HIV Medical Case Management in Maine

New Case Manager Training

Updated 11/28/12

- Ensure understanding of terms and concepts associated with Ryan White HIV medical case management
- Ensure understanding of state expectations for service provision
- Ensure understanding of required documents, including:
  - Their purpose
  - How to complete them

HIV 101

Definitions

- HIV – Human Immunodeficiency Virus
  - Acute, Asymptomatic
  - Symptomatic
  - AIDS
- AIDS – Acquired Immune Deficiency Syndrome
  - HIV diagnosis
  - CD4 count below 200 or percentage below 14%
  - Diagnosed with one or more AIDS-defining illness aka Opportunistic Infection

AIDS-Defining Illnesses

- Candidiasis of bronchi, trachea, or lungs (see Fungal Infections)
- Candidiasis, esophageal (see Fungal Infections)
- Cervical cancer, invasive
- Coccidioidomycosis, disseminated (see Fungal Infections)
- Cryptococcosis, extrapulmonary (see Fungal Infections)
- Cryptosporidiosis, chronic intestinal (>1 month duration) (see Enteric Diseases)
- Cytomegalovirus disease (other than liver, spleen, or lymph nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related (see Dementia)
- Herpes simplex: chronic ulcer(s) (>1 month duration) or bronchitis, pneumonitis, or esophagitis

AIDS-Defining Illnesses, cont.

- Histoplasmosis, disseminated (see Fungal Infections)
- Isosporiasis, chronic intestinal (>1 month duration) (see Enteric Diseases)
- Kaposi's sarcoma
- Lymphoma, Burkitt's
- Lymphoma, immunoblastic
- Lymphoma, primary, of brain (primary central nervous system lymphoma)
- *Mycobacterium avium* complex or disease caused by *M. Kansasii*, disseminated
- Disease caused by *Mycobacterium tuberculosis*, any site (pulmonary or extrapulmonary) (see Tuberculosis)
- Disease caused by *Mycobacterium*, other species or unidentified species, disseminated
- *Pneumocystis carinii* pneumonia
- Pneumonia, recurrent (see Bacterial Infections)
- Progressive multifocal leukoencephalopathy
- *Salmonella* septicemia, recurrent (see Bacterial Infections)
- Toxoplasmosis of brain (encephalitis)
- Wasting syndrome caused by HIV infection

The Basics

- Four fluids that transmit HIV
  - Blood
  - Semen
  - Vaginal Fluids
  - Breast milk
- Most commonly spread through unprotected sex
  - Anal, Vaginal, Oral
- Also spread through sharing needles
  - Injection Drug Use
  - Tattoos
  - Piercing
- HIV needs a way into the body for transmission
- Not spread through casual/daily living activities, kissing, mosquitoes, or animals

HIV Testing

- Rapid HIV Tests
  - Oral Swab
  - Results in 20 minutes
  - Negatives do not require follow-up; Reactives DO
- OraSure Tests
  - Oral Sample
  - Sent to lab, time for results vary depending on lab
  - No additional testing required
- Blood Draw Tests
  - Sent to lab, time for results vary depending on lab
  - No additional testing required

HIV Testing

- Anonymous Testing
  - Client gives no name or identifying information
  - Use a numeric/alphanumeric system to ID tests
  - Available at many Maine CDC-funded testing sites
- Confidential Testing
  - Client gives name, but name is not shared with anyone
  - Many Family Plannings and some Maine CDC sites offer this option

If a client tests positive…

- Test results are reported to the HIV, STD, and Viral Hepatitis Program at the Maine CDC
- The client is assigned to a Disease Intervention Specialist to assist with partner notification and offer referrals

- Confidentiality is paramount in this process
- Participation is voluntary
- If client opts, DIS can contact past partners to let them know they should get tested

Ryan White Program

General

- Federal program that provides HIV-related health services
- For those who do not have sufficient health care coverage or financial resources for coping with HIV disease
- Fills gaps in care not covered by these other sources
- Oversight by US HHS Health Resources & Services Administration (HRSA)

Ryan White in Maine

- Part B
  - ADAP
  - Medical Case Management
- Part C
  - Medical care
  - Medical Case Management in Northern Maine
- Part F
  - AETC

Note

- This training is focused on the Ryan White Part B program's requirements and expectations
- In some cases, MaineCare requirements may differ
- It is your agency's responsibility to determine whether and when you need to follow MaineCare standards
  - Ask your supervisor if you have questions/concerns

Service Provision

Medical Case Management is

- Focused on treatment adherence
  - This includes making sure the client has adequate health coverage (including applying for/maintaining MaineCare and ADAP); helping the client keep medical appointments; etc.
- Supposed to link clients with health care, psychosocial services, and other services
  - Case managers should not be directly providing services (e.g. emotional support) but linking clients to appropriate resources in their identified need areas
- The coordination and follow-up of medical treatments, and other activities that increase access to and retention in medical care

- Does client have a PCP?
- Does client have an HIV specialist?
- Does client have insurance?
- Is client having labs drawn at least every six months?

Key Activities (per HRSA)

1. initial assessment of service needs;
2. development of a comprehensive, individualized care plan;
3. coordination of services required to implement the plan;
4. client monitoring to assess the efficacy of the plan; and
5. periodic re-evaluation and adaptation of the plan as necessary.

Key Activities Explained - Assessment

- Refers to the process of assessing the client (not just filling out the form called “assessment”)
- Performed at initial intake and each year after that
- Includes assessment of client acuity level
- If a client has been discharged for more than a year, it’s a “reintake”
- Same form used for all types of assessment

Key Activities Explained – Care Plan

- Process of completing the care plan with the client
- Must be done every six months
  - More often for MaineCare
- Includes reviewing previous care plan (if client is not new)

Key Activities Explained – Coordination & Monitoring

- Process of referring a client to a service identified in the care plan
- Facilitating the client's link to a service identified in the care plan
- Process of following up to ensure that a client has received a service identified in the care plan
- Screening for barriers related to accessing a service identified in the care plan
- Includes collateral contacts

Paperwork

- Considered part of a key activity **ONLY** when it supports a care plan goal and
  - CM is working directly with client to complete it (e.g. assessment, semi-annual certification)
  - Accessibility
    - Client is illiterate, has language barriers, physical incapacity
  - Emergency involving loss of health insurance
- Otherwise, considered an “Other Activity” as described on next slide

Other Activities

- **CMs may document in case notes, but should NOT enter a service in CAREWare for:**
  - Phone messages
  - Letters, other mailings, e-mails
  - Dispensing assistance or dropping items at a client's house (outside of a home visit)
  - Picking up items for a client (food, prescriptions, etc.)
  - Scheduling case management visits without working on a care plan goal
  - Any activity that does not relate to a care plan goal and a need identified on the assessment

Medical Case Management is not

- Mental health counseling
  - If your client needs MH counseling or intense support, you should refer the client to appropriate mental health services
- Meant to be a long-term intervention
  - If a client no longer has any identifiable needs, the client should be discharged
  - Clients may always resume services at a later date, if new needs arise

Assessment
Identify needs

Care Plan
Prioritize needs
Establish goals

Encounters with Client
Actions taken toward achieving short-term goals

Outcomes
Goals achieved
Improved quality of life
Independence

If it's not documented, it didn't happen

Ryan White Required Form	When
Standard Client Contact Information	• Initiation of services • As needed
Semi-Annual Certification	• Initiation of services • Every **six** months
Standard Comprehensive Assessment	• Initiation of services • Annually
Standard Semi-Annual Care Plan	• Initiation of services • Every **six** months
Standard Discharge Summary	• Discharge
Standard Client Rights & Responsibilities and Consent to Services	• Initiation of services • Annually
HIV Verification	• Initiation of services • If client progresses to AIDS dx • If client changes name
Release of Information	• Initiation of services • As needed
Grievance Policy	• Initiation of services • Annually
Notice of Privacy Practices	• Initiation of services • Annually
Information about services available in emergency situations	• Initiation of services • Annually

It’s Not Just Paperwork

- Outdated assessment OR care plan = unbillable contacts
  - If your agency bills MaineCare for services for a client with an outdated assessment OR care plan, MaineCare could recoup the payment
- The assessment and care plan are the client’s opportunity to direct services and prioritize goals
  - How can services be directed by client/client need if needs have not been assessed or prioritized?

It’s Not Just Paperwork

- Records are legal documents
  - May be subpoenaed
- Always use blue or black ink only
- Correct errors by drawing a line through, initialing, and dating
- Never use concealing material (such as white-out)
- Never leave blank spaces – draw a line through or write “N/A”
- Information added after form is completed is initialed and dated

Semi-Annual Certification

- HRSA requires verification of eligibility every 6 months
- Must be conducted face-to-face
  - To obtain appropriate documents and client signature

HRSA-required processes

- Verification of household income
  - Household income cannot exceed 500% FPL
- Verification of HIV status
  - Obtain most recent labs and complete Care Status section of certification form
- Verification of insurance status
  - Document insurance types and status
  - Copy insurance cards if client has insurance
- Verification of residence
  - Document any changes to address

HIV/AIDS Verification

- Acceptable sources:
  - Medical records
  - Confidential detectable viral load results
  - Confidential HIV antibody test results
  - Statement from the client's medical provider verifying the client's HIV status
- Must include client's full name
- Received within 30 days of initial referral/request for service

Income Verification

Household Size and Income – Annual Review/Annual screen in CAREWare

Legal household size: ______

Income must be verified for all members of the legal household.

Income Source	Annual Amount	Date of Verifying Document*
Earned Income (wages, salaries, overtime, commissions, fees, tips, severance and bonuses, before any payroll deductions; net income from self-employment; all regular pay, special pay and allowances for members of the Armed Forces.)		
Unemployment		
Supplemental Security Income (SSI)		
Social Security Disability Income (SSDI)		
Veteran's disability pay		
Private disability insurance		
Worker's compensation		
Temporary Assistance for Needy Families (TANF)		
General assistance		
Social Security Retirement before deductions		
Veteran's pension before deductions		
Pension from a former job before deductions		
Child support		
Alimony or other spousal support		
Trust/endowment/investments		
Rental property		
Other:		
Total Annual Household Income: $		

* **Verifying documents must be attached.** Acceptable forms of verification include:

- Social Security award letter
- Copy of Social Security check
- W2 tax forms
- Year-end 1099 forms
- Federal income tax return
- Pay stubs (must be 4 consecutive weeks)
- Bank statement
- DHHS statement

If client reports no income for household CM must complete box below:

Client has not received income since ______

Client does not expect to receive any income until ______

Client has applied for:
☐ SSD/SSI
☐ Other assistance: ______

Client currently pays rent and/or utilities by: ______

Client gets food, hygiene items, and household supplies by: ______

Income Verification

- Required as part of semi-annual certification – even if the income amount hasn't changed
- Required for all members of the legal household
- Supporting documentation is required, not just the Income Verification form
  - Documents must be dated within the last 12 months
- Remember to update the Income Date in CAREWare

Income Verification

- Note: Any client whose household income exceeds 500% of the Federal Poverty Level must be discharged due to ineligibility for services

Household Size and Income

- Client and legal spouse and/or other legal dependents
- Otherwise, household size is 1
- This definition may be different from other programs, such as HAVEN and MaineCare.
- "Household Income" should reflect the income for all of the people counted in "Household Size."

Clients who report no income

If client reports no income for household CM must complete box below:

Client has not received income since ____________________

Client does not expect to receive any income until ____________________

Client has applied for:
☐ SSD/SSI
☐ Other assistance: ____________________

Client currently pays rent and/or utilities by: ____________________

Client gets food, hygiene items, and household supplies by: ____________________

- Blanks and NA are <u>unacceptable</u>
- Must demonstrate that Ryan White (including ADAP) is payer of last resort

Client Agreement and Informed Consent

- Client must sign every 6 months to:
  - document understanding of income limits
  - assure income is accurately reported
  - consent to services

Client agreement (initial each area and sign below)

_______ I understand that my case manager has to complete this form with me every six months for me to receive HIV medical case management services.

_______ I understand that some of this information is entered into a computer database. Information about me and the services I receive are entered into this secured database and reported to the federal government. I understand that my information has to be reported for me to receive HIV medical case management services funded by Ryan White.

_______ I understand the Client Rights and Responsibilities. I know my rights and responsibilities. I have a copy to take home.

_______ I understand the Notice of Privacy Practices. I know my privacy rights. I know when my information can be given to others. I have a copy to take home.

_______ I understand the Grievance Policy. I know how to file a complaint and what to expect. I have a copy to take home.

_______ I understand that my household income has to be less than 500% of the Federal Poverty Level for me to receive HIV medical case management services in Maine.

_______ I understand that the federal government requires proof of all income. I understand that I have to report any change in income, from any source, within 10 business days of the change.

_______ All information I shared with my case manager for this form is true.

I want to receive HIV medical case management services for the next six months.

Client Signature: ______________________________________ Date: ______________

Case Manager Signature: _________________________________ Date: ______________

What we look for in chart audits

- Chart includes Semi-Annual Certification in last 6 months?
- Chart includes all required Semi-Annual Certifications for past year?
- Current Semi-Annual Certification signed by client?
- Current Semi-Annual Certification includes income verification?
- Current income verification present for all members of client's legal household?
- Current Semi-Annual Certification includes insurance verification?

Review of Semi-Annual Certification

Assessment

- Supposed to guide the client’s services for the next year
- Sets the framework for the care plan
- **There must be something in the narrative to support any identified needs**
- Must be completed by the CM, not the client

Assessment

- Clients who have been discharged and re-initiate services must undergo an assessment if
  - it has been more than one year since the client was discharged, or
  - the client was due for an assessment in the time between discharge and re-initiation of services.

What we look for in chart audits

- We will compare the acuity assessment to the needs identified on the care plan to ensure they match
- We will check to make sure the assessment was completed in the last 12 months (either from audit date or discharge date)

Review of Assessment

Care Plan form

Client Name/ID:		Original Plan Date:	

Problem Areas from Assessment (check all that apply)

	1. Access		5. Education/Employment/Financial Support		9. Substance Use
	2. Housing		6. Treatment Adherence		10. Relationships
	3. Food/Nutrition		7. Dental Care		11. Legal
	4. Transportation/Home Care		8. Mental Health/Social Support		12. Other

Goals and Plan

Prioritized problem area:

Relation to HIV treatment/care:

Long-term goal:

Goals for six months, including resources to be accessed:	Start Date	Target Date	Review		
			Outcome	**If goal not achieved, indicate reasons**	**Continued use of CM for this?**
			☐ Achieved ☐ Not Achieved ☐ Unknown	☐ System barriers ☐ Financial/economic barriers ☐ Language/cultural barriers ☐ Active mental health issues ☐ Active substance use issues ☐ No longer prioritized by ct	☐ Yes ☐ No
			☐ Achieved ☐ Not Achieved ☐ Unknown	☐ System barriers ☐ Financial/economic barriers ☐ Language/cultural barriers ☐ Active mental health issues ☐ Active substance use issues ☐ No longer prioritized by ct	☐ Yes ☐ No

Care Plan form

<table>
<tr><td colspan="6">Client Agreement: I have helped make this plan. I understand that I am responsible for parts of this plan. My case manager has explained this plan to me. I agree to follow this plan and to tell my case manager if anything changes. I agree to stay in contact with my case manager.</td></tr>
<tr><td>Client Signature</td><td colspan="3"></td><td>Date</td><td></td></tr>
<tr><td>CM Signature</td><td colspan="3"></td><td>Date</td><td></td></tr>
<tr><td>Date of Review</td><td></td><td>Reviewed: ☐ in person
☐ by phone</td><td>CM Review Signature</td><td colspan="2"></td></tr>
</table>

Care Plans

- **New form every 6 months**
  - Every 3 for MaineCare
- To prioritize and address client needs, facilitate client access to services, and enhance coordination of care
- Focus on what <u>the client will achieve</u> this period– not the CM’s work plan
- Care plan must be signed once per year
- Each section must focus on one need area/goal area

Care Plans – Goal Areas

- Must be developed based on **needs identified** in the assessment
- Do not anticipate changes clients may experience
  - Any area could change at any time
- Monitor client needs continuously for changes
  - When changes occur, amend the assessment or use the Assessment Update form to show the emerging need before amending care plan

Care Plans – Goal Areas

- Clients may have too many needs to address in one quarter
  - Client and CM should agree on prioritization of needs/goals
  - CM should document which need areas were prioritized in the case note
- Treatment Adherence (area 6) should only be checked if client has a specific need from this area of the assessment
- <u>Every goal</u> must support Treatment Adherence in some way

Short-Term Goals: SMART

- Specific
  - What is the client going to do? How?
  - What will the CM do on the client's behalf? How?
- Measurable
  - Establish concrete criteria for measuring progress
- Attainable
  - Should be attainable within the three-month period of the plan
- Realistic
  - Do-able at this time, given the available resources
- Timely
  - Must give clear Target Date

Clients with No Needs

- **Case managers are expected to help clients work toward achieving goals to meet their needs, with a focus on treatment adherence**
- Clients who have no identified needs should be discharged
  - They can always come back if new needs arise
- **Continuing the same goal from care plan to care plan for a year will come under scrutiny during chart reviews**

Care Plan Review

- Care plan must be reviewed every six months for Ryan White
  - MaineCare regulations apply for MaineCare clients
- Sections of form highlighted in yellow must be completed during review

Review		
Outcome	**If goal not achieved, indicate reasons**	**Continued use of CM for this?**
☐ Achieved ☐ Not Achieved ☐ Unknown	☐ System barriers ☐ Financial/economic barriers ☐ Language/cultural barriers ☐ Active mental health issues ☐ Active substance use issues ☐ No longer prioritized by ct	☐ Yes ☐ No

Care Plan Review

- Care plan must be reviewed with the client in person or by phone
- Review each need area to see if anything has changed
  - If so, amend the assessment or use the Assessment Update form to show the emerging need and add new goal area to care plan

Note

- **We are NOT saying you only have to do care plans every 6 months**
- The Ryan White program will only be seeking evidence that clients' care plans are updated every six months
- If you bill MaineCare for services, you must still abide by MaineCare rules
  - Check in with your supervisor if you have questions/concerns

What we look for in chart audits

- Chart includes Care Plan created/updated in last 6 months?
- Care Plan signed within the last year?
- Chart includes all required Care Plans for past year?
- Care Plans in chart are reviewed with client in person or by phone and signed by CM?
- Care Plan goals are needs identified on the Assessment?
- Client achieved at least 4 short-term goals in the past year?

Review of Care Plan

Encounters with Clients

- According to Rider A of your Contract for Services:
  - Case managers have a minimum of quarterly contact with clients.
  - It is expected that case managers will spend 20 hours per FTE per week on direct client service (face-to-face contact, collateral contact, and/or non-face-to-face contact) as evidenced by CAREWare service entries.

Encounters with Clients

- According to Rider A of your Contract for Services:
  - The objectives of client contact are to ensure that:
    - The Care Plan is being implemented and is adequate to meet client service needs;
    - The services the client receives from different providers are coordinated to ensure adequate care and avoid duplication of services;
    - Any barriers, gaps or issues related to needed service are identified and addressed; and
    - Any changes in the client's condition or circumstances are adequately addressed to avoid crisis situations.
  - These activities can occur through direct face-to-face or non-face-to-face contact with the client, and/or guardian, or through collateral contacts with family members or other involved individuals.

Case Notes

- According to Rider A of your Contract for Services:
  - Case notes provide evidence of monitoring of the client’s status and progress in achieving the Care Plan goals.
  - A narrative case note, indicating which goal area was the basis for the contact, is required for each client encounter.
  - Like care plan, case note must indicate how contact related to treatment adherence.
  - Each case note indicates date of service and CM name.

Case Notes

- To document that the actions you take with a client toward achieving the goals outlined in the care plan, which were established based on the needs identified in the assessment
- What Maine CDC needs:
  - Goal being worked on
  - How contact supported treatment adherence
  - Any referrals made
  - Basic detail of contact (e.g. “met with client at home” or “telephone call to client”)
  - Plan for follow up

Case Notes

- Encounters must be documented <u>correctly</u>
- Leave agencies vulnerable
  - Legal ramifications
  - Recoupment

Case Notes

- **All case managers are <u>required</u> to use Part B-provided templates for case notes**
- There are two templates for each agency
  - Use the **General Contacts** template to document any contact with the client or on the client's behalf
  - Use the **Contacts NOT logged as services** template when you need to document an action that should not be logged as a service, as described on slide 24

Sample Documentation

1/20/12

Care Plan Goal: Client will pursue new housing options.

How Contact Supports Treatment Adherence: Client needs stable housing to store medications.

Place of Service Delivery: Office visit

Description of Encounter: CM gave client housing referral list and applications for housing assistance. Client completed applications, called to schedule appointments to view apartments.

Referrals Made: BRAP, HOPWA

Follow Up: Case manager will meet with client on Tuesday to review progress and discuss next steps in housing search

Signature of CM – Credentials and Title

You are not the client's biographer!

- Because of HIPAA, clients have the right to view their records at any time
- Records have been subpoenaed in the past – do you want to see your case notes blown up on 24" x 24" paper labeled "Exhibit A"?

Subjective vs. Objective Statements

- Subjective statements are personal. They often look like someone's opinion.
  - Client was angry. Client had a bad attitude. Client is doing well. Client is stable.
- Objective statements are based on observable things, presented factually. They are not influenced by emotion, personal opinion or prejudices.
  - Client appeared angry; writer notices his voice was raised and his face was red.
  - Client reports doing "well." He stated he has a new home that he feels safer in. Client also reports taking his meds as scheduled.

Objective Documentation

- You – "Writer," "Case Manager"
- Client – "Client"
- Statements made by client: "client reports" or "client states"
- Include pertinent info discussed at visit
- Describe actions taken to reach client goals
- Identify barriers and resolutions for reaching goals

You should:

- Be brief
- Give the necessary detail
- Identify the care plan goal(s) that apply to the contact
- Describe how the contact supported treatment adherence

You should not:

- **Identify someone else’s status**
- Discuss someone else’s mental health
- Discuss someone else’s substance abuse

What we look for in desk audits

- Remote audit conducted by Part B program directly in CAREWare
  - All services logged as appropriate
  - All case notes entered as appropriate
  - Basic QM review of case notes
    - Provide one-on-one feedback for any identified issues
  - Required data elements are complete
  - Discharges are entered correctly

What we look for in chart audits

- Each Case Note entry includes date and case manager’s name?
- Each Case Note indicates care plan goal that contact supports?
- Referrals are documented?
- Collateral contacts are documented?
- Case Notes indicate how contact supports treatment adherence?
- Prevention contacts are documented at least once per year?

Discharge

Reasons for Discharge

- Client is found to be HIV-negative.
- Client's legal household income exceeds 500% of FPL.
- Client has no identified needs for HIV medical case management at this time.
- Client becomes self-sufficient.
- Client dies.
- Client and/or legal guardian request case closure.
- Client is lost to care after 45 days of reasonable attempts to engage with no response.
- Client moves into a system of care which provides in-house case management.
- Client needs are more appropriately addressed in other programs.
- Client is abusive of agency staff, property or services, and abuse is documented.

Discharge Procedures

- Use the Standard Case Management Discharge Summary form
- Document all attempts to engage the client in case management services in case notes
- Complete Discharge Summary within two weeks of the final decision to discontinue services

If agency initiates termination

- The case manager consults with a supervisor about the intent to discharge the client.
- The client is informed of the intent to discharge, and is provided with the agency grievance policy.
- The client is informed of other available community resources that may be able to meet his or her needs.
- The Case Management Standard Discharge Summary is prepared for transfer and/or closure of the case.
- The Discharge Summary is reviewed and co-signed by the clinical supervisor.

- Is the Discharge Summary form complete?

Review of Discharge Summary