New York State Department of Health
AIDS Institute

Standards for Medical Case Management

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1. Intent

This document establishes core standards for HIV medical case management services funded by the New York State Department of Health AIDS Institute (AI) through state and federal grants under the following initiatives:

- Outreach, HIV Prevention and Primary Care Services for Substance Users
- Community Based HIV Primary Care and Prevention Services
- Family-Focused HIV Health Care for Women
- HIV Health Care and Related Services for Adolescents and Young Adults

These standards are not intended to supersede other AIDS Institute initiative standards.

The standards set minimum service expectations for all programs, funded under the aforementioned initiatives, providing HIV medical case management in medical settings regardless of caseload or target population. Defining medical case management responsibilities is paramount to preventing duplication of effort and promoting cooperation and coordination with community case management efforts. Furthermore, medical case management standards will:

- Clearly define the medical case management model
- Clarify service expectations across the HIV continuum of care
- Encourage more efficient and effective use of resources
- Promote the quality provision of medical case management services
- Improve medical outcomes of people living with HIV/AIDS (PLWHIV/AIDS)

Medical case management is intended to address the needs of HIV-positive individuals in ambulatory medical settings to:

- Coordinate all medical-related care and services
- Diminish barriers to care
- Facilitate receipt of social and supportive services to maintain optimal health

2. Scope

Medical case management may be provided in a variety of medical settings, including community health centers, County Departments of Health, hospitals, or other Article 28 facilities.

Note: The AIDS Institute's Outreach, HIV Prevention and Primary Care Services for Substance Users Initiative will allow for the provision of Medical Case Management at substance use treatment facilities that do not have co-located HIV primary medical care on-site. This exception is to ensure optimal care coordination for PLWHIV/AIDS in substance treatment programs.

3. Medical Case Management Definition

Medical Case Management is a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are key components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care. This is accomplished 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 with a multidisciplinary medical team and community partners required to implement the plan; (4) patient monitoring and interdisciplinary conferencing 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 for the provision of appropriate medical care and/or review of utilization of services. This includes all types of case management encounters: face-to-face, phone contact, and any other forms of communication.

Medical case management services must be provided by trained professionals who will provide a range of client-centered services that result in a coordinated service and care plan which links clients to medical care, psychosocial, and other services. Outcomes of medical case management for PLWHIV/AIDS include prevention of disease transmission and delay of HIV progression.

Medical case management process requires the consent and active participation of the patient in decision-making. Medical case management supports a patient's right to: privacy, confidentiality, self-determination, dignity and respect. Providers must offer medical case management in an environment that is nondiscriminatory, compassionate, and nonjudgmental. Providers must be culturally and linguistically competent.

Medical case management does not replace or mitigate the need for community case management (COBRA Community Follow-up Program (CFP) and grant funded Comprehensive and Supportive Case Management). Some patients will benefit from receiving both medical case management and COBRA CFP or grant funded case management. The need for both medical case management services and either COBRA CFP or grant funded case management will most often be required for clients with multiple, complex needs that demand interventions that can not routinely be addressed by a Medical Case Management Program i.e., homelessness, domestic violence. *To best address the needs of those patients requiring both service models, Medical Case Management Programs must closely coordinate with the Community Case Management Programs. Routine case conferencing and coordination will ensure that optimal patient services are provided and avoid duplication of effort.*

4. General Guidance on Medical Case Manager Qualifications, Caseload and Training

The position qualifications for a medical case manager, the number of anticipated clients to be served, (caseload), as well as annual training requirements are defined within the agency's Medical Case Management Policies and Procedures Manual. The qualifications, caseload and training will be in compliance with the requirements set forth in the AIDS Institute's procurement (Request for Applications) under which the medical case management services were funded. Staff qualifications for Medical Case Managers will be documented in the contract work plan. It is recommended that medical case managers, at a minimum, have a baccalaureate degree and one year experience in health and human services.

The number of patients to be served is negotiated during the funding application process.

Training for medical case managers will include:

- An orientation upon hire to the population served, grant program services, facility services and community partner services
- Annual training on HIV confidentiality **and**
- At a minimum, eight (8) additional hours of training annually for professional development. Training must be on HIV-related topics and skills building activities for the provision of optimal medical case management client service.

5. Data Reporting

All providers are required to submit data on medical case management activities in the AIDS Institute Reporting System (AIRS). The submission requirements are detailed within the contract funding application.

6. Medical Case Management Standards

The definitions and purpose of each process is presented, followed by a chart stating the standard, time frame and criteria that will be used to determine if the standard has been met. Best practices are at the end of each medical case management process.

The processes of medical case management are:

I. Intake and Engagement

II. Assessment and Initial Service Plan

III. Service Plan

IV. Care Coordination and Case Conferencing

V. Reassessment/Service Plan Update

VI. Crisis Intervention

VII. Reengagement

VIII. Case Closure

I. Intake and Engagement

The Intake and Engagement Process involves the initial meetings with the patient during which the medical case manager gathers information to address the patient's immediate needs and to encourage his/her engagement and retention in services. Medical case managers will assure the patient's privacy and confidentiality in all phases and activities of medical case management.

Standard	***Criteria***
Basic patient information and social service needs (e.g. medical insurance, housing, and transportation) are discussed and documented. There is a focus on issues that may immediately impact on patient's ability to adhere to medical appointments and/or medications. Note: Medical case management services under the Family-Focused HIV Health Care for Women Initiative would include an assessment of family needs. Patient is oriented to clinic staff and procedures, and educated about ancillary/sub-specialty services available on-site or through referral. **Time requirement:** Completed at first visit with medical case manager and within 15 days of presentation at medical facility.	1. Patient need and eligibility for medical case management program services is assessed and confirmed. 2. Immediate needs are identified during the Intake interview. 3. Immediate needs are addressed promptly. 4. Initial documentation includes, at minimum: a**) Basic information** • contact and identifying information (name, address, phone, birth date, etc.) • language spoken • demographics • health insurance status • emergency contact • confidentiality concerns • household members • proof of HIV status • former HIV medical providers, including reasons for terminating care • current/former medications • other current health care and social service providers, including other community case management providers (COBRA or grant funded). b) **Brief overview of status and needs regarding** • housing • transportation • immediate medical concerns c) **Identification of immediate issues that impact patient's ability to be retained in care.** • assessment of the patient's history regarding their continuity of medical care • strategies for keeping next scheduled medical appointment 5. Documentation includes appropriate consents and releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F, and other releases for information as required by applicable law. 6. Agency's Medical Case Management Policies and Procedures contain guidelines for conducting the intake and engagement as well as process for patient interview, staff responsible, and supervisory oversight.

Best Practices

Clinicians providing HIV primary care discuss the role of the medical case manager in care coordination with their patients at the first care encounter. Emphasis on the collaborative partnership and role of the medical case manager in the patient's care coordination are explained.

Case managers must have good interviewing skills and be able to put patients "at ease". Obtaining key personal information and recognizing potentially urgent situations are tasks performed during the Initial Intake and Engagement Process. This is a sentinel event for establishing rapport between the patient and the care team. The care team must provide the patient with "an invitation to stay connected".

II. Assessment and Initial Service Plan

The assessment builds upon information from the intake and provides information to enable the development of an initial service plan. Patient needs identified through the assessment are prioritized and translated into a Medical Case Management Service Plan. The plan defines specific goals, objectives, and activities to address patient needs.

Standard	***Criteria***
Key information concerning the patient and supports is collected and documented to determine level of patient need for ongoing medical case management services. Assessment of other services utilized or needed, ability/intent to adhere to medical appointments, treatment regimens and self management skills is determined. **Time requirement:** Within 30 days of completion of intake. For the Family-Focused HIV Health Care for Women and HIV Health Care and Related Services for Adolescents and Young Adults Initiatives, within 60 days of intake or at the time of the second medical appointment.	1. Assessment documentation includes, at minimum: **a) Brief overview of status and on-going needs regarding** • food/clothing, other concrete needs • finances/benefits • health literacy • housing • transportation • legal services • substance use • mental heath • domestic violence/physical or sexual abuse • history of incarceration • support system • HIV and other medical conditions, • barriers and facilitators to access and retention in care • prevention/risk reduction issues • health behaviors(e.g. treatment adherence, nutrition, physical activity, tobacco use) • children* *An HIV-positive primary caregiver's health care is often impacted by the needs of infected and affected dependent children in their household. Assessment of the needs of dependent children in the household is conducted to identify psycho-social issues and behaviors that have the potential to impact the parent's ability to be retained in care and adhere to an effective treatment plan. To effectively address significant issues of dependent children a referral to a community provider and/or linkage to a community case manager will be required. **b) Referrals needed/recommended** **c) Name of the Medical Case Manager completing assessment and date completed** 2. Initial Service Plan A Service Plan is developed in response to the assessment and is driven by the needs identified. An update of the plan is required following a change in patient circumstances or a formal reassessment. Service Plan implementation should begin immediately to enable patients to secure services to meet initial presenting needs as well as be responsive and supportive of the prescribed medical treatment plan. A more extensive service plan is developed as additional information is being collected.

Standard	*Criteria*
	The Service Plan is a medically focused document which includes: • Goals consistent with assessed needs and abilities. • Activities (work plan, action to be taken, follow-up tasks) • Individuals responsible for the activity (patient, medical case manager, care team member, facility representative, community case manager) • Anticipated time frame for each activity • Patient approval and date, signifying agreement with plan • Medical Case Manager Supervisors are responsible for assuring that assessments and plans are comprehensive and appropriate. The medical case manager has primary responsibility for development of a medically focused plan. For patients with significant needs such as housing, legal assistance or home visits etc. the program must have linkages with community case management programs. The medical case manager is to **refer** patients in need of services outside the purview of their work scope. Furthermore, the medical case manager must track referral outcomes through coordinated efforts with a community case manager and/or other providers. *Referral without confirmation of linkage to care/service is not acceptable.* Patients receiving both medical and community case management require the managing case workers to routinely dialogue. At a minimum, for patients that receive both community and medical case management services, case conferencing must occur every six months. The service plan is updated with outcomes and is revised or amended in response to changes in patient's life circumstances or goals. The Service Plan is included in the medical chart. 3. Documentation Documentation includes appropriate consents and releases for sharing confidential information, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F, and other releases for information as required by applicable law. If the client is receiving case management services from another agency, in addition to the release(s) for service coordination efforts being on file, there must be documentation in the patient record of collaboration on the patient's service plan. Immediate collaboration with other case managers is necessary to ensure service plan development works in tandem to support the patient and avoid duplication of effort. The agency's Medical Case Management Policies and Procedures must contain guidelines for conducting the Medical Case Management Assessment and development of the Service Plan, including staff responsible for completing each and supervisory oversight.

Best Practices

Heath care facilities coordinate with a variety of service providers and hold multiple reciprocal service agreements to best meet diverse patient needs.

Agencies are culturally competent and, to the extent possible, employ staff who culturally and linguistically represents the community served.

When patients are receiving or are referred for community case management services, case notes include documentation of follow-up, coordination and case conferencing with the community case manager.

Service plans developed during face-to-face meetings and negotiated between patient and medical case manager encourage the patient's active participation and patient empowerment. A copy of the service plan is offered to the patient to reinforce patient ownership and involvement in the medical case management process.

Health-related measurable goals are activities based upon the patient's cognitive and physical abilities, available resources, support networks and motivation. Patient signature on a service plan denotes acceptance of a plan, however, a patient may decline all or any portion of a service plan.

Service plans document changes or updates as needed, as well as actual outcomes, to track patient progress and emerging needs.

III. Service Plan

The medical case management service plan is responsive to the needs identified by the patient and the medical team. The service plan builds upon the activities identified in the initial assessment/service plan and upon reassessment. The service plan outlines incremental steps to reaching a goal and who is responsible for what activity. The activities are measurable and there are timeframes for the completion of each activity. Outcomes of the service plan activities are noted in the medical case management record.

Standard	***Criteria***
Needs identified in the Assessment dictate the sequence of activities developed in the Service Plan. Service Plan drives medical case management interventions/activities. Evaluating success is judged by the patient's improved medical outcomes. **Time requirement:** Following completion of Assessment/Initial Service Plan through formal reassessment. Reassessment required at 6 months, or sooner if significant changes in patient's needs. Provision of medical case management services as outlined in the Service Plan proceeds immediately upon completion. Patients are contacted based on their level of need. Patient status is monitored. Medical case management staff tracks outcomes and receipt of service.	The agency has an ongoing monitoring process to assess the patient's ability and motivation to complete service plan activities and to address barriers to achieving goals. For example, if the patient is unable to perform specific activities, alternative approaches to meet goals should be explored such as skills development or crafting incremental steps that will support the patient in working towards completing the desired activity. Dedicated staff time and effort is required for the implementation of the service plan. Medical case manager and patient will have contact in person, by phone, or in writing. In general, the type and frequency of contact should be based on patient needs. Implementation involves: • assistance to the patient in obtaining and completing applications for services or entitlements • assistance in arranging services, making appointments, confirming service delivery dates and encouragement to the patient to carry out tasks as agreed upon • direct education to the patient as needed including treatment adherence and prevention with positives activities • support to enable patient to overcome barriers and access services including but not limited to reminders for and arranging accompaniment to appointments • skills development to allow for patient self-management • building a referral network for services not provided through medical case management • navigation for health services • negotiation and advocacy as needed • other medical case management activities as needed by the patient and as permissible through this program initiative. 1. Oversight of service plan is the responsibility of the medical case manager. 2. Progress notes detail the medical case management activities or interventions to meet the goals of the service plan on behalf of patients and record next steps and outcomes. 3. Status of the patient is monitored on a regular basis and evidence is documented in the patient's chart that the case manager and/or team members contact the patient and/or providers by a means and frequency appropriate to the patient's needs. Clinical indicators and outcomes are routinely assessed and documented.

Standard	*Criteria*
	4. Documentation indicates contact with the multidisciplinary team, all medical providers, community case managers and/or other providers related to retention in care and treatment adherence. Documentation is inclusive of additional actions to be taken and who is responsible. 5. The patient's right to privacy and confidentiality in contacts with other providers and individuals is assured: • Copies of all appropriate consents are on file.

Best Practices

The agency's Medical Case Management Policy and Procedure Manual clearly define the parameters for patient services delivered by the medical case management multidisciplinary team. For example, an agency may indicate that client accompaniment for navigation assistance and acquisition of services may be limited to the campus of the medical provider.

Timelines for supervisory review and approval of the Service Plan are outlined in the agency's Medical Case Management Policy and Procedure Manual. The manual is a valuable resource to staff and administration providing information on who does what, when and how.

IV. Care Coordination and Case Conferencing

Care Coordination includes communication, information sharing, and collaboration, and occurs regularly between medical case management and other staff serving the patient within the agency and among other agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages and confirming service acquisition.

Case Conferencing differs from care coordination. Case conferencing is a formal, planned, and structured event separate from routine contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication of services. Case conferences also present opportunities for providers to share information that will enhance patient care and improve medical outcomes. Case conferences are **multidisciplinary** and may include internal and external providers, and when appropriate, the patient and family members/close supports.

Furthermore, case conferences can be used to identify or clarify issues regarding a patient's status, needs, and goals; to review activities including progress and barriers towards goals; to delineate roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

Case conferences may be face-to-face or by conference call/videoconference. At a minimum, case conferences occur once every six months. More frequently case conferences must occur during periods of significant patient change or given patient absence from care. Case conferences are documented in the patient's record.

Standard	***Criteria***
Medical Case Management providers routinely conduct care coordination for all necessary services along the continuum of healthcare, including institutional and community-based, medical and non-medical, social and support services, with the goal of facilitating engagement and retention in care and achieving optimal medical outcomes. Case conferencing is utilized as a specific mechanism to enhance care coordination among members of a multidisciplinary team. **Time requirement for Case Conferencing:** • Required, at a minimum, every six months and occurs when there is a significant decline in the patient's health or absence from care.	1. Coordination activities include frequent contacts with other service providers and case managers and are documented in the progress notes within the patient's chart. 2. Evidence of timely case conferencing with key providers is found in the patient's records. 3. The patient's right to privacy and confidentiality in contacts with other providers is maintained. • The patient's consent to consult with other service providers is obtained. The provider complies with Article 27-F of the Public Health Law regarding confidentiality of HIV-related information.

Best Practices

Case conference documentation identifies the topics discussed and the agreed upon follow-up plan as a result of a case conference. Documentation outlines the case conference participants' role, activities they will perform, and the timeframe for completion. A form outline will limit time needed to craft a lengthy narrative report, avoid loss of information and facilitate review by all participants.

Ideally, case conferencing is initially conducted upon patient entry into the program and then at intervals as described above.

Involving patients in face-to-face case conferences with their providers encourages participation and reinforces the patient's role in their own health care plan.

V. Reassessment/ Service Plan Update

Reassessment provides an opportunity to review a patient's progress, consider successes and barriers, and evaluate the previous period of medical case management activities. ***A reassessment is always accompanied by an updated service plan.*** However, a service plan may be updated between reassessments to reflect significant changes in patient goals, health status and medical case management activities.

Standard	*Criteria*
A reassessment is performed to re-evaluate patient functioning, health and psychosocial status; identify changes since the initial or most recent assessment; determine progress and new or ongoing needs. **Time requirement:** Reassessment required 6 months after completion of Initial Assessment. Thereafter, every 6 months at minimum, or sooner if patient medical or life circumstances change significantly.	In **Medical Case Management** programs 1. Each Reassessment includes review, and if necessary, update of: a) Personal information b) Patient health history, health status, and health-related needs outlined in the comprehensive Assessment, c) Patient status and needs related to psychosocial issues and required services/referrals d) Need for partner counseling and assistance services Name of staff completing reassessment and date of completion is noted in the patient file. ➢ The medical case manager has primary responsibility for the reassessment and meets face-to-face with the patient at least once during the reassessment process. Information garnered from coordination with a community-based case manager, as appropriate, is incorporated. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F, and other releases for information as required by applicable law. ➢ The agency's Medical Case Management Policies and Procedures include guidelines for conducting the reassessment, staff responsible for performing it, and supervisory oversight of the reassessment process.

Best Practices

Reassessments include a review of the existing service plan with the patient. Dialogue occurs with the patient on what was achieved, what remains to be achieved and what barriers prevented goals from being met. An effective reassessment necessitates a review of activities conducted by the patient, the medical case manager and other members of the medical team.

Incremental activities to support the development of the service plan are agreed upon during the reassessment period.

The agency's Medical Case Management Policy and Procedures includes information on supervisory review, timelines for review and signatory as defined by the agency. Best practice dictates supervisory review of a reassessment plan.

VI. Crisis Intervention

A crisis intervention policy must be in effect to address emergencies and minimize damaging consequences from acute medical, social, physical or emotional issues that patient's present. Medical case managers must be trained on crisis intervention and adherence to the agency's crisis intervention policy.

Standard	***Criteria***
Agency has a policy for patient crisis intervention services that ensures all onsite emergencies are immediately and effectively addressed. Patients are provided resources to address a crisis after hours.	1. All patients are provided with emergency contact information that includes internal and external resources and guidance to secure assistance outside of agency business hours. 2. The need for a crisis plan is determined for each patient. Individual crisis plans must include at minimum information on service providers who are accessible 24 hours a day and able to handle emergency situations. 3. Program staff is trained on agency crisis policy and how to be an effective first responder given a crisis situation. 4. Medical Case Management Policy and Procedure manual addresses crisis intervention protocol for incidents that occur on site.

Best Practices

A crisis plan is specific to an individual patient's needs and cognitive ability. Plans are developed to ensure a patient is able to navigate services during crisis and has specific instructions and provider contact information. Co-occurring disabilities or life circumstances affect the nature and extent of the plan, i.e. people with mental illness or at risk of domestic violence need to have their special needs addressed in advance to minimize the impact of emergencies.

Medical Case Managers discuss with patients what constitutes a crisis.

The agency assesses crisis intervention service providers to ensure quality and appropriateness of their services and care. Best practice dictates a site review of agency(ies) annually.

Programs develop a mechanism to assess a pattern of individual use of crisis intervention services (i.e., frequency, repeat types of situations, resolutions) in order to minimize situations leading to crisis and ensure linkage and coordination with internal and external programs to respond to crises.

VII. Reengagement

Reengagement strategies are aimed at patients who are lost to care or those who are only episodically involved in care. Proactive measures should be instituted and maintained to achieve both retention in care and treatment adherence. Reengagement interviews should initiate a reassessment/service plan update and, when appropriate, a case conference.

Standard	***Criteria***
Strategies are in place to reach out to patients lost to follow-up to re-engage them in medical care. All efforts are documented. Information concerning any interim medical care and/or medications received is documented. Reasons for a patient's non-adherence to medical appointments or episodic involvement in care are discussed and documented, including psychosocial issues, health beliefs or other barriers. Where appropriate, patient is re-oriented to clinic staff and procedures, and re-educated about ancillary/sub-specialty services available on-site or through referral.	1. a) Medical case managers are responsible for coordinating reengagement efforts. b) Steps are taken to contact the patient directly (letters, phone calls, e-mail, text, or via collateral contacts). c) There are processes in place with external programs serving the patient to promote patient's return to care. d) Processes are in place with internal programs as appropriate to flag patient charts and to alert providers when the patient accesses other services at the facility. 2. Immediate psychosocial needs are identified during the reengagement interview and immediate service needs and barriers are addressed promptly. 3. Patient "basic information" and releases are reviewed and updated. 4. Counseling and education are initiated for a patient whose health beliefs are having a negative impact on treatment adherence. 5. Medical Case Management Policies and Procedures contain guidelines for reengagement strategies and conducting a reengagement interview, including staff responsible and supervisory oversight.

Best Practices

Retention in care and treatment adherence are the overarching goals of Medical Case Management Services. Retention in care begins with the initial visit. Medical case managers work with patients to promote optimal treatment adherence. (HAART is most successful when 95% adherence is achieved.)

VIII. Case Closure

Patients who are no longer engaged in HIV treatment and care services should have their cases closed based on the criteria and protocol outlined in the agency's Medical Case Management Policies and Procedures Manual.

Reasons for case closure may include:

- Patient lost to care, does not reengage in service.
- Patient chooses to terminate service.
- Patient relocates outside of service area.
- Agency terminates patient from services due to issues defined in the agency's Medical Case Management Policies and Procedures Manual.
- Patient is referred to another facility better able to address patient's needs.
- Patient is deceased.

Standard	***Criteria***
Upon termination of active HIV treatment and care, a patient's case is closed and the case record contains a closure summary documenting the case disposition.	1. Programs document all reengagement attempts conducted prior to case closure. 2. Closed cases include documentation stating the reason for closure and a closure summary, including facility to follow up with the patient's medical treatment (if appropriate). 3. The agency's Medical Case Management Policies and Procedures Manual outlines the criteria and protocol for case closures. All required activities, individuals responsible and the number of attempts for required activities must be documented in the Medical Case Management Policies and Procedures e.g., phone call, letter, home visit, alerts to community case managers.

Best Practices

When services are terminated by the patient, an exit interview is conducted.

A management review is completed in situations where an agency terminates services due to the patient being threatening, harassing or inflicts physical harm to staff.

If a patient is not engaged in any services at the medical facility for one year, the agency will close the medical case management file in AIRS.

Supervisory review and signatories are defined in the agency's Medical Case Management Policies and Procedures Manual.