Riverside/San Bernardino, CA TGA Policy and Procedure Policy #3 Care Coordination Minimum Requirements	By..... Bonnie Flippin, MBA Effective.....September 1, 2009 Revised.....February 23, 2010 Revised.....August 1, 2010 Revised.....January 19, 2011 Revised.....March 1, 2012 APPROVED Scott Rigsby, Public Health Program Coordinator

PURPOSE This policy is intended to establish and communicate minimum expectations for Ryan White Program (RWP) client care coordination across the TGA.

POLICY RW-funded agencies are required to meet the minimum care coordination expectations when providing Ryan White (RW)-funded services to eligible clients.

SCOPE This applies to all contracted agencies providing RWP services to eligible clients in the Riverside/San Bernardino, CA TGA.

PROCEDURE

A. General Requirements

Refer to the Inland Empire HIV Planning Council (IEHPC) standards of care, the RW contract, and agency-developed scopes of work for detailed requirements. In general, agencies must ensure that each client receiving RW-funded services is eligible for RW-funded services. In addition, agencies must define and document the need for services, ensure that individuals cannot and are not obtaining the services from another source, and develop a plan for assisting clients towards self management and the utilization of available non-RW sources of funding.

B. Levels of Care Coordination

Clients receiving RW-funded services are at various stages of the disease continuum. Some require extensive services, care, and follow-up while others are self-managing, requiring only minimal assistance and follow-up. As a result, different levels of care coordination are required to ensure clients' health outcomes are maintained/improved without unnecessarily burdening the client and the care system. For simplicity, clients are placed into two levels: *MCM-Level* and *CM-Level*.

1. *MCM-Level*

a. Client Ratio

The caseload ratio for the *MCM-Level* shall not exceed one Medical Case Manager to 100 clients (1:100). When possible, however, the caseload ratio should be smaller.

b. Qualifying Clients

Those in the *MCM* (Medical Case Management)-*Level* of care coordination are those that need extensive care and follow-up and, therefore, require coordination by a Medical Case Manager. Agencies must *develop qualifying criteria* to determine which clients need extensive care and, therefore, which clients will receive MCM services. These qualifying criteria must be reviewed and approved by the RWP office.

c. Agency Responsibilities

- Medical Case Manager: When possible (ratio and funding permitting), all *MCM-Level* clients must be assigned a RW-funded Medical Case Manager. Ideally, if the client is receiving RW-funded Outpatient/Ambulatory Medical Care, MCM should be provided by the agency that is providing the client with RW-funded Outpatient/Ambulatory Medical Care.

- Care Plan: The Medical Case Manager is responsible for developing and maintaining the client's comprehensive Care Plan that contains the minimum service-need components listed in ***Section C*** for all care services received by the client (both RW and non-RW).
  - The client must be involved in the development and indicate that they are aware of the plan by signing and dating the initial plan as well as updates (annually, at a minimum).
  - The Care Plan must be shared with all parties involved in the client's care (e.g. physician, mental health counselor, home health provider, dental provider, food voucher distributor, non-medical case manager, etc.). Those involved in the client's health care may be within the RW-system of care and/or outside the RW system of care. HIPAA regulations must be followed when sharing information. Documentation must be obtained and maintained to verify that the information was shared with all parties (e.g. signatures, faxes, mailings, etc.)
  - The client's acuity level should be assessed at intake and periodically thereafter to track change in acuity. Agencies must enter all acuity scores in the *AIDS Regional Information Evaluation System* (ARIES).
- Case Conferencing: The objective of case conferencing is to improve client health outcomes through interdisciplinary, coordinated, and documented communication with parties significantly involved in the client's care *(e.g. physician, medical case manager, mental health counselor, substance abuse counselor, outreach worker, etc.)* to facilitate the highest quality of coordinated care for the client and to establish an agreed upon individualized care plan.
  - This effort must consist of at least one annual meeting/teleconference with all involved parties and the client.
  - This meeting/teleconference could occur with all available parties and the client at the same time or could consist of separate meetings/ conversations with each of the involved care providers and the client during a focused period of time (e.g. within the same month).
  - The meeting with the client must occur in person at least once, annually, so that the client can review, sign, and date their plan.
- Minimum Health Outcomes Tracking: All clients must have a CD4 count and viral load test every 6 months, at a minimum. Medical Case Managers must ensure that these test results are recorded in the ARIES for each client and track progress.
- Change in Status: If a client no longer qualifies as a *MCM-Level* client, reclassify the client as a *CM-Level* client and refer and link the client to a Case Manager (non-Medical) for continued follow-up.

2. ***CM-Level*:**
   a. **Qualifying Clients**

   Those in the *CM* (Case Management non-Medical)-*Level* of care coordination are those that need minimal assistance and may be self-managing their care. These clients do not need extensive medical follow-up and, therefore, require only minimal assistance from a non-medical Case Manager. *CM-Level* clients are those that do not meet the *MCM-Level* of care criteria developed by the agency and approved by RWP.

b. Agency Responsibilities

- Case Manager (non-Medical): It is strongly suggested that all *CM-Level* clients be assigned a RW-funded Case Manager (non-Medical). If a client does not have an assigned Case Manager (non-Medical), the following are the responsibility of each service provider for the services that they provide.
- Service-Need Documentation: Although a comprehensive, shared Care Plan is not required for *CM-Level* clients, the need for RW-funded services received by a *CM-Level* client must be documented.
  - Documented service-need must include information related to the minimum components listed in ***Section C*** below.
  - The Case Manager (non-Medical) or direct service provider is responsible for documenting and tracking progress concerning the service-need. This documentation should be updated annually, at a minimum, to ensure clients are contacted at least once, annually.
  - If the client has a Medical Case Manager, the service-need information should be shared with the Medical Case Manager for inclusion in the client's comprehensive Care Plan.
  - The client's acuity level should be assessed at intake and periodically thereafter to track change in acuity and to help determine if clients require *MCM-Level* coordination. Agencies must enter all acuity scores in the *AIDS Regional Information Evaluation System* (ARIES).
- Case Conferencing: Case conferencing is not required for *CM-Level* clients.
- Health Outcomes Tracking: All clients must have a CD4 count and viral load test every six months, at a minimum. Case Managers must ensure that these test results are recorded in the AIDS Regional Information Evaluation System (ARIES) for health outcomes tracking purposes.
- Change in Status: If a client's needs change and they require the types and level of service associated with *MCM-Level* clients and/or their test results qualify them as a *MCM-Level* client, the client should be reclassified as a *MCM-Level* client and referred to a Medical Case Manager.

C. Service-Need Documentation Components

The following information must be captured for each RW service, regardless of care coordination level:

a. **Problem/Presenting Issue:** What is preventing the client from accessing/remaining in medical care or adhering to treatment?
b. **Service Need:** What service(s) are needed to address the problem(s)?
c. **Goals:** What is the desired outcome for each service need?
d. **Action Plan:** What specific action(s) are required to meet each goal?
e. **Responsibility:** Who is responsible for ensuring service delivery, providing service delivery, and/or performing the action?
f. **Timeframes:** What is the estimated timeframe for each action?

D. Service-Need Documentation Examples

The following are a couple examples of acceptable documentation, one for MCM-Level clients that require a comprehensive Care Plan and one for CM-Level clients that require minimal service-need documentation. This format is not required:

MCM-Level Care Plan Example:

Problem/Issue: Substance abuse issues are preventing the client from adhering to their medication regimen and medical appointments.

Service Need: Client needs substance abuse counseling.

Goal #1: Client will reduce/eliminate substance abuse.

Action	Who is responsible	Date/Timeframe
Referral to Substance Abuse counselor	MCM	By __/__/__
Client will attend all Substance Abuse counseling appointments	Client	Ongoing, reassess __/__/__
Monitor progress	MCM	Ongoing, reassess __/__/__

Goal #2: Client will improve treatment adherence.

Action	Who is responsible	Date/Timeframe
Develop a treatment adherence plan	MCM and Client	By __/__/__
Client will adhere to plan	Client	Ongoing, reassess __/__/__
Monitor treatment adherence and health outcomes	MCM	Ongoing, reassess __/__/__

Goal #3: Client will improve attendance of medical appointments.

Action	Who is responsible	Date/Timeframe
Develop a plan for medical appointments	MCM and Client	By __/__/__
Client will attend all medical appointments	Client	Ongoing, reassess __/__/__
Monitor medical appointment attendance	MCM	Ongoing, reassess __/__/__

CM-Level Service-Need Documentation Example:

Problem/Issue: Lack of adequate nutritional food intake is preventing the client from adhering to their medication regimen.

Service Need: Client needs assistance with accessing food (food vouchers).

Goal #1: Client will obtain necessary levels of food.

Action	Who is responsible	Date/Timeframe
Develop a plan to obtain necessary levels of food	CM and Client	By __/__/__
Identify other sources of food in the community	CM and Client	By __/__/__
Assess need for RW-funded food services	CM	Ongoing, reassess __/__/__

E. Data Collection Suggestions:

Each agency may develop its own processes and procedures for ensuring compliance with this policy. However, the following are a couple of suggested methods for gathering the required information.

Hard Copy: If your agency chooses to collect the required information in hard-copy format, **Attachment A** provides suggested formats for gathering the required Care Plan and Case Conference information. These must be maintained in the client's chart and be accessible for monitoring. In addition, your agency must determine a method to ensure that the information is shared with all of the client's care providers and that this communication is documented.

ARIES: If your agency chooses to collect the required information in ARIES, utilize the main tab, "Care Plan", and the secondary tab, "Care Plan", to input and track the required information for the Care Plan. **Attachment B** provides guidance for how to utilize the "Services" main tab to collect the necessary Case Conferencing information. All clients are required to agree to ARIES "share status". Therefore, entering this information in ARIES serves as "communication" to all other service providers with access to ARIES. However, your agency must still determine a method to ensure the information is shared with any of the client's care providers that may not have access to the ARIES system and ensure that the communication is documented.

F. Compliance

RWP staff will run reports in ARIES and visit provider sites as necessary to ensure compliance with this policy. Violation of this policy will result in a monitoring finding and may result in delay or denial of payment.

If deviation from this policy and/or the agency's qualifying criteria are necessary (e.g. classifying a client as *CM-Level* when they qualify as *MCM-Level* and vice versa), the deviation must be clearly justified in the client's record and easily located by monitors/auditors. To be certain the deviation will not result in a finding, the agency should consult with the RWP office before deviating from policy.

Ryan White Care Plan

*For use with clients who are receiving Case Management Non-Medical **and/or** Medical Case Management*

Client Name: **Date:** **Agency:**

Problem / Issue: **Service Need:**

Goal:		
Action	**Responsible Party**	**Date/Timeframe**

Problem / Issue: **Service Need:**

Goal:		
Action	**Responsible Party**	**Date/Timeframe**

Problem / Issue: **Service Need:**

Goal:		
Action	**Responsible Party**	**Date/Timeframe**

Problem / Issue: **Service Need:**

Goal:		
Action	**Responsible Party**	**Date/Timeframe**

Signatures

Signature / Print Name	Date	Client or Agency Name

Notes

Ryan White Care Plan Case Conferencing Summary

For Medical Case Management clients

Client Name:_____

Use this form to document case conferencing with other service providers as required by the Medical Case Management Policy.

Participant Name	Agency Name (if applicable)	Date
Notes:		

Participant Name	Agency Name (if applicable)	Date
Notes:		

Participant Name	Agency Name (if applicable)	Date
Notes:		

Participant Name	Agency Name (if applicable)	Date
Notes:		