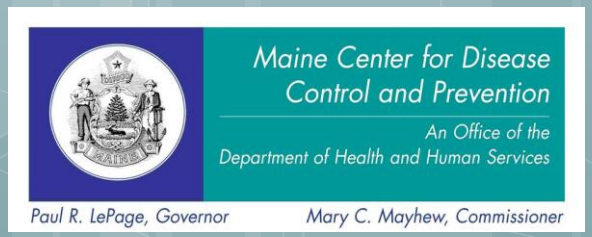
Ryan White Medical Case Management

Practice and documentation review



Originally presented March 28, 2013
Slides 59-61 amended March 29, 2013

Important reminders

Client records are legal documents

- Records may (and have been in the past) subpoenaed
- Be careful about putting too much detail in case notes that may open your agency to liability
- All documentation must be objective and professional
  - No happy faces, no subjective statements unless quoting a client
- Date of document must match signatures
  - No pre- or post-dating documents to technically meet deadlines

Client records are legal documents

- Never identify someone else's status, mental health conditions, or substance abuse in your client's record
  - Do not assume that writing "partner" is deidentifying -- you likely have a release to that partner with his or her name on it in the record as well
- Remember: Clients have a right to review their records at any time per HIPAA

Face-to-face contacts

- The annual assessment must be completed face-to-face for both Ryan White and MaineCare
- Semiannual certifications must be completed face-to-face for Ryan White
  - You cannot complete the document over the phone and then have the client sign next time he or she comes into the office
  - You cannot mail to client to sign

ADAP

- ADAP is the payer of last resort
  - Clients **must** apply to MaineCare
  - ADAP coverage is based on clients' eligibility
    - If a client is **eligible** for MaineCare but lost it for failing to recertify, client only receives ADAP coverage wrapping around typical MaineCare coverage (i.e. ADAP pays $3 or $10 copay)
  - **If client has no insurance and then gets any kind of insurance, notify ADAP immediately**

CAREWare issues

Services

- If you log a care plan and/or assessment and/or semiannual certification service, you do NOT need to log "1200 Referral and monitoring service from care plan" for the same contact (unless you work at FPC)
- Do not forget to log "1100 Client Certification" or you will not be able to run reports to show when next certification is due

Annual review

- Discrepancy between annual review information (required to be reported to the feds) in CAREWare and info on semiannual certification in chart
  - If housing, insurance, medical care, or income information changes, you must update CAREWare

Household size and income

- "Household" is defined as the client and any legal household members (legally married spouse, dependent children, dependent adults)
  - More on this later
- Income for all members of the household must be included
- Ryan White definitions of household may be different from MaineCare and HOPWA. **Always report the Ryan White information in CAREWare.**

Labs

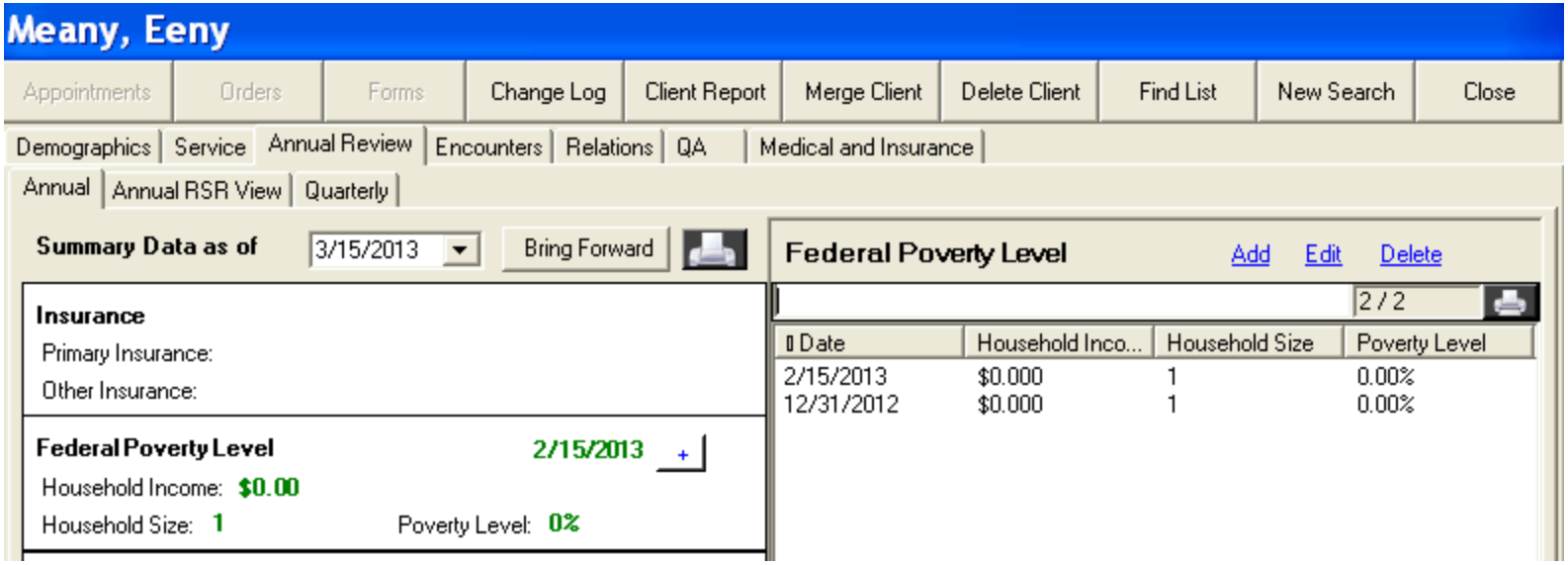
- CMs are required to enter CD4s and Viral Loads in CAREWare when they are collected for the semiannual certification

CAREWare upgrade

- This is the buggiest upgrade we've ever installed
- Known bugs:
  - Searching by drop downs (e.g. CM assigned) doesn't work
  - You can't sort any of the search terms that don't filter correctly in the find list
  - Provider Notes ARE NOT restricted to Providers (think of them as being the same as Common Notes)
  - Some issues with permissions and custom fields

CAREWare upgrade

- Income info may look a bit strange, because of the way information rolls over



CAREWare upgrade

- Any other questions about the upgrade?
  - If you come across a problem, please send a detailed email about it to be forwarded to the Help Desk

Semiannual certification

Updates to form

Now two processes

- New client intake
  - 1-page form completed once at intake
  - Focused on demographic data that do not usually change
  - No service in CAREWare
- Semiannual certification
  - 5-page form completed every six months
  - Enter service # 1100 Client Certification

HIV Medical Case Management Standard New Client Intake Form

Client ID: _____ Case Manager: _____

Date: __/___/_____ Person completing form: _____

Demographics – Demographics screen in CAREWare

Legal first name: _____ Middle: _____

Legal last name: _____ Preferred name: _____

Date of birth: __/___/____ Gender: ☐ M ☐ F ☐ MTF ☐ FTM

Ethnicity: (choose one)
- ☐ Hispanic
- ☐ Non-Hispanic

Race: (check all that apply)
- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other

HIV status:
- ☐ HIV-positive, not AIDS — Date of HIV diagnosis __/__/____
- ☐ HIV-positive, AIDS status unknown
- ☐ CDC-defined AIDS — Date of AIDS diagnosis __/__/____

Transmission category: (check all that apply)

☐ Male who has Sex with Male(s)	☐ Heterosexual contact	☐ Blood transfusion/blood products
☐ Injecting Drug Use	☐ Perinatal Transmission	☐ Other: Presumed heterosexual contact
☐ Hemophilia/Coagulation Disorder	☐ Undetermined/Unknown	☐ Other: _____

Other Demographics - QA screen in CAREWare

SSN: _____

Country of origin: _____ Subculture/tribe: _____

Preferred language(s): _____

Special populations: (check all that apply)
- ☐ Domestic violence survivor
- ☐ Veteran
- ☐ Currently incarcerated
- ☐ Past history of incarceration

Updates to semiannual certification form

- Some elements rearranged for flow
- Labs now highlighted to remind CMs to enter in CAREWare
- Expanded insurance section

Insurance Screening

Insurance Type - Annual Review/Annual screen in CAREWare
(indicate one primary and check all that apply)

☐ Primary	☐ Private Insurance
☐ Primary	☐ Medicare Part A/B (Hospital/Outpatient coverage)
	☐ Medicare Part D (Prescription coverage)
	☐ Full Low-Income Subsidy
☐ Primary	☐ Medicaid (MaineCare)
☐ Primary	☐ Other Public - Veterans Benefits, etc.
☐ Primary	☐ High Risk Insurance Pool
☐ Primary	☐ Other: _____
☐ Primary	☐ No insurance/ADAP only

Additional Information – Medical and Insurance screen in CAREWare

Private Insurance/COBRA/High Risk Insurance Pool

Plan Name:		Plan #:	

Medicare

Medicare #:			
Part D Plan Name:		Part D Plan #:	

MaineCare

MaineCare Type:	☐ Full benefit ☐ Limited benefit HIV waiver ☐ Emergency only ☐ Other: _____	MaineCare #:	
Review Date:			
If coverage pending, date of application:			

ADAP – Do NOT change ADAP info in CAREWare. Contact ADAP to make changes.

ADAP ID:	

Documentation review

Results from Dec chart reviews

Total number of records reviewed:	**48**		
Section 1: Client Identification and Eligibility			
Total number of records with Section 1 complete:	46	96%	
Section 2: Semi-Annual Certification			
Total number of records with Section 2 complete:	38	79%	
Section 3: Assessment			
Total number of records with Section 3 complete:	47	98%	
Section 4: Consent Forms			
Total number of records with Section 4 complete:	37	77%	
Section 5: Care Plan			
Total number of records with Section 5 complete:	32	67%	
Section 6: Case Notes and Monitoring			
Total number of records with Section 6 complete:	41	85%	
Section 7: Client Record Documentation			
Total number of records with Section 7 complete:	33	69%	
Section 8: Discharge Summary			
Total number of records with Section 8 complete:	47	98%	
Total number of records with <u>all</u> sections complete:	**18**	**38%**	*
* Contractual expectation: 90% of client records audited during the contract year are complete			

Improvement

- Continuing to have high completion rates in certain areas
  - Client identification & eligibility (96%)
  - Assessment (98%)
  - Discharge (98%)
- Ratings in care plan section showing progressive improvement
  - Currently at 67%

Problem areas

- Client record documentation
  - Down to 69% (from 84% in June)
- Income verification
- Consent forms
- Case notes & monitoring
- Care plan

Client record documentation

Forms must be completed

- If a client identifies no needs in an area, the zeroes still need to be filled out on the acuity scale
- If you use a second page of a care plan only for signatures, the blank boxes above must have a line drawn through them

Forms must be completed

Acuity Assessment					
Area	0 pts Client identifies no needs in this area	1 pt Client identifies low needs in this area	2 pts Client identifies moderate needs in this area	3 pts Client identifies high needs in this area	4 pts Client is in crisis in this area
1. Access					
2. Housing					4
3. Food/Nutrition					
4. Transportation/Home Care					
5. Education/Employment/Financial Support					
6. Treatment Adherence			2		
7. Dental Care					
8. Mental Health/Social Support					
9. Substance Use					
10. Relationships					
11. Legal		1			
12. Other					

NO

Forms must be completed

Acuity Assessment					
Area	0 pts Client identifies no needs in this area	1 pt Client identifies low needs in this area	2 pts Client identifies moderate needs in this area	3 pts Client identifies high needs in this area	4 pts Client is in crisis in this area
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5. Education/Employment/Financial Support					
6. Treatment Adherence			2		
7. Dental Care					
8. Mental Health/Social Support					
9. Substance Use					
10. Relationships					
11. Legal		1			
12. Other					

YES

Forms must be completed

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	Review: If goal not achieved, indicate reasons	Review: 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

NO

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.

Client Signature	Hokey Pokey	Date	1/1/13
CM Signature	Tara Thomas	Date	1/1/13

Forms must be completed

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	Review: If goal not achieved, indicate reasons	Review: Continued use of CM for this?
			☐ Achieved ☐ Not Achieved ☐ Unkn	☐ System barriers ☐ Financial/economic barriers ☐ Language/cultural barriers ☐ Active mental health issues ☐ Active substance use issues ☐ No longer prioritized by ct	☐ Yes ☐ No
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Client Agreement: I have helped make this plan. I understand 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.

Client Signature	Hokey Pokey	Date	1/1/13
CM Signature	Jane Thomas	Date	1/1/13

YES

Why be so picky?

- From Maine's Notary Guide:
  - Blanks may affect the validity of a document
  - Never use "white out" products to alter a document. If language needs to be altered, the signer should cross out or line through the language and initial all altered areas in the document.
- Although forms are not notarized, **they are legal documents** and must be held to the same standard

Income verification

Continuing issues

- Required for entire legal household
  - If client has a legal spouse, the spouse's income must be documented as well
- Required to be verified every six months
- Document must be less than one year old

What's a "legal spouse"?

- Same-sex spouses previously married in other states
- Same-sex spouses recently married in Maine
- Separated spouses who are not yet divorced

Income verification

- If client fails to provide income verification **within 30 days**, he or she must be discharged from Ryan White case management per HRSA requirements

Consent forms

Releases for MaineCare

- You do not need a release to MaineCare to discuss services they pay for that you provide
  - e.g. "Did you see John Doe on Thursday?"
- You **DO** need a release to MaineCare to discuss:
  - a client's coverage and eligibility
  - the client's adherence to medication/med pickups
  - the client's use of the ER

Other issues

- Make sure release forms are completely filled out
  - Draw a line through blank areas, just like any other document
  - Fill in all dates
- Clearly indicate the intent of the release

Case notes & monitoring

Recurring issue

- Leaving parts of the case note template blank
  - Fill in blank areas, just like any other document
  - If no referrals made or no follow up necessary, write “none”

Most common issue

- Insufficient statement of how the contact supports treatment adherence
- Lengthier does not mean more accurate

Examples of good treatment adherence statements

- transition to new PCP
- Viral load increasing
- follow up for PCP blood work
- client experiencing difficulty getting prescriptions through new mail-order pharmacy
- Coordination and monitoring of housing needs helps client stay focused on adherence to treatment.
- Coordination of insurance enables client to access meds without interruption.
- Addressing barriers to care enables client to maintain focus on adherence to treatment.
- Stable living situation allows client to attend to HIV self-care
- good dental hygiene decreases risk of opportunistic infection

More examples

- good vision allows clients to read medicine bottles
- To go over goals to ensure client is getting enough services to stay adherent to meds.
- maintaining a good diet helps with keeping client adherent to meds.
- to obtain stable housing for medication adherence, to obtain job so that client is able to get some income to afford basic necessities and to see his provider to get medications to stay healthy
- Continued connection to PCP enhances health outcomes

More examples

- Adequate food/nutrition enhances health outcomes
- Access to dental care enhances overall health.
- Transportation to attend medical appointment
- Good mental health/social supports improves overall wellbeing, and decreases depression and despair, which improves treatment adherence
- Accessing/ maintaining benefits ensures that client is able to access services and care

Care plans

Care plan issues

1. Care plan goals do not match needs identified on assessment
2. Care plans in chart not reviewed in person or by phone and signed by CM
   - Usually relates to client who was discharged (see next slide)
3. Client has not achieved at least 4 short-term goals
   - Usually due to goals not being specific enough or issue on next slide

Review care plans at discharge

- When discharging a client, review the care plan to show the status of goals at the time of discharge

Care plan goals

- Must correspond to an identified need on the assessment
- If a new need arises, use the Assessment Update form to document
- Make sure it is clear from the narrative in the section why this is a need
  - Although this will not keep a chart from passing a review, it is a common issue noted in state audits

Problems with goals

- Many care plans with exact same goals carried over for a year or more
- Many care plans with exact same goals for all clients on a caseload
- Care plan goals not specific enough
- Care plan goals not achievable

SMART Goal Writing

For client care plans and agency action plans

SMART Goals

- Specific
- Measurable
- Achievable
- Relevant
- Time-bound

Specific

- A specific goal has a much greater chance of being accomplished than a general goal.
- Who is doing the activity?
- What is the action/activity?

Measurable

- Establish concrete criteria for measuring progress toward the attainment of each goal you set.
- How much change is expected?
- Will there be an increase or decrease?
- Can you measure it?

Achievable

- Can it be done?
- Can you accomplish it in the prescribed timeframe?
- Do you have the necessary resources?

Relevant

- Does the action relate to what you want to accomplish?
- Is it important and meaningful?
- Does it relate to broader, long-term goals for the client/program/organization?

Time-bound

- What is the timeline for change?
- When will this be accomplished?

Action Planning

- Every agency continues to fall below performance targets for complete records
- Every agency fell below the performance target for hours per FTE per week for at least one quarter this year
  - Most fell below the performance target every quarter

Hours per FTE per week

- Since 2008, the Ryan White Part B Program has been tracking hours per FTE per week
- Expectation is that MCMs will spend half of their RW-funded time on direct client service
  - The other half is for paperwork, CAREWare entry, meetings, etc.

Why?

- It is not unreasonable to expect that half of a case manager's RW-funded time be spent on direct service
- If this is not happening, there are important questions to ask:
  - Is the CM spending time on non-RW activities?
  - Is the CM not accurately reporting RW time?
  - Should the budget be adjusted to pay for less direct RW time?

How we calculate it

- All client time logged in CAREWare for the period Jan. 1-Dec. 31, 2012
- Travel time to and from client appointments logged in CAREWare for the period Jan. 1-Dec. 31, 2012
- Divided by 44* weeks (to get hours per week)
- Hours per week divided by FTE in contracts (to get percent of FTE)

* Reduced from 52 to account for 12 holidays and 28 vacation/sick days

CM	% FTE
1	82%
2	63%
3	59%
4	54%
5	51%
6	42%
7	40%
8	39%
9	37%
10	34%
11	34%
12	31%
13	31%
14	26%
15	22%
16	12%

- 5 out of 16 RW-funded medical case managers meet the standard for calendar year 2012
- Median = 38%
  - That means, in a regular 40-hour work week, 15 hours were spent
    - meeting with clients by phone or in person
    - having collateral contact on behalf of clients
    - driving to and from client appointments

CM	% FTE
1	86%
2	66%
3	62%
4	55%
5	52%
6	43%
7	42%
8	40%
9	39%
10	35%
11	35%
12	33%
13	33%
14	28%
15	27%
16	15%

Adding Training Time

- Add 20 hours per year to total hours for training (per contract standard), regardless of FTE
- Same 5 out of 16 RW-funded medical case managers meet the standard for calendar year 2012
- Median = 39%
  - 16 out of 40 hours

Action Planning

- Continued issues with record reviews and hours per FTE show that current improvement strategies aren't working
- Now what?

How to write an action plan

- Current action plan form has two columns:
  - Issues to be addressed (filled in by Maine CDC)
  - Specific steps agency will take to address the issue in the next three months
- An explanation for performance is not a specific step to change the outcome in the next quarter

How to write an action plan

- Choose one idea to implement immediately to get you from your **current state** to your **desired state**
- What action(s) will you take to implement the idea?
- What do you expect to happen as a result of your actions? (i.e. what are the outcomes?)
- How will you know if you've made an improvement? (i.e. how will you measure success?)
- If no improvement, revisit the idea or select a new idea to test

Exercise

Action Planning

Group 1

- Brainstorm about how to improve record completion
- Pick a strategy
- Come up with an action plan

Group 2

- Brainstorm about how to improve hours per FTE per week
- Pick a strategy
- Come up with an action plan

More on record reviews

State audits vs. agency audits

- For many years, agency-conducted audits result in higher percentages of complete records than state-conducted audits
- Audit lists are selected randomly
- Why the differences?

Review criteria vs. other problems

- A chart can pass the review and still have many significant issues, including possible legal ramifications
- State audit results include notes on items that did not cause the chart to fail review but should still be reviewed and, if possible, corrected

Examples

- Missing case notes or missing service entries
- Late services (assessment, care plan, certification)
- Identifying someone else's (usually a partner's) HIV status
- Case notes indicating that contacts that are required to be face-to-face occurred by phone
  - **All semiannual certifications and the assessment are required to be conducted face-to-face**

Examples

- Releases not being specific enough
- Releases being too specific
- Case notes containing too much detail
  - Risk of identifying another person's (usually client's partner) HIV status, mental health conditions, and/or substance abuse without permission
  - Unnecessary in most cases
  - Wastes time

What Maine CDC looks for in audits

1. Client identification & eligibility

- Chart includes client contact information?
  - Compared to what's in CAREWare. Discrepancies noted without affecting section rating.
- Chart includes acceptable documentation of HIV/AIDS diagnosis?
  - Must include client's full legal name. 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

2. Semiannual certification

- 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?
  - Copies of insurance cards
  - Printout from MIHMS portal

3. Assessment

- Assessment done within last year?
  - From audit date or discharge date

4. Consent forms

- All required releases on file?
  - A release for every collateral contact in case notes, including specific people identified
- All releases are completely filled out, signed, and dated?
  - No blanks
- All releases clearly indicate the intent of the contact/release of information?

5. Care plan

- 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?

5. Care plan

- Care Plans in chart are reviewed with client in person or by phone and signed by CM?
  - Review section of form is filled in, including outcomes of goals
  - CM signs review section
- Care Plan goals are needs identified on the Assessment?
  - Compares acuity areas from assessment/assessment updates to goal areas on care plans
- Client achieved at least 4 short-term goals in the past year?

6. Case notes & monitoring

- Each Case Note entry includes date and case manager's name?
- Each Case Note indicates care plan goal that contact supports?
- Referrals are documented?
  - If none, write "none"
- Collateral contacts are documented?
- Case Notes indicate how contact supports treatment adherence?
- Prevention contacts are documented at least once per year?
  - Usually in assessment, otherwise in case notes

7. Client record documentation

- All forms are complete, with N/A notes in sections that are not filled in?
  - Whole sections of forms must be left blank or there must be numerous repeated blanks to receive a "No." Other blanks will be noted, but will not affect the chart rating.

8. Discharge summary

- Discharge summary completed?
  - If applicable
  - No blanks on form

Exercise

Mock chart review