Ryan White Part A Quality Management

Medical Case Management Service Delivery Model

Palm Beach County

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Statement of Intent

All Ryan White Part A funded providers are required by contract to adhere, at a minimum, to the Florida HIV/AIDS Case Management Operating Guidelines.

Service Definition

Provided by trained professionals; including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which link clients to medical care, psychosocial, and other 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/reassessment 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, at least every six (6) months, as necessary during the enrollment 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.

Case Management providers must be PAC Waiver providers or demonstrate that they have begun the PAC Waiver application process.
Medical Case Management services exclude determining/re-determining clients' eligibility. (Approved by CARE Council 5/20/13)

Practitioner Definition

Case managers that meet the staff qualifications documented within the Florida HIV/AIDS Case Management Operating Guidelines.

Practitioner Continuing Education Recommendation

Case managers must complete annual trainings as described in the Florida HIV/AIDS Case Management Operating Guidelines.

Standards of Care

Standard	Indicator	Data Source
1. Agency complies with standards of applicable staff qualifications.	1.1 Comprehensive case managers must meet 1 of the minimum qualifications: Bachelor's or master's degree in social science or be a registered nurse; Bachelor's degree not in social science with at least 6 months case management experience; Individual may substitute applicable experience on a yr-to-yr basis for required education. 1.2 Comprehensive case managers must receive direct supervision. 1.3 Comprehensive case managers must become familiar with local community resources. 1.4 Supervisors must meet comprehensive case management qualifications and: must have related experience in providing case management services; routinely review and approve case manager records; provide routine support and supervision to case managers; provide interim staff for vacancies and staff on leave; supervisory experience is preferred but not required.	1.1 Documentation in Personnel File 1.2 Documentation in Personnel File 1.3 Documentation in Personnel File 1.4 Documentation in Personnel File

2. Case managers will have awareness of the field of HIV/AIDS/STI case management.	2.1 Case managers will receive, within 6 months of hire, the following required training : annual confidentiality w/attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); *basic and advanced information on HIV/AIDS (501); *DOH sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC training, local resources.	2.1 Documentation in Personnel File
3. Case manager conducts brief intake/enrollment screening within two weeks of referral and conducts updates as needs change or annually.	3.1 Case manager will complete brief intake/enrollment documentation, which includes: Basic information • Notice of Eligibility • Confidentiality • Other current health care and social service providers, including other CM providers • Presenting problem • Contact and demographic information • Language choice Overview of status of needs regarding • HIV/AIDS disease, other medical concerns, access, and adherence to other health care services • Substance abuse	3.1 Intake forms and documentation 3.2 Client rights and responsibility form 3.3 Documentation of signed releases 3.4 Eligibility determination forms

	• Mental health • Housing • Food/clothing • Finances/benefits • Transportation • Legal services • Domestic violence 3.2 Document in the client's chart Client's Rights and Responsibility Form. 3.3 Obtain appropriate confidentiality releases. 3.4 Client meets program eligibility per Notice of Eligibility.	
4. Upon completion of brief intake/enrollment screening, client is enrolled in a comprehensive or supportive case management program.	4.1 Case Manager will determine appropriate case management model. • Client's level of need is ascertained • Services are explained • Readiness and interest in CM are assessed. • Client is enrolled in model most suited to his/her needs. 4.2 Program capacity is evaluated. • Program has caseload capacity. • Program has capacity to meet clients' cultural and linguistic needs. • Program service level and staff qualifications and/or expertise meet the client's needs. 4.3 Clients are enrolled in comprehensive or supportive case management within the agency or referred appropriately. • Consent for CM services is obtained.	4.1 Brief Intake and Enrollment Screening Form in client file 4.2 Consent forms in client file 4.3 Brief Intake and Enrollment Screening Form in client file 4.4 Referrals noted in progress 4.5 Referrals noted in progress 4.6 CAREWare caseload reports

	• Client signs all required forms and releases, if necessary. 4.4 For providers who are not able to provide level or type of case management services necessary for client (where applicable): • Agency refers the client to another case management program. • Referral to another case management program occurs within 5 business days after determination of appropriate level of care. • Referring agency follows up and verifies with client that placement was appropriate and client is receiving service. 4.5 Agency has referral arrangements with local case management providers to ensure diverse needs of clients are met. 4.6 Agencies providing both models of case management: • Are able to identify which clients receive comprehensive or supportive case management. • Are able to report total number of clients served in either model. • Have a process to move clients between models.	
5. Upon completion of brief intake/enrollment screening, client is informed of their rights and responsibilities.	5.1 All clients have the right to be treated respectfully by staff, and the client's decisions and needs should drive services. 5.2 Agencies must develop a written Client Rights and Responsibilities Statement that is reviewed with each	5.1 Client Rights and Responsibilities in client file 5.2 Client Rights and Responsibilities form in client file 5.3 Documentation in client file 5.4 Site visit documentation on monitoring tool

	client, signed by the client, and a copy provided to the client during the intake or assessment process. 5.3 Agencies can reserve the right to refuse services to clients who are verbally or physically abusive to staff, or who possess illegal substances or weapons on agency property. 5.4 The Client Rights and Responsibilities should be posted in an area accessible to the public.	
6. Upon initial brief intake/enrollment screening, client is informed of the grievance policy.	6.1 The grievance procedure must include: • Staff responsible • Required documentation • Review process • Time frames • Maintenance of confidentiality • Process for advising consumer and staff of outcome • Appeals process 6.2 New clients are to be informed of the grievance policy and procedures during the initial intake and as necessary. 6.3 Provider grievance policy must be posted in area accessible to the public. 6.4 Written documentation that client received grievance policy must be in client file.	6.1 Client grievance procedure documented in client file 6.2 Documentation in client file of policy 6.3 Site visit documentation on monitoring tool 6.4 Documentation in client file of policy
7. Within 30 business days of completion of the brief intake/enrollment screening, Case manager conducts comprehensive needs assessment of client	7.1 Initial Comprehensive Needs Assessment includes at a minimum: a. Assess history and current needs in these primary areas: • Outpatient/Ambulatory health services • AIDS Drug Assistance Program (ADAP) treatments	7.1 Comprehensive Needs Assessment in client file 7.2 Documentation of face-to-face meeting in client file

to identify resources and needs.	• AIDS Pharmaceutical Assistance (local) • 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 Nutrition Therapy • Substance Abuse Services b. Assess history and current needs in these secondary areas: • Child Care Services • Emergency Financial Assistance • Food Bank/Home-Delivered Meals • Health Education/Risk Reduction • Housing Services • Legal Services • Linguistic Services • Medical Transportation Services • Outreach Services • Psychosocial Support Services • Referral for Health Care/Supportive Services • Rehabilitation Services • Respite Care • Treatment Adherence Counseling c. Additional information • Client strength and resources • Collaboration with other agencies serving client • Brief narrative summary 7.2 The case manager has primary responsibility for the Initial Comprehensive Assessment and meets face-to-face with the client at least once during the assessment	

	process.	
8. Case manager and client develop Plan of Care every 6 months, or as needed when changes occur, with a copy received by client.	8.1 The Comprehensive Service Plan includes at a minimum: • Goal (s) – address client needs/gaps in services • Activities: • Individuals responsible for action or activity • Time-frame for completion of action or activity • Barriers and denials to service • Expected outcome of goals • Client signature and date • Case Manager signature and date 8.2 The case manager and the client have primary responsibility for developing the service plan. 8.3 The plan is included in the case record as well as updated with outcomes and revised or amended in response to any changes in client life circumstances or goals.	8.1 Comprehensive Service Plan in client file 8.2 Documentation in client file. 8.3 Documentation in client file.
9. Case managers routinely monitor client progress toward meeting goals as stated in Plan of Care.	9.1 Case manager is responsible for the oversight of service implementation plan. 9.2 Case manager is responsible for keeping progress notes recording the results of client's goals and outcomes. 9.3 Documentation in client's chart of type and frequency of contact made on the client's behalf or to and from client. 9.4 Documentation indicates contact with client and providers after arranging services to determine if services are: • Delivered and utilized by the client • Continue to be appropriate to the client's needs	9.1 Documentation in client file 9.2 Documentation in progress notes 9.3 Documentation in progress notes 9.4 Documentation in progress notes and on service plan 9.5 Documentation in progress notes 9.6 Confidentiality releases in client file

	9.5 Case manager follows up on any problems with service delivery. 9.6 The client's right to privacy and confidentiality in contacts with other providers and others is ensured. Documentation of client's consent to consult with other service providers is obtained.	
10. Every 6 months, or as needed when changes occur, case managers reassess clients' status and determines new or ongoing needs.	10.1 Each reassessment includes: a. Updated personal contact information • Demographic information • Insurance status • Other health and social service providers b. Updated health history, health status, and health-related needs outlined in the Initial Comprehensive Assessment (see Initial Comprehensive Assessment, criteria 1: a, b). c. Any additional information • Client strength and resources • Collaboration with other agencies serving client • Brief narrative summary • Case manager signature and date 10.2 The case manager has primary responsibility for the reassessment of the client and meets face-to-face with the client at least once during the reassessment process. 10.3 The reassessment is documented in client's chart. 10.4 The client's right to privacy and confidentiality is ensured.	10.1 Eligibility documentation and updated demographics 10.2 Documentation in client file 10.3 Reassessment dates in client file 10.4 Client Rights and Responsibility and confidentiality releases in client file
11. All client records/files will be	11.1 All client records will contain at a minimum the following documentation:	11.1 Documentation in client file 11.2 Progress notes in client file 11.3 Confidentiality releases in

neatly maintained and organized.	a. Brief intake b. Initial comprehensive assessment (if applicable) c. Initial service plan (if applicable) d. Current Notice of Eligibility e. Revised service plan (every six months if applicable) f. Case conferences (if applicable) g. Case closure (if applicable) 11.2 Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in client file. 11.3 Confidentiality forms (if applicable). 11.4 Other documentation an agency deems appropriate.	client file 11.4 Documentation in client file
12. As needed, case managers routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical and non-medical, social and support services.	12.1 Coordination activities include frequent contacts with other service providers and case managers and are documented in the progress notes. 12.2 Evidence of timely case conferencing with key providers is found in the client's records through case note documentation. 12.3 The client's right to privacy and confidentiality in contacts with other providers is maintained.	12.1 Documentation in progress notes 12.2 Documentation in progress notes 12.3 Client Rights and Responsibility and confidentiality releases in client file

13. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	13.1 Closed cases include documentation stating the reason for closure and a closure summary. 13.2 Supervisor signs off on closure summary indicating approval. 13.3 Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff.	13.1 Case Closure Form in client file 13.2 Case Closure Form in client file 13.3 Documentation in progress notes