provider agency:
Medications Medical funding source: RW Part A, ADAP, Med Co- Pay Medicaid, Medicare, other:

List other services client is receiving. Give provider name and source of funding.

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

-List those in attendance at staffing.

-List issues discussed at staffing.

-Describe outcome or resolution of each issue discussed.