Indiana Department of Health HIV Services Program
Medical Case Management Service Standard

HRSA Service Definition:

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 provided under this service category may be provided 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 member's 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

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other State or Local health care and supportive services, and insurance plans through health insurance Marketplaces/Exchanges).

Program Guidance:

- Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category 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.

Key Service Components and Activities:

Key service components and activities and are noted in the Service Standards below.

1. Staff provide a service distinct from Part B non-medical case management (and Part A non-medical case management), one that focuses on disease management for those experiencing treatment challenges.
2. The intervention runs concurrent with (and does not replace) standard non-medical case management services if the subrecipient is funded for non-medical case management. Service providers will establish a process to communicate successes and remaining challenges to the HIV Non-Medical Case Manager at the completion of the intervention.

HIV Services Program Service Standard:

Standard	Documentation
1. Personnel Qualifications	
1. Service providers are trained professionals, either medically credentialed persons or other health care personnel who are part of the clinical care team. 2. Providers must obtain the appropriate amount of continuing education as outlined by license/credential governing body.	1. Documentation is present in personnel files and available for review by IDOH upon request.
2. Eligibility Criteria	
1. Sub-recipients must have established criteria for the provision of medical case management services that includes, at minimum: a. Eligibility verification consistent with recipient requirements: i. Maintaining legal Indiana residency ii. Proof of HIV status iii. Verifying lack of Comprehensive care coverage and ensuring Ryan White is used as the payer of last resort iv. Confirming household income meets current program eligibility standards established by IDOH.	1. Subrecipient criteria for provision of service category. 2. Service providers and sub-recipients must maintain documentation of current eligibility if providing HIV services reimbursable under the RWHAP Part B Program. 3. Documentation must be made available for review by IDOH upon request.

3. Intake	
1. Client will be contacted within three (3) business days of initial connection to schedule an intake with the first available appointment at selected agency. Clients receive initial screening to determine needs. If the agency has a waitlist, that should be documented in client file. 2. In the event of any delay to accessing care three (3) reasonable attempts within 30 days of initial contact will be made to maintain communication with the client for the purpose of an intake into MCM.	1. Sub-recipient will have established policy stating client will be contacted for scheduling intake within three (3) business days of referral. In the agency has a waitlist, that should be documented in client file. 2. Documentation of reasonable attempts must be in client file and available for review by IDOH upon request.
4. Assessment	
1. All clients are assessed for specific treatment challenges within 30 days of initial client visit (and reassessed annually) including: a. Primary medical care needs; b. Medication needs; c. Access to medications; d. Medication adherence; e. Coordination of multiple physicians; f. Oral health care needs; g. Vision needs; h. Mental health needs; i. Substance use needs; and j. Need for Non-Medical Case Management to address concerns related to: i. Eligibility for benefits such as Medicaid, Medicare, Veteran's Administration, Healthy Indiana Plan (HIP) ii. Other psychosocial needs (including domestic violence screening); iii. Legal needs;	1. Condition is confirmed by review of applicable documentation in service records. a. Documentation includes evidence of mental health and substance use screenings having been performed by the medical case manager or evidence of communication with a provider who has conducted such screening.

iv. Supportive service needs (including but not limited to transportation, food, financial and housing needs); and v. Knowledge of HIV disease disclosure requirements, and risk reduction techniques 2. The above assessment is not required for a service provided under the MCM-pharmacist subservice.	
5. Service Delivery/Treatment	
1. The following activities are performed to address the client's treatment challenges: a. Development of a comprehensive, individualized service plan; b. Treatment adherence counseling; c. Coordination of other services, including pertinent personnel, required to implement/support the individualized service plan; d. Periodic re-evaluation and adaptation of the plan (at least every six (6) months) 2. All individualized service plans address: a. Client challenges and proposed interventions; b. Client goals and expected outcomes; c. Applicable resources and referrals made; d. Person responsible for action steps in the individualized service plan; and e. Time frame for completion of action steps in the individualized service plan	1. Condition is confirmed by review of applicable documentation in service records. 2. Providers document all encounters and services rendered, including: a. Types of services provided; b. Types of encounters and communications; and c. Duration and frequency of the encounters 3. Services provided must be recorded in CAREWare service tracking system no later than 20 days after the end of each month in which services were provided.

3. Each encounter relates to the treatment challenges described by the client and focuses on: a. Treatment adherence counseling; b. Coordination and follow-up of medical treatments; c. Ongoing assessment of client's and other key family members' needs and personal support systems; d. Client-specific advocacy; e. Coordination with Non-Medical Case Management to ensure linkage to other client centered services and to facilitate access to other public and private programs for which the client may be eligible 4. Staff follow-up with clients who miss scheduled medical visits to address barriers and to reschedule the appointment.	
6. Discharge	
1. Reasons for case closure are documented when applicable. Notes reflect attempts to provide continuity of care (such as linkage with another service, attempts to contact client, referrals made for or on behalf of client, or a plan for after-care) prior to closure. Allowable reasons for closure include: a. The client has requested termination of services b. The client has moved out of the service area or is no longer eligible; c. The service provider has had no contact with the client for 12 months or more; d. The client has transferred to another service provider;	1. Client record documentation notes reason for case closure and appropriate referrals if indicated.

e. The client has violated the agency's client code of conduct; or f. The client is deceased	

Subservices:

- MCM – Intake
- MCM – Case management
- MCM – Discharge
- MCM – Pharmacist

Service Unit Definition:

- Unit = 1 visit/interaction