Medical Case Management

Service Definition

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. MCM services are based primarily in a medical setting; however, MCMs may conduct services outside of a clinic. MCM services include all types of case management encounters (for example, face-to-face, phone contact, and any other forms of communication).[1]

Key service components and activities for MCM services include:[2]

- Program enrollment and eligibility determination.
- Initial assessment of service needs.
- Development of a comprehensive, individualized service 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 any service plan made in accordance with acuity score.
- Re-evaluation of any service plan at least every six months regardless of acuity score.
- 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.
- Resource referral and system navigation.
- Client-specific advocacy and review of utilization of services.
- Providing pillbox fills and ongoing support to ensure client adherence of medications and medical appointments.

Benefits counseling may also be provided by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (for example, Medicaid, Medicare Part D, AIDS/HIV Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance marketplaces and/or exchanges).

Subrecipients providing MCM services are expected to comply with the Universal Standards of Care, as well as these additional standards:

[1] PCN 16-02: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
[2] National Monitoring Standards Program: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf

Standard 1: Providers of Medical Case Management services in Wisconsin must ensure services are delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

Providers are responsible to determine eligibility at enrollment and to confirm eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500% of the federal poverty level (FPL) at initial enrollment in accordance with the Wisconsin Ryan White Part B Eligibility Policy.

Standard 2: During initial contact, key information about the client must be collected or verified in the Electronic Medical Record (EMR).

Providers must attempt to collect and/or confirm the following client information:

- Contact and identifying information
- Emergency contact, if available
- Insurance status
- Documentation of income and status of residing in Wisconsin
- Demographic information
- Contact information for other service providers and corresponding release(s) of information (ROI)
- Proof of HIV diagnosis

Documentation

Documentation of all elements outlined above must be completed within 30 days of first medical visit, initial referral, or contact. Documentation must show any corresponding ROIs as needed and applicable.

Standard 3: Immediate referrals must be made for clients with most needs.

Immediate referrals, internal and external, to the appropriate services are required for clients who:

- Are not engaged in medical care.
- Are taking medication but will run out prior to first medical appointment.
- Are a danger to themselves or others.
- Are under the age of 18.
- Are pregnant.

Documentation

Documentation of immediate referrals made for needs listed in this standard must be included in the client record.

Standard 4: Intake may be performed by providers, non-service provider staff, or interns.

Intake may be performed by subrecipient staff or interns who are not MCMs provided they meet all the following criteria:

- Are an employee or intern of the subrecipients
- Received proper onsite training and signed the agency confidentiality agreement
- Completed the HIV Basics Online Course offered through the University of Wisconsin HIV Outreach Project Training System

Documentation

The client record must indicate who performed the intake.

If the client record shows that intake is performed by someone who is not a MCM, the required criteria must be documented in their personnel file.

Standard 5: The Wisconsin Acuity Index Tool (WAI) is used to determine clients' needs and level of self-sufficiency.

The WAI must be completed within 30 days of intake and evaluates client level of needs.

Documentation

The client record must document that the initial WAI was completed within 30 days of intake and the completed WAI form must be available for review. The WAI elements can be imbedded in the EMR but must be easily accessible for Wisconsin Communicable Disease Harm Reduction (CDHR) Section review upon request.

If initial WAI was completed past 30 days of intake, the client record must document circumstances leading to delay in completion.

Standard 6: Based on the WAI, the provider determines if the client should continue in MCM or be referred to another type of service.

The client is referred to Brief Services if WAI score is category 0.

When appropriate and available the client is referred to Linkage to Care if WAI score is category 3.

Documentation

Documentation of WAI score and actions taken are consistent with the WAI score and are present in the client record. Any referrals based on the WAI must be documented in the client record.

Standard 7: Within 30 days of the WAI completion, clients with a score above 0 must receive an initial Comprehensive Assessment.

A comprehensive assessment that describes the client's medical and psychosocial needs in detail must be completed. The assessment identifies service needs being addressed and by whom; service gaps; barriers to service access; and service coordination gaps. This assessment also evaluates the client's resources and strengths, including family and other supports.

Information gathered at intake can be used to inform a comprehensive assessment.

A comprehensive assessment must address client needs in the following areas:

- Education
- Financial information
- Medical care team
- Adherence to HIV medications
- Substance use
- Housing
- Social support and relationships
- Overall health
- Employment
- Health insurance
- Retention in HIV medical care
- Mental health
- Harm reduction methods
- Transportation
- Oral health
- Nutrition
- Vision care
- Activities of daily living
- Domestic violence screening
- Dependents
- Alternative therapies/medicines
- Legal
- General health literacy
- Medical comorbidities
- Knowledge of HIV

Documentation

The client record must document that all required information in each relevant area was collected through a comprehensive assessment.

Providers are encouraged to use the Comprehensive Assessment form developed by the Wisconsin CDHR Section to ensure they are gathering all the required information listed above. Subrecipients may revise the Comprehensive Assessment form or develop their own assessment tool as long as all of the elements listed above are covered. Any assessment tools developed must be strengths-based and easily accessible. If subrecipients have questions about a created tool being adequate they can reach out to the HIV Care Services Coordinator at the Wisconsin CDHR Section.

Standard 8: The provider has primary responsibility for completion of a comprehensive assessment.

Providers must meet face-to-face with the client at least once during the assessment process, either virtually or in-person.

If the provider is unable to acquire all relevant information necessary to complete the assessment within 90 days of the assessment date due to no response from the client, the provider must make three outreach attempts within 90 days of the last contact. If no response is received from the client within an additional 90 days, the client can be transferred to brief services.

Documentation

The client record must document actions taken by the case manager consistent with this requirement.

Standard 9: Based on the findings of an initial comprehensive assessment, the provider and client collaboratively develop an initial service plan.

Development of a service plan is a central component of MCM and provides the client and case management team with a proactive, concrete, and step-by-step approach to addressing client needs. An initial service plan must be completed within 30 days of a finalized comprehensive assessment.

Client needs identified during a comprehensive assessment are prioritized and translated into a service plan, which defines specific goals, action steps needed to meet goals, and who will be the responsible party for each action step.

The provider has primary responsibility for the development of the service plan. Active client involvement, defined by having client participation, input, and agreement, in each aspect of the service plan development is required. Goals, objectives, and activities of the service plan are determined with the participation of the client and, if appropriate, family, close support persons, and other providers.

At minimum, the initial service plan includes:

- Goal(s)
- Action steps [to be taken towards goal(s)]
- Individual(s) responsible for the action step
- Anticipated timeframe for each action step
- Client signature and date, or documentation of verbal approval
- Supervisor's signature and date indicating review and approval, when applicable

Documentation

A service plan, with all required elements, must be available for review by the Wisconsin CDHR Section upon request.

Standard 10: Action steps begin immediately after development of the service plan.

Specific activities performed during the service plan use will vary based on the unique needs of each client. However, all activities must promote and support client engagement in HIV medical care and overall health.

Documentation

The client record must document specific activities performed and promotion and support of client engagement in HIV medical care and overall health.

Standard 11: Communication and coordination with the client's HIV medical care team is essential for effective MCM to occur.

Frequent care consultation will happen with other members of the client medical and social service care team, including other providers and case managers.

Documentation

The client record must contain evidence of regular and ongoing contact with key members of the client's HIV medical care team, with frequency consistent with WAI score.

Standard 12: The type and frequency of contact with the client is based on client needs.

Expectations for type and frequency of client contact are based on WAI score and listed on the WAI form.

Documentation

The client record must document a frequency of contact consistent with the most recent WAI score.

Standard 13: Client acuity must be reassessed periodically, based on acuity level.

The WAI must be re-administered annually at minimum for all MCM clients. Expectations for re-administering WAI are listed on the WAI document.

Documentation

The client record must document that the client's acuity was reassessed at the frequency consistent with the most recent WAI score.

Standard 14: The client must receive a comprehensive assessment periodically, based on the acuity level.

A comprehensive assessment must be re-administered annually at minimum for all MCM clients. Expectations for re-administering a comprehensive assessment are listed on the WAI document.

A comprehensive assessment does not need to be re-administered for clients who have significant life changes. Instead, a new WAI is to be administered and the timing of other required documents will be determined by that score.

Documentation

The client record must document that a comprehensive assessment was re-administered at the frequency consistent with the most recent WAI score.

If not already documented in another way, the client record must also include a brief narrative of reassessment findings in progress notes, documentation of any referral(s) made, and outcome of referral(s).

Standard 15: The client's service plan must be reviewed based on acuity level.

Service plan review includes updating the status of existing action steps and identifying new goals and action steps to work towards meeting goals.

The provider has primary responsibility for the updated service plan.

Client input and approval of the plan is required each time the MCM reviews the plan.

The frequency of service plan review is based on the client's WAI score. Expectations for reviewing a service plan are listed on the WAI document.

When applicable, supervisory review of the service plan occurs at intervals stated on WAI form.

Documentation

The client record must document that the service plan was reviewed by the client, the case manager, and the supervisor when applicable, at the frequency consistent with the most recent WAI score.

Changes in the service plan must be documented in the client record.

When applicable, the supervisor's signature indicates review and approval of the plan.

Standard 16: Upon termination of MCM services, the client is discharged from MCM.

Criteria for client discharge are:

- Client completes service plan goals.
- Client acuity score reaches 0.
- Client is no longer eligible for services.
- Client is lost to follow-up or does not engage in service.*
- Client is referred to another HIV MCM program.
- Client is incarcerated for longer than six months.
- Client relocates outside of service area.
- Agency initiates termination due to behavioral violations. This should be a last resort.
- Client chooses to terminate service.
- Client has died.

*See Universal Standards for guidance.

Documentation

The client record must document which discharge criteria were met. Documentation must show notification of the client and other care team members as outlined in the Universal Standards.

A brief discharge narrative must be included in the client record.