Metropolitan Washington Regional
RYAN WHITE
PLANNING COUNCIL

SERVICE STANDARDS
FOR
MEDICAL CASE MANAGEMENT (MCM),
INCLUDING TREATMENT ADHERENCE SERVICES

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The Ryan White HIV/AIDS Program (RWHAP) is funded by the Ryan White HIV/AIDS Treatment Extension Act of 2009 and is administered by the U.S. Department of Health and Human Services (HHS) in the Health Resources and Services Administration (HRSA) within the HIV/AIDS Bureau (HAB).

I. PURPOSE OF SERVICE STANDARDS

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC EMA such that clients of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all clients and will be used as contract requirements, in program monitoring, and in quality management.

II. GOAL

The goal of Medical Case Management (MCM) is to improve the health care outcomes of people living with HIV (PLWH) by identifying and removing barriers to medical care, facilitating continuous engagement in primary medical care and supporting adherence to treatment regimens.

III. SERVICE DESCRIPTION

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care 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 the care plan at least every 6 months with adaptations as necessary
- 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
- Client-specific advocacy and/or review of utilization of services

Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

IV. HRSA NATIONAL MONITORING STANDARDS AND PERFORMANCE MEASURE/METHOD

The National Monitoring Standards are designed to ensure that Ryan White service providers meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Ryan White service providers will work with the recipient/administrative agent in their respective jurisdiction to further discuss the implementation of the National Monitoring Standards and the required performance measures. For this service category, the following performance measures are required:

Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team

- Documentation that the following activities are being carried out for clients as necessary:
  - Initial assessment of service needs
  - Development of a comprehensive, individualized care plan
  - Coordination of services required to implement the plan
  - Continuous client monitoring to assess the efficacy of the plan
  - Periodic re-evaluation and adaptation of the plan at least every 6 months, during the enrollment of the client

- Documentation in program and client records of case management services and encounters, including:
  - Types of services provided
  - Types of encounters/communication
  - Duration and frequency of the encounters

- Documentation in client records of services provided, such as:
  - Client-centered services that link clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible
  - Coordination and follow up of medical treatments
  - Ongoing assessment of client's and other key family members' needs and personal support systems
  - Treatment adherence counseling
  - Client-specific advocacy

V. PROVIDER AGENCY POLICIES & PROCEDURES

A. Agency must be licensed and/or accredited by the appropriate city/county/state/federal agency, **if required.**

B. Staff must meet minimum qualifications detailed in the job description and service standards.

C. Services will be provided through the facility or through a written affiliation agreement.

D. **Records Retention** – Policies must exist for the production, maintenance and retention of client clinical records. The agency will keep inactive client records in a confidential locked location. Client records will be kept for seven (7) years.

E. **Confidentiality Policy -** All providers must assure the client that information provided by the client or information obtained on behalf of the client is confidential. All written and verbal communications regarding the client will be maintained with strict confidentiality according to the policy of the agency and in accordance to HIPAA (Health Insurance Portability and Accountability Act) requirements.

F. There will be a private confidential office space for seeing clients.

G. **Cultural and Linguistic Appropriateness** – The agency will adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Further information on the National CLAS Standards are located at www.thinkculturalhealth.hhs.gov . Agencies are to ensure that culturally sensitive and linguistically appropriate services are available in the client's preferred language or arrange for a certified interpreter. When providing medical services, the agency will arrange for a certified medical interpreter.

H. **Americans with Disabilities Act Compliance** – The agency must demonstrate that the needs of disabled clients are met.

I. **Client Consent** – Signed consent must be obtained from client prior to initiating services.

J. **Release of Information** - Written consent must be obtained to release/exchange client information. The consent must be specific as to type of information, agency to which the information will be shared, and length of time during which the consent is valid.

K. **Grievance Policy**- All providers must review the policy with the client and provide a copy in a language and format the client can understand.

L. The Agency must have a written **Emergency Continuity of Operation Plan (COOP)** that includes procedures for service provision during a wide range of emergencies, including localized acts of nature, fire, bomb threat, evacuation, accidents, technological or attack-related emergencies and natural disasters.
M. Service providers must receive training/education annually in relationship to HIV, substance abuse, mental health, co-occurring disorders, health and related subjects such as “Prevention with Positives”.
N. A **Quality Management Plan** shall be developed for HIV-specific patient care. This plan must be updated annually.
O. Agencies must maintain linkages via detailed Memoranda of Understanding/Agreement (MOUs/MOAs) among other agencies to enhance the coordination of service provision.
P. The agency must demonstrate input from clients via a client satisfaction survey or similar method at least annually.
Q. **Continuity of Care -** Agencies must ensure that service provision occurs regardless of staffing changes, shortages and closures. Clients must also be made fully aware of business operating hours and any changes, as needed.

VI. ACCESSIBILITY IN SERVICE DELIVERY

A. There will be no barriers due to client disability. The Agency must comply with ADA requirements for the provision of reasonable accommodations to address clients with special needs.
B. The agency must demonstrate a commitment to provide services that are culturally sensitive and linguistically appropriate in accordance to the National Standards for Culturally and Linguistically Appropriate Services (CLAS).
C. There will be no barriers due to language differences between the provider and clients. Agencies must have the ability to provide native language speakers for services when twenty percent (20%) or more of their clients prefer another language or arrange for a certified interpreter. When providing medical services, the agency will arrange for a certified medical interpreter.
D. Eighty percent (80%) of all persons initially seeking services will be established into the care system of the provider within five (5) working days of initial contact. If this is not possible, the reason must be documented in the client’s file.

VII. RIGHTS AND RESPONSIBILITIES

AGENCY/PROVIDER

A. Agencies funded for Ryan White services shall have the ability to provide service in non-English languages when twenty percent (20%) or more of the clients speak a specifically identified language and must provide information for clients in that language or arrange for a certified interpreter.
B. All written materials must be printed in a language that is understandable to the client and must be written at no higher than a 5th grade reading level.
C. The agency will have a Clients Rights Statement posted and available to the client upon request.
D. The agency will have a Consent for Services Form, which is dated and signed by the client or person legally able to give consent. This form will be signed by the client upon initial intake, and at least annually thereafter.
E. The agency will have a Release of Information Form that is specific to the type of information released/exchanged, the agency to which the information will be shared, and the length of time during which the consent is valid. This form is used as needed and is signed by the client or person legally able to give consent.
F. The agency will have a written policy related to Client Grievance Procedures which is reviewed with the client in a language and format the client can understand as stated in A.
G. The agency will have a written Client Confidentiality Policy in conformance with State and Federal Laws.
H. Agencies must provide clients with complete and accurate information about services provided.

CLIENT

I. Clients have the right to be treated with dignity and respect. Clients have the responsibility to treat other clients and agency staff/volunteers with dignity and respect.
J. Clients have the right to refuse services and receive a full explanation of the consequences of refusing services.
K. Clients must be an active participant in the development, implementation, coordination and monitoring of their individual service plans. Clients must be provided with complete and accurate information about services received.
L. Clients are responsible for providing complete and accurate insurance, medical, financial and other eligibility information.

M. Clients are responsible for respecting the confidentiality of other clients receiving services.
N. Clients have the right to file a grievance if they feel their rights are being violated. Clients are responsible for following the proper procedures as outlined for grievances against any services, organization, or employee of organization.
O. Clients have the responsibility to keep illegal drugs, alcohol and weapons off agency property.

SERVICES MAY BE DISCONTINUED OR DENIED WHEN:

P. The client refuses to sign a Consent for Services and Release of Information Form.
Q. The client violates the rights of other clients or staff/volunteers
R. The client is involved in illegal activities on agency property
S. The client does not provide accurate insurance, medical, financial or benefits information
T. The client is receiving duplicate services from multiple providers.
U. The client is no longer eligible for Ryan White Services.

VIII. SERVICE DELIVERY COMPONENTS AND ACTIVITIES

A. INITIAL ELIGIBILITY DETERMINATION & ANNUAL RECERTIFICATION REQUIREMENTS

1. Proof of HIV diagnosis (Confirmatory HIV test [multi-spot, P24antigen, western blot], Viral load within 6 months, or written statement from treating physician).
2. Proof of residence (Current lease mortgage statement or deed settlement agreement, current driver's license/government identification, current voter registration card, current notice of Decision from Medicaid, Fuel/utility bill (past 90 days), property tax bill or statement (past 60 days), rent receipt (past 90 days), pay stubs or bank statement with your name and address (past 30 days), letter from another government agency with your name and address, active (unexpired) homeowners or renters insurance policy, DC Healthcare Alliance Proof of DC Residency Form, if homeless; letter from service provider on agency letterhead or homeless verification form.
3. Verification of income/gross annual income (must be less than or equal to 500% of the Federal Poverty Level [FPL]) as required by the Recipient.
4. Insurance verification as proof of un-insured or under-insured status.
5. Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. Providers are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.
6. For under-insured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare.
7. Proof of compliance with eligibility determination as defined by the jurisdiction.
8. Living arrangements/Household size
9. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services

B. INTAKE

To collect demographic information and establish a care relationship. Intake may be done by an Intake specialist or non-medical case manager. The client intake must include the following:

1. Date of intake
2. Name and signature of person completing intake
3. Client name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (client self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program.

C. COMPREHENSIVE NEEDS ASSESSMENT

The Comprehensive Needs Assessment is an information gathering process to identify client issues and care needs. It is a cooperative and interactive process between a client and Medical Case Manager. The Medical Case Manager collects, analyzes, synthesizes, and prioritizes information which identifies client needs, resources, and strengths, for purposes of developing an Individualized Care Plan (ICP) to address those needs.

Each client will participate in at least one face-to-face interview with their assigned Medical Case Manager within ten (10) business days of determining Ryan White eligibility to complete the Comprehensive Needs Assessment.

Client Assessment is an ongoing process and is used to evaluate progress, identify unresolved and/or emerging needs, guide appropriate revisions in the Individualized Care Plan (ICP), and inform decisions regarding discharge from HIV Medical Case Management (MCM) services and/or transition to other appropriate services. Client Assessments must also be conducted in the event of significant changes in the client's life.

The following information must be recorded and is required if a client does not already have a current assessment on file. (See Chart Below)

ESSENTIAL ELEMENTS OF THE COMPREHENSIVE NEEDS ASSESSMENT	
FUNCTION AREA	**SPECIFICS**
Access to Care and Support *This section describes the client's needs and eligibility for health benefit programs and support services to assist him/her in establishing, maintaining, and participating in medical care and treatment services.*	▪ Medical care provider with HIV treatment history, including date of last appointment ▪ Health Insurance and Benefit coverage, including Veteran's status ▪ Income/Financial Resources/Assistance monthly totals (client & household) ▪ Cultural values and beliefs/ practices that may impact access to medical care and services ▪ Linguistic needs, including communication and literacy skills ▪ Access to transportation to medical appointments ▪ Social support and HIV disclosure status
Health Status *This section captures general baseline health information and identifies health benefits and other support service providers involved in the client's care.*	▪ Activities of Daily Living (ADLs), including amount of assistance needed. (If receiving home health or personal chore services, include contact information). ▪ HIV disease progression; Past opportunistic infections (OI); ▪ Hospitalizations (HIV and non-HIV-related) ▪ Co-morbid Diseases (such as Tuberculosis and/or Hepatitis) ▪ Allergies ▪ Vaccination history ▪ Oral Health Needs, include date of last visit ▪ Nutritional status and needs, including Supplemental Nutrition Assistance Program (SNAP) formerly known as food stamps and/or nutritional supplements, ▪ Vision care needs (ex. problems reading or driving), include date of last visit) ▪ Obstetrics/Gynecology (OB/GYN) Care, including reproductive history and needs, include date of last visit) ▪ Family Medical History ▪ Clinical trials -(if engaged, contact nature and sponsor of trial, location and time period)

FUNCTION AREA	SPECIFICS
Treatment Adherence *This section identifies past and potential barriers to treatment.*	▪ Clinical trials -(if engaged: Type of trial, sponsor of trial, location and time period) ▪ Most recent viral load and CD4 count, with dates ▪ HIV Drug-resistance testing ▪ Current and previous Antiretroviral (ARV) regimens and date of initiation of ARV therapy ▪ Previous adverse ARV drug reactions ▪ Previous adverse reactions to drugs used for OI prophylaxis ▪ Treatment Adherence to past regimens and/or appointments, including barriers (physical, emotional and/or environmental)
Health Knowledge *This section evaluates the client's knowledge of general health and HIV.*	▪ Health Literacy ▪ HIV Knowledge: Understanding of HIV and treatment
Behavioral Health *Behavioral Health details any emotional or cognitive disorder and/or addictive behaviors diagnosed, displayed, or reported by the client and the impact of these behaviors on the client's ability to collaborate with health care professionals and adhere to health care regimens.*	Mini-assessment of current mental health status (depression or at risk of harm, etc.). Check to see if medical care staff completed a Global Appraisal of Individual Needs- Short Screener (GAIN-SS) or other mental health and Substance Abuse assessment. If not, use the GAIN-SS or other assessment that has been approved by DOH/HAHSTA that addresses all of the following: ▪ Familial history of mental health, substance abuse or tobacco use ▪ Mental health history/diagnoses ▪ Psychotropic medications (Name purpose and duration) ▪ Past psychiatric hospitalizations (when, where, why and how long) ▪ Past and current history of substance abuse of any of the following: o Street drugs—marijuana, cocaine, heroin, methamphetamine, 3,4-Methylenedioxymethamphetamine (MDMA)/ecstasy o Illicit use of prescription drugs o Alcohol ▪ Frequency of use and usual route of administration or length of sobriety ▪ Risk behaviors—drug/needle sharing, exchanging sex for drugs, sexual risk-taking while under the influence of drugs or alcohol ▪ History of mental health and/or substance abuse treatment and barriers to treatment ▪ Use of Tobacco, include number per day, date started ▪ Past partners notified since HIV diagnosis ▪ History of sexually transmitted infections ▪ Sexual practices—vaginal, anal, and/or oral ▪ Risk behavior assessment, including use of latex or polyurethane barriers, and/or number of partners. Also see risks associated with Behavioral Functions.
Children and Families *Describes the client's primary, self-identified familial relationships particularly any individuals dependent on the client for basic life needs, the level of support needed to assist the client in sustaining these primary relationships;*	▪ Marital status ▪ Dependent responsibilities: list name, relationship, living arrangements, age, HIV status, HIV disclosure status and status of relationship and backup support plan. ▪ Level of support needed to assist the client in sustaining their primary relationships ▪ Degree to which their relationships impact their ability to adhere to recommended medical practices;

and the degree to which these relationships impact the client's ability to adhere to recommended medical practices;	
Social and Physical Environment *Describes the client's current social and physical environment, how contributing environmental factors either support or hinder the client's ability to maintain medical care and achieve positive health outcomes, and the level of external support needed to address critical barriers to successful outcomes.*	▪ Housing information as it impacts on client's access and engagement in medical care services ▪ Employment, including work hours and issues affecting getting to medical appointments or taking medication at work ▪ Health and Pharmacy Insurance- current status ▪ Level of Education /Education/literacy assessment ▪ Family and partner contacts ▪ Stability of personal relationships ▪ Domestic violence screening to determine if client is perpetrator ▪ Physical and/or Sexual Abuse screening to determine if client is victim ▪ Legal Issues, including immigration, guardianship, denial of health insurance or disability benefits, wills and power of attorney ▪ Living will and health care proxy ▪ Permanency planning for dependent children (for clients with severely advanced disease) ▪ Incarceration history that could affect housing or employment

D. ACUITY SCALE

Using the information collected during the assessment, the medical case manager will complete an acuity scale to determine the intensity level of MCM services/level of care (LOC) and frequency of visits/interactions the client needs. The LOC must be documented on the Individualized Care Plan (ICP). The acuity scale must address all of the specific areas of functioning as assessed by the comprehensive needs assessment. As the client's needs change over time, the medical case manager will reassess them at prescribed increments, to ensure the most appropriate level of care is provided.

The agency's selected Acuity Scale must be approved by the recipient's program officer or administrative agent. Examples of acuity scales can be obtained from the recipient/administrative agent.

E. INDIVIDUALIZED CARE PLAN (ICP)

The Individualized Care Plan (ICP) should document long and short term goals and objectives to improve the client's health care outcomes. It should be reviewed and modified based on the acuity level identified. Within ten (10) business days of determining Ryan White eligibility, the MCM will develop the Individualized Care Plan with input from client. Progress notes should document the development of the Individualized Care Plan and whether the client was offered/received a copy.

In an ongoing interactive process with the client, problems are identified and prioritized. Identified problems are addressed through a planning process that includes the mutual development of goals, assigned activities and reporting outcomes.

The Individualized Care Plan (ICP) should contain the following:

1. Prioritized goals and measurable objectives responding to client needs and addressing barriers.
2. Planning tasks and action steps to be completed to help a client meet his/her goals with a specified timeframe. The name of the person who will be responsible for the assigned task: either the client, the Medical Case Manager, or both; should be notated.
3. Referrals for support services.
4. Documentation of the client's participation in primary medical care.
5. Notation of ongoing HIV education/counseling.
6. Client signature and date, signifying participation with development and agreement with Plan.

F. TREATMENT ADHERENCE COUNSELING

The medical case manager is responsible for the provision of treatment adherence counseling to ensure readiness for or adherence to complex HIV/AIDS regimens. Information regarding their readiness for treatment should be shared with the prescribing physician. Treatment adherence must be incorporated into the Care Plan to support the client with taking all their medications as prescribed, making and keeping appointments; addressing barriers to care and treatment; and reducing risky behaviors by encouraging therapeutic lifestyle changes as necessary. The agency must have clear policies and procedures for missed appointment follow-up, especially with clients who are homeless, peri-incarcerated, pregnant, or report no contact information.

TREATMENT ADHERENCE STRATEGIES TO REINFORCE THROUGHOUT THE MCM PROCESS	
Intake	▪ Assess if the client has health/pharmacy coverage, such as ADAP, Medicare Part D, or Medicaid, etc. If not, provide with information on available programs and link with entitlement coordinator/benefits specialist or a non-medical case manager for further assistance. ▪ Assess if the client is engaged in HIV medical care. If not, link with a provider or schedule for medical appointment. ▪ Assess if the client has a pharmacy. If not, link with a community pharmacy for filling prescriptions.
Comprehensive Needs Assessment	▪ Use the treatment adherence section of the biopsychosocial assessment, which can be supplemented with a more in-depth tool. ▪ Identify barriers to treatment adherence. ▪ For clients on ARVs, reinforce adherence.
Individualized Care Plan	▪ Develop individually tailored intervention strategies to address barriers and maintain optimal adherence. ▪ Communicate with the primary care provider.
Care Plan Implementation & Client Monitoring	▪ Monitor viral load and CD4 count. ▪ Educate on adherence to avoid resistance and encourage viral suppression. ▪ Use adherence tools to support client. ▪ Assist client to maintain active status in any health/drug payer programs (ADAP, Alliance, Medicare Part D, and Medicaid, etc.).
Re-assessment	▪ Ensure re-establishment of access to health and/or drug payer programs (ADAP, Alliance, Medicare Part D, and Medicaid, etc.) if there has been a lapse in services (client has been out of care or is out of medication). ▪ Ensure client is recertified in any lapsed health/drug payer programs (ADAP, Alliance, Medicare Part D, and Medicaid, etc.). ▪ Identify new barriers that could influence adherence and incorporate into the Care Plan.

G. COORDINATION & MONITORING OF INDIVIDUALIZED CARE PLAN (ICP)

There must be at least one documented contact with active clients every 90 days or as dictated by client need. The medical case manager must monitor the Care Plan and document the client's progress on their goals. The client record should include:

1. Progress notes for each contact
2. Progress notes recording activities on behalf of the client to implement the Care Plan
3. Progress toward Goals
4. Communication with referring agency i.e., if appointments were kept and medications prescribed.
5. Maintain contact with client by phone or at face-to-face meetings. Depending on client need;
6. Documentation of follow-up for referred services

7. Documentation of follow-up to missed appointments
8. Address emergency situations as they arise.
9. Adjustment to Care Plan if necessary
10. Case conferencing when necessary
11. Crisis intervention when necessary

H. REFERRALS & LINKAGES

The medical case manager will refer the client in applying for medical, social, financial, housing and/or other needed services as specified in the client's Individualized Care Plan.

I. FORMAL RE-ASSESSMENT OF NEEDS

A formal re-examination of the client's condition, needs and resources to identify changes which occurred since the initial or most recent assessment. The Re-assessment should include:

1. Individualized Care Plan updates must occur at least every six months.
2. Summary of progress in achievement of goals must be documented in client's file.
3. Review of client's clinical, financial and support needs to identify changes and/or additional service needs.
4. Multidisciplinary team case conference with other providers, when appropriate.
5. Re-assessment for Nutritional, mental health, oral health and substance abuse issues should be completed annually.

J. RE-CERTIFICATION (six months) REQUIREMENTS

To maintain eligibility for Ryan White services, the client (while active), must complete the sixth-month recertification process to verify the following information:

- Proof of residence
- Low income documentation
- Un-insured or under-insured status (Insurance verification as proof)
- Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare

Note: *At six month recertification one of the following is acceptable: full application and documentation, self-attestation of no change or self- attestation of change with documentation.*

K. PROCEDURE FOR MISSED APPOINTMENTS

- The client must be contacted within 2 days of missed appointment to determine if there was a reason why the appointment was not kept.
- The provider must attempt to reach the client no less than 2 times during a one-week period using the client-identified preferred contact method.
- Documentation of attempts to contact client must be noted in case file.

L. TRANSITION & DISCHARGE/CASE CLOSURE

Case Closure/Discharge

1. Reasonable efforts must be made to retain the client in services by phone, letter and/or any communication method agreed upon by the client. These efforts must be documented in the client's record.
2. The provider will make appropriate referrals and provide contacts for follow-up.
3. The provider must document date and reasons for closure of case including but not limited to: service provided as planned, no contact, client request, client moves out of service area, client died, client ineligible for services, etc.
4. A summary of the services received by the client must be prepared for the client's record.

Case Transfer

1. If the client is being transitioned, the provider must facilitate the transfer of client records/information, when necessary.
2. The client must sign a consent to release of information form to transfer records which is specific and dated.

M. DOCUMENTATION

Documentation must be kept for each client, which includes:

1. Client's name
2. Name and contact info of client's Primary Care provider, if they have one
3. Proof of HIV+ status.
4. Initial comprehensive needs assessment.
5. Signed, initial and updated Individualized Care Plan.
6. Evidence of consent for services.
7. Progress notes detailing each contact with or on behalf of the client. These notes must include date of contact and names of person providing the service.
8. Evidence of the client receiving rights and responsibilities information.
9. Signed "Consent to release information" form. This form must be specific and time limited.
10. Discharge information including person completing discharge, date and reason for discharge.

IX. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

Medical case managers must be able to work effectively with their clients; developing supportive relationships, facilitating access to needed services, and assisting clients in achieving their maximum possible level of independence in decision making. The ability to accomplish these objectives requires specific skills that can best be acquired through education and previous work experience. The required qualifications are as follows:

- <u>Medical Case Manager</u>
  - Licensure as a Physician, Nurse or Social Worker in the jurisdiction(s) in which services are rendered, and
  - A minimum of one (1) year experience working with HIV case management or relevant adult/pediatric community health work- clinical or hospital based.

- <u>Medical Case Management Supervisor</u>
  - Licensure as a Physician, Registered Nurse (RN), Nurse Practitioner (NP), or as an Advanced Level (Graduate/Clinical) Social Worker in the jurisdiction(s) in which services are rendered, and
  - A minimum of three (3) years' experience working with HIV case management or relevant adult/pediatric community health work- clinical or hospital based.
  - One (1) year of supervisory experience, preferred.

MEDICAL CASE MANAGER EDUCATION REQUIREMENTS AND TRAINING

The minimum education and/or experience requirements for Medical Case Managers are:

1. All Medical Case Management staff must complete a minimum training regimen within one year of their hire date that includes: (a) HIV Case Management Standards, (b) training in HIV 101 to include HIV disease processes, treatment, testing, legal ramifications to include confidentiality, counseling/referral and prevention, (c) cultural competency and (d) AIDS Drug Assistance Program (ADAP)/Insurance training. If newly hired Medical Case Managers have previously obtained all of the required training, they do not need to repeat it. Documentation of completion of required trainings must be kept in the Medical Case Manager's person
2. All Medical Case Managers must complete at least 12 hours of continuing education in an HIV care related program each year. Documentation of completion of continuing education must be kept in the Medical Case Manager's personnel file.
3. All Medical Case Management staff must complete all required training as prescribed by the recipient/administrative agent.

PARA-PROFESSIONALS IN A MEDICAL CASE MANAGEMENT TEAM

Medical Case Managers may be supported by highly skilled para-professionals who provide high quality services that support the implementation of Medical Case Management Services under the supervision of the Medical Case Manager/MCM Supervisor. These professionals can be integrated into a tiered structure that ensures appropriately provided medical monitoring, planning, advocacy, and linkage to care, including Treatment Adherence services. Some examples are Medical Care Technicians, Assistant Medical Case Managers, etc.

Qualifications for the para-professionals are as follows:

1. Associate's/Bachelor's degree in health or human services related field preferred. High School diploma or GED required.
2. A minimum of 2 years of past experience working with persons living with HIV or at high risk of HIV acquisition preferred.
3. Ongoing education/training in HIV related subjects.

Agency will provide new hires with training regarding confidentiality, client rights and the agency's grievance procedure.