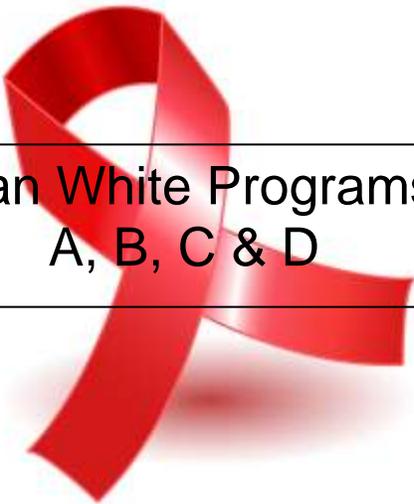


# Connecticut Statewide Core Standards for Medical Case Management

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Ryan White Programs  
A, B, C & D



## EXECUTIVE SUMMARY

After three decades, HIV remains a chronic disease which affects many of Connecticut's low income residents. Over 10,000 individuals live with HIV/AIDS in Connecticut. Although the epidemic has claimed thousands of lives, HIV transmission rates in Connecticut remain constant with our state ranking seventh in the United States in number of cases. Advances in medical care and treatment for people with HIV have resulted in people living longer, healthier, and more productive lives. Ryan White Medical Case Management services are designed to enhance access to and retention in medical care for eligible people living with HIV utilizing a range of client-centered services, counseling techniques, and referrals such as culturally competent core medical and other supportive services to reduce HIV-related health disparities. When People Living with HIV (PLWH) are engaged in effective medical care and support services, it promotes positive health outcomes and reduces transmission of HIV to new individuals in the hope of an AIDS free generation in the future.

The Ryan White HIV/AIDS Program is funded by the Title XXVI of the Public Health Services Act first enacted in 1990 as the Ryan White Care Act. There were other amendments to this act in 1996, 2000, and 2006. Finally, the legislation was amended as the Ryan White HIV/AIDS Treatment Extension Act of 2009 to accommodate emerging needs, which is how it is referred to today.

The Medical Case Management Standards of Care were developed by a collaboration of representatives from the Ryan White Parts A-D Programs in an effort to comply with the Health Resources and Services Administration (HRSA) 2006 mandate which included an amendment to provide Medical Case Management (MCM) services for PLWH instead of traditional Community/Supportive Case Management services. Each state was required to develop their own definition of Medical Case Management, the Program Model, and the Standards of Care. The goals of the new MCM Model included strengthening and enhancing the statewide Ryan White Care services, increasing collaboration, eliminating duplication of efforts, documenting quality management activities, and keeping clients in medical care. Furthermore, Ryan White grantees now have to adhere to the funding being spent 75% on core medical services and 25% on support services. The Connecticut team worked diligently on this project and the first Standard of Care including definitions of Medical Case Management was completed in November 2007. Case Management trainings were provided statewide using the enhanced MCM model. The Standards of Care have been updated in 2009, 2010, and 2014.

**Medical Case Management Standards**

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### Background

The Ryan White HIV/AIDS Treatment Extension Act of 2010 provides the Federal HIV/AIDS programs in the Public Health Service (PHS) Act under Title XXVI flexibility to respond effectively to the changing epidemic.

Under the 2010 Extension Act, grantees receiving funds under Parts A, B, C and D (formerly called Titles I, II, III and IV) must spend at least 75 percent of funds on “core medical services” with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country.

Essential medical core services are defined as:

- Outpatient/ambulatory health services
- AIDS Drug Assistance Program (ADAP) treatments
- AIDS Pharmaceutical assistance
- Oral health care
- Early intervention services
- Health Insurance Premium & Cost Sharing Assistance
- Home health care
- Home and Community-based Health Services
- Hospice services
- Mental health services
- Medical Nutritional Therapy
- Medical Case Management (including Treatment Adherence)
- Substance abuse services-outpatient

Remaining funds may be spent on support services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. The Act outlines support services as:

- Case Management (non-medical)
- Child Care Services
- Emergency Financial assistance
- Food bank/home delivered meals
- Health Education/risk reduction
- Housing services
- Legal services
- Linguistics Services
- Medical Transportation Services
- Outreach Services
- Psychosocial support services
- Referral for health care/supportive services
- Rehabilitative Services
- Respite care
- Substance Abuse Residential
- Treatment adherence counseling

**Note:** Part A and B Ryan White grant funds may be used to support only the service categories listed above. The *Ryan White Program Service Category Definitions* list includes additional categories that are fundable under Part C and/or Part D only.

The U.S. Department of Health and Human Services, HIV/AIDS Bureau, and Health & Resources Service Administration (HRSA) define Medical Case Management (MCM) services (including treatment adherence as):

**“Medical case management services** are a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. 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 needs and personal support systems of the client and other key family members. 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, at least every 6 months, 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 meetings, telephone calls, and any other forms of communication.”

Medical case managers, in collaboration with their client, develop and implement the service plan. The MCM will monitor the client to assess efficacy of the service plan which includes client health outcomes, periodic reevaluation, and adjustment of the service plan.

Medical Case Managers record relevant data in each client’s file and the statewide Ryan White data base, including referrals to specialty care, hospital admissions, and outcomes of services delivered. Medical Case Managers perform these activities in consultation with and as part of a clinical care team in clinical and community settings.

Core medical services, as defined by HRSA include:

- Primary medical care (outpatient and ambulatory services),
- Specialty care,
- Mental health and substance abuse treatment,
- Oral health,
- HIV medications,
- HIV medication adherence services,
- Health and risk reduction education and related services,
- Early intervention services,
- Home health care,
- Medical nutrition therapy,
- Hospice services,
- Home and community-based health services,
- Local AIDS Pharmaceutical Program, and
- Health insurance premium and cost sharing assistance

## Goal of Medical Case Management:

The goal of medical case management services is to enhance access to and retention in medical care for eligible Connecticut residents<sup>2</sup> living with HIV to a range of client-centered services, to facilitate access to health insurance and to advocate for the client to ensure access to and retention in culturally competent core medical and other services.

**Statement of principle:** The Medical Case Manager will perform the roles and responsibilities as outlined in the following core MCM standards by demonstrating:

- Professionalism
  - Provider/client boundaries
  - Adhering to agency standards
- Maintaining client's confidentiality
- Respect for client's dignity
- Cultural competence including sexual orientation and gender identity

## **Statewide Medical Case Management Core Standards**

These core standards are a collaborative effort developed by Ryan White Parts A, B, C and D in the State of Connecticut and form a minimum model of care standards for the delivery of medical case management services in the state. Each Part has the option of adding to but not deleting from the core standards agreed upon in the document.

### **1.0 Administration**

- 1.1 All provider agencies who offer medical case management services shall have a client record system that collects and maintains information about client demographics, assessments, service plans, treatment/services provided, client response to services, updates, treatment goals, etc., that conforms to the information required by the funding Part.
- 1.2 Contents of the client record shall be protected within the parameters of state and federal laws. Record retention expectation is seven years.
- 1.3 Client's right to privacy shall be safeguarded and respected in accordance with federal and state laws including a private interview area and communications made on the client's behalf.
- 1.4 All provider agencies shall have a quality management program that is reviewed and updated annually.
- 1.5 All provider agencies must have a documented, periodic internal client record review process.
- 1.6 All provider agencies must provide clinical supervision by a licensed medical/board certified professional, (i.e. PA, APRN, RN, and LPN) for medical case manager, at least on a monthly basis.

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<sup>2</sup> As defined by each Ryan White Part

**2.0 Medical Case Manager Roles and Responsibilities**

- 2.1 The Medical Case Manager (MCM) shall maintain a professional relationship with the client as evidenced by a signed “Rights and Responsibilities of Client” document in the client file.
- 2.2 Maintain the client’s privacy by adhering to federal, state and agency specific policies.
- 2.3 Protect the oral, written and electronic confidentiality of the client, as per HIPAA guidelines.
- 2.4 Define role expectations and tasks of both the medical case manager and client throughout the entire medical case management service agreement.
- 2.5 Inform the client of agency and grievance policies and procedures.
- 2.6 Conduct an intake that includes all necessary information to link and retain Ryan White care. This includes and an initial assessment of needs, client strengths and challenges. An initial plan is developed with the client based on the level of acuity of needs. Goals set with the client should strive to achieve self-empowerment and self- efficacy.
- 2.7 Provide benefit/entitlement counseling and referral activities to assist clients to access other private and public programs (e.g. Medicaid, Medicare, or Insurance Marketplace/Exchange etc.)
- 2.8 Conduct on going care planning, including re-evaluation and updating as evidenced by an ongoing assessment of client’s medical and psychosocial needs to the extent that the assessment supports access to and retention of care for the client. The medical core services assessment with full eligibility, financial and support services assessment conducted every six (6) months.
- 2.9 Monitor and document client’s progress in meeting established goals of care.
- 2.10 Coordinate referrals and track linkages and outcomes of clients to other core medical, support services, partner services and prevention to support identification of those unaware of their HIV status, access to and retention in care as evidenced by documentation, including forms, CAREWare and progress notes.
- 2.11 Actively participate in team meetings or case conferences for the clients to sustain retention in care and/or to improve the client’s quality of life as evidenced by document information in the client’s chart.
- 2.12 Participate in training as mandated by Parts A, B, C, and D baseline for new MCMs and annually.
- 2.13 Participate in quality management and improvement activities.

**3.0 Eligibility for and Assessment of Service Delivery Needs**

- 3.1 The MCM will determine eligibility for services as evidenced by documentation via an eligibility worksheet. Note: Medical Case Management services are offered to HIV+ individuals upon eligibility at the current federal poverty level (FPL) that is set by Ryan White Grantees. If a client reports no income that should be documented and dated. Verification that the client meets the current eligibility requirement must be obtained prior to payment for services. Acceptable proof of income includes, but not limited to unemployment or pay stubs, Supplemental Security Income, Social Security Disability Income, income tax return, DSS Budget Sheet, etc.
- 3.2 Ryan White funds are to be used as a last resort. All Ryan White services that are not covered by Medicaid or another medical insurer must have evidence of documentation<sup>3</sup> to indicate that the service(s) provided was not an allowable service under the health plan.
- 3.3 Federal Legislation mandates (HRSA Monitoring Standards – Section D – Part B Fiscal Monitoring) that all grantees use a sliding fee scale for services to maximize the use of available resources.
- 3.4 On an annual basis sliding scale charges will be assessed and applied to client's with incomes greater than 100% of the federal poverty level (FPL) that are based on a discounted fee based on clients' annual incomes and family size (not family income), with the exception of clients with incomes less than 100% FPL which will be not charged. Clients who are unable to pay CANNOT be denied services but must sign a waiver and MCM must document why fees were not imposed. Any payments made will apply to the clients' caps on charges and tracked by the MCM. Clients will be responsible for providing any financial documentation, including payments to the MCM. No client may be charged once they reach their yearly cap on charges.
- 3.5 Ryan White grantees or contractors may refer eligible veterans to the VA for services when appropriate and available. Ryan White grantees or contractors may not require that eligible veterans access VA care against their will. Ryan White funded agencies may not deny services, including prescription drugs, to a veteran who is otherwise eligible for said funded services.
- 3.6 The MCM must secure documentation of the client's HIV status prior to providing services. Acceptable sources for HIV documentation are one of the following:
- *A HIV Test Result:* A copy of a seropositive blood test for antibodies to HIV with confirmed by western blot assay with the client's name on the test report.

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<sup>3</sup> Documentation could be in the form of a letter or medical case manager notes in file, for example, that the medical case manager called and received verification of denial.

## Connecticut Statewide Core Standards for Medical Case Management

- A *confidential* test result from a State-funded Counseling and Testing site is acceptable; an *anonymous* test result is not acceptable, or
- A laboratory test result from a licensed medical provider (MD, PA, APRN or nursing staff)
- Documentation from a medical provider: A signed letter or medical progress note from a licensed provider with identified agency/medical provider logo stating that the client has HIV/AIDS.

3.7 The MCM will conduct a face-to-face assessment of each client, which will be documented in the client record and in CAREWare as applicable. The assessment must include, but may not be limited to the following:

|                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Client Demographics                                                                                                                                                                                                                                                                                                      | Other information as required by the Parts A, B, C, or D (i.e. Special population)                                                                                                                                                                                                        |
| Functional HIV health literacy                                                                                                                                                                                                                                                                                           | Client strengths and limitations                                                                                                                                                                                                                                                          |
| Legal history, including criminal history (incarceration, arrests), immigration status, conservatorship, guardianship and custody of minor children                                                                                                                                                                      | Biopsychosocial (biological, psychological, and social factors) support                                                                                                                                                                                                                   |
| Name of Client's Medical Provider                                                                                                                                                                                                                                                                                        | Last medical appointment, next medical appointment                                                                                                                                                                                                                                        |
| Barriers (perceived and actual) to access and retention in care (refer to some of the Part A & B Support Services)                                                                                                                                                                                                       | Referrals to core medical and support services to access or retain linkages to health services                                                                                                                                                                                            |
| Name, address and telephone number of pharmacy                                                                                                                                                                                                                                                                           | Access to pharmaceuticals                                                                                                                                                                                                                                                                 |
| Primary Care and Health Maintenance assessment and referral for: <ul style="list-style-type: none"> <li>• Oral health</li> <li>• Substance Use</li> <li>• Mental Health</li> <li>• Nutritional Health</li> <li>• HIV Medication Adherence</li> <li>• Cervical cancer, Hepatitis A, B, &amp; C, TB, &amp; STDs</li> </ul> | Partner Services and other Risk Reduction Counseling: <ul style="list-style-type: none"> <li>• Early Intervention Services</li> <li>• Early Identification of Individuals with HIV/AIDS</li> <li>• Comprehensive Risk Counseling Services</li> <li>• Outreach, Testing Linkage</li> </ul> |
| CD4 counts & viral load test results with dates                                                                                                                                                                                                                                                                          | Follow-up after urgent, emergency, and hospital care                                                                                                                                                                                                                                      |
| Assess for insurance coverage                                                                                                                                                                                                                                                                                            | English language proficiency                                                                                                                                                                                                                                                              |
| Assess for Connecticut residency                                                                                                                                                                                                                                                                                         | Photo identification card, if possible                                                                                                                                                                                                                                                    |

- 3.8 The assessment should be completed with the client as evidenced by documentation in assessment form(s).
- 3.9 All clients who request or are referred for HIV MCM services will be contacted within two (2) business days after a referral has been received. Every effort should be made to meet with a client within ten (10) business days\* and complete the initial intake information.

*\*Circumstances that necessitate a deviation from this time frame should be documented in the progress note in the client record.*

### **4.0 Care Plan**

- 4.1 Medical case managers, in collaboration with the client, shall develop and implement the service plan to ensure that the identified medical and support service needs are addressed. The service plan goals, timeframes and expected outcomes must also be addressed and documented in the plan.
- 4.2 MCMs must ensure that medical and support needs are identified and prioritized.
- 4.3 Initial service plan should be developed within ten (10) business days of the intake.
- 4.4 Periodic re-evaluation and adaptation of the plan at least every 6 months, throughout the clients enrollment with MCM services
- 4.5 The service plan should be signed by the medical case manager and by the client. The client's signature confirms that the client understands and agrees to the service plan. If the client does not sign the service plan, the MCM should document and date reason in the client's progress note and/or service plan.

### **5.0 Progress Notes**

- 5.1 A progress note must be done on a client at least monthly that includes adherence (medical, medication, service plan, etc.), health outcomes, etc.<sup>3</sup>
- 5.2 The MCM will document the progress on meeting the goals addressed in the Care Plan in the client's record.

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<sup>3</sup> Required by HRSA: See page 21-22 of 2013 HRSA HAB, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and B Grantees

- 5.3 The person making the progress note entry (either electronic or hand written) must sign his/her full legal name and title. The entry must also be dated with title and credentials within five (5) days after an interaction with the client.
- 5.4 The MCM will document efforts to contact the client as needed (e.g., to update client information, reassess service care plan, assess completion of referral, etc.)
- 5.5 The MCM shall not leave blank spaces, or in any form, alter the progress notes.

### **6.0 Confidentiality**

- 6.1 All clients must be given the opportunity to read, or have read to them, as well as understand, the confidentiality agreements between client and the Ryan White provider network. Client will indicate approval of referral by initials and signature. This agreement will expire after 12 months.
- 6.2 The MCM must assure that when a client or the client's legal guardian signs and initials a *Release to obtain and disclose Information*, the client/legal guardian *understands* that information from his record will be shared and with whom and for what purpose.
- 6.3 The client has a right to know for what period of time the disclosure will occur and what safeguards are in place against unauthorized disclosure. Release of information expires after twelve (12) months.
- 6.4 Documentation with signature of client indicating an understanding of and acceptance of the client bill of rights and grievance procedure must be in place and in the client record.
- 6.5 MCM's who wish to share data within CAREWare, must obtain a client signed Consent to Share CAREWare Data form. This consent expires after 12 months.

### **7.0 Training**

- 7.1 New MCMs must receive training in the following areas, within one year of hire date:
  - Pre-requisite training: HIV 101, HIV Care Continuum/Treatment Cascade, STDs 101, Hepatitis B & C, Tuberculosis, Introduction to Substance Abuse & Mental Health, Cultural Competency (gender, language, sexual identity, etc.), Risk Reduction Counseling, Secondary Prevention, Partner Services, and HIV Legal Issues (including confidentiality and HIPAA).
  - Basic MCM training: Overview of the Ryan White Program, MCM Standard Of Care, Core Medical and Support Services, Managing HIV Disease for MCMs, HIV Medications, Medication Adherence for MCMs, Eligibility & Enrollment, Client Assessment (including risk categories, basic intake, progress notes/documentation, interviewing skills and complete referral process), Development of Care Plan, Entitlements (medical, financial, etc.), Financial Management, Affordable Care Act, and CAREWare 101.

- Intermediate training: Oral Health, Interpersonal Violence, Sexual Assault, , Early Intervention Services, Early Identification of Individuals with HIV/AIDS, Quality Measurement in the context of medical case management services (HAB measures), and Boundaries & Ethics.
- 7.2 Upon completion of the above training, MCM must complete 12 hours of continuing education in subsequent years.