Ryan White Part A
Quality Management

Disease Case Management
Service Delivery Model

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Broward EMA Definition:
Disease Case Management has a central role in addressing the health needs of persons with HIV infection. Disease Case Management refers to a system of coordinated health care interventions to help clients self-manage their HIV infection and prevent complications from other chronic health conditions through health coaching and disease-specific educational materials.

Disease Case Management is the critical foundation for client self-management efforts through client monitoring, education and communication. The main goal of Disease Case Management is to improve the client’s quality of care and health outcomes through services conducted by licensed nurse case managers. The delivery of this service is restricted to funded providers of Ryan White Part A Integrated Primary Care and Behavioral Health Services.

Services shall include assisting clients with HIV to improve and sustain adherence to their medication regimen by providing multidisciplinary education interventions, training to teach the importance of maintaining the clients’ treatment regimen, techniques to manage side effects and drug interactions, and support regarding adherence to recommended therapeutic regimens, medical procedures, behavioral health needs, and self-care for clients that require ongoing medical management for their HIV medical condition.

HRSA Definition:
Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the needs and personal support systems of the client and other key family members. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan, at least every 6 months, as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face meetings, telephone calls, and any other forms of communication. This service includes referrals for additional services to other service providers. If you provide referrals as part of this service, please do not indicate this in the clinical data section unless the referral was provided as part of an OAMC service. Similarly, if you provide adherence counseling as part of this service, please do not indicate this in the clinical data section unless it was provided as part of an OAMC service.
### OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

<table>
<thead>
<tr>
<th>Client Outcomes</th>
<th>Outcome Indicators</th>
<th>Inputs</th>
<th>Strategies</th>
<th>Data Source</th>
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</thead>
<tbody>
<tr>
<td>1. Increased access, retention, and adherence to Integrated Primary Care &amp; Behavioral Health</td>
<td>1.1. 80% of clients achieve Plan of Care goals related to Integrated Primary Care &amp; Behavioral Health services by designated target dates.</td>
<td>Funding</td>
<td>1.1.1. Collaborate with client to assess client medical needs.</td>
<td>1.1.1.1. Progress Notes</td>
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<td>Clients</td>
<td>1.1.2. Develop POC goals that reflect client’s medical &amp; behavioral health needs.</td>
<td>1.1.1.2. Plan of Care</td>
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<td></td>
<td>Staff</td>
<td>1.1.3. Develop obtainable target dates.</td>
<td>1.1.1.3. Progress Notes</td>
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<td>1.2. 80% of clients are retained in Integrated Primary Care &amp; Behavioral Health.</td>
<td>Facilities</td>
<td>1.2.1. Assist client in making medical appointments as needed.</td>
<td>1.1.1.4. Progress Notes</td>
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<td>Supplies</td>
<td>1.2.2. Follow-up to ensure client attended medical appointments.</td>
<td>1.1.1.5. Plan of Care</td>
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<td>1.2.3. Educate client on the importance of attending medical appointments.</td>
<td>1.1.1.6. Plan of Care</td>
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<tr>
<td>NOTE: Retention in care reflects an Integrated Primary Care &amp; Behavioral Health visit with a provider with prescribing privileges in the first 6 months and the last 6 months of a 12-month measurement period.</td>
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<td>1.1.2.1. Progress Notes</td>
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<td>1.1.2.2. Plan of Care</td>
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<td>1.1.2.3. Progress Notes</td>
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<td>1.1.2.4. Plan of Care</td>
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**NOTE**: Retention in care reflects an Integrated Primary Care & Behavioral Health visit with a provider with prescribing privileges in the first 6 months and the last 6 months of a 12-month measurement period.
### STANDARDS FOR HIV/AIDS SERVICE DELIVERY

<table>
<thead>
<tr>
<th>Standard</th>
<th>Indicator</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>1. Each client will receive an initial comprehensive health assessment.</td>
<td>1.1. 100% of client records will have a completed initial comprehensive health assessment.</td>
<td>1.1.1. Health Assessment 1.1.2. Electronic Health Record 1.1.3. Behavioral Health Assessment 1.1.4. Designated HIV MIS</td>
</tr>
<tr>
<td>2. Each client will be assessed to determine if he/she currently receives Primary Care.</td>
<td>2.1. 100% of client records will have documented client’s Primary Care status in the client record.</td>
<td>2.1.1. Health Assessment 2.1.2. Electronic Health Record 2.1.3. Designated HIV MIS</td>
</tr>
<tr>
<td>3. Each client will be assessed for treatment adherence, adherence to medications, and culturally specific needs.</td>
<td>3.1. 100% of client health assessments will have documented adherence to treatment, adherence to medications, and culturally specific needs as agreed with client.</td>
<td>3.1.1. Coordinated Plan of Care 3.1.2. Health Assessment 3.1.3. Electronic Health Record 3.1.4. Designated HIV MIS</td>
</tr>
<tr>
<td>4. Each client will be assessed for adherence to ART.</td>
<td>4.1. 100% of clients are assessed for ART adherence.</td>
<td>4.1.1. Health Assessment 4.1.2. Client Progress Notes 4.1.3. Designated HIV MIS</td>
</tr>
<tr>
<td>5. Ensure each client will be assessed for other prescription medication usage and contraindications with drugs prescribed for mental health therapy.</td>
<td>5.1. 100% of clients are assessed for adherence to other non-HIV medications.</td>
<td>5.1.1. Health Assessment 5.1.2. Client Progress Notes 5.1.3. Designated HIV MIS</td>
</tr>
<tr>
<td>6. Ensure each client will be assessed for disease co-morbidities (e.g. hypertension, diabetes, heart disease, and hepatitis).</td>
<td>6.1. 100% of clients are assessed for their understanding of co-morbid diseases.</td>
<td>6.1.1. Health Assessment 6.1.2. Electronic Health Record 6.1.3. Client Progress Notes 6.1.4. Designated HIV MIS</td>
</tr>
<tr>
<td>7. Ensure each client will be assessed for behavioral health needs and screened for mental health and substance abuse.</td>
<td>7.1. 100% of clients are screened for mental health and substance abuse.</td>
<td>7.1.1. Health Assessment 7.1.2. Behavioral Health Assessment 7.1.3. Electronic Health Record 7.1.4. Client Progress Notes 7.1.5. Designated HIV MIS</td>
</tr>
<tr>
<td>8. Each client will receive an individualized Plan of Care based on the client’s risk level, identified needs, and cultural needs.</td>
<td>8.1. 100% of client records will have a POC within 30 days of the health assessment.</td>
<td>8.1.1. Designated HIV MIS 8.1.2. Plan of Care</td>
</tr>
<tr>
<td>9. An individualized Plan of Care will be developed and coordinated with Primary Care and Behavioral Health needs in agreement with the client.</td>
<td>9.1. 100% of clients’ Plan of Care will have client and/or caregiver’s signature.</td>
<td>9.1.1. Plan of Care 9.1.2. Designated HIV MIS</td>
</tr>
<tr>
<td>10. Each client receiving Disease Case Management services will have their Plan of Care reassessed every six months or sooner if client circumstances change significantly.</td>
<td>10.1. 100% of clients will have their Plan of Care reassessed every six months or sooner if client circumstances change significantly.</td>
<td>10.1.1. Client Progress Notes 10.1.2. Electronic Health Record 10.1.3. Designated HIV MIS</td>
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<tr>
<td>11. Ensure each client receives follow-up assessments every six months after the initial assessment or sooner if the client circumstances change significantly.</td>
<td>11.1. 100% of client records will have documented follow-up assessments.</td>
<td>11.1.1. Health Assessment 11.1.2. Electronic Health Record 11.1.3. Designated HIV MIS</td>
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<tr>
<td>12. Each client will have face to face contact with the Disease Case Manager at least once every four months or more often depending</td>
<td>12.1. 100% of clients are seen face to face at least once every four months or more often depending</td>
<td>12.1.1. Client Record 12.1.2. Electronic Health Record 12.1.3. Designated HIV MIS</td>
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<tr>
<td>13. Each client will be assisted to establish short term and long term Primary Care and Behavioral Health goals based on Plan of Care.</td>
<td>13.1. 100% of Plans of Care document measurable health goals.</td>
<td>13.1.1. Plan of Care 13.1.2. Designated HIV MIS</td>
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<td>13.2. 100% of progress notes document assistance to achieve medical goals.</td>
<td>13.2.1. Progress Notes 13.2.2. Designated HIV MIS</td>
</tr>
<tr>
<td>14. Each client will be assisted to develop practical time frames for the client’s Primary Care and Behavioral Health goals identified in the Plan of Care.</td>
<td>14.1. 100% of progress notes document assistance to develop time frames.</td>
<td>14.1.1. Progress Notes 14.1.2. Designated HIV MIS</td>
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<td></td>
<td>14.2. 100% of client records document the interventions to achieve the client’s Primary Care and Behavioral Health goals.</td>
<td>14.2.1. Client Record 14.2.2. Designated HIV MIS</td>
</tr>
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<td></td>
<td>14.3. 80% of clients achieve Plan of Care goals by target time frames.</td>
<td>14.3.1. Target resolution dates in Plan of Care 14.3.2. Designated HIV MIS</td>
</tr>
<tr>
<td>15. Ensure each client’s viral load and CD4 count will be collected and included in the client’s record.</td>
<td>15.1. 100% of client viral loads and CD4 count will be documented in the client record.</td>
<td>15.1.1. Client Record 15.1.2. Lab Report 15.1.3. Electronic Health Record 15.1.4. Designated HIV MIS</td>
</tr>
<tr>
<td>16. Each client’s viral load and CD4 count will be tracked to observe trends and discussed with client.</td>
<td>16.1. 100% of the collected client viral loads and CD4 will be monitored.</td>
<td>16.1.1. Client Record 16.1.2. Lab Report 16.1.3. Electronic Health Record 16.1.4. Designated HIV MIS</td>
</tr>
<tr>
<td>17. Ensure each client will receive education for adherence to treatment, medications, and their side effects.</td>
<td>17.1. 100% of progress notes document treatment adherence counseling.</td>
<td>17.1.1. Client Progress Notes 17.1.2. Designated HIV MIS</td>
</tr>
<tr>
<td>18. Ensure each client receiving Disease Case Management for at least six months during the measurement year will have attended two or more Primary Care visits.</td>
<td>18.1. 95% of clients receiving Disease Case Management for at least six months during the measurement year will have attended two or more Primary Care visits.</td>
<td>18.1.1. Client Progress Notes 18.1.2. Documented Provider Visit 18.1.3. Electronic Health Record 18.1.4. Designated HIV MIS</td>
</tr>
<tr>
<td>19. Conduct multi-disciplinary case staffing for appropriate clients, defined as clients identified with a moderate to significant decrease in CD4 count, increase in viral load, or several consecutively missed medical appointments.</td>
<td>19.1. 100% of clients with a moderate to significant decrease in CD4 count, increase in viral load, or several consecutively missed medical appointments will be assessed for a multi-disciplinary case staffing.</td>
<td>19.1.1. Plan of Care 19.1.2. Client Record 19.1.3. Electronic Health Record 19.1.4. Designated HIV MIS</td>
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<tr>
<td>20. Upon termination of active Disease Case Management services, a client case is closed and contains a closure summary documenting the case disposition and an exit interview with Disease Case Manager.</td>
<td>20.1. 100% of closed cases include documentation stating the reason for closure and a closure summary.</td>
<td>20.1.1. Case Closure Summary 20.1.2. Progress Notes 20.1.3. Designated HIV MIS</td>
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<td>20.2. 100% of case closure summaries are signed off by a Disease Case Management Supervisor.</td>
<td>20.2.1. Case Closure Summary 20.2.2. Progress Notes 20.2.3. Designated HIV MIS</td>
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<td>20.3. 100% of Exit Interviews document client discharge.</td>
<td>20.3.1. Case Closure Summary 20.3.2. Designated HIV MIS</td>
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<td>20.4. 100% of clients noted as lost to care are referred to Outreach services for identification and reentry into care.</td>
<td>20.4.1. Case Closure Summary 20.4.2. Progress Notes 20.4.3. Designated HIV MIS</td>
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<tr>
<td>Section</td>
<td>Description</td>
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<td>21.</td>
<td>Progress notes and all program and service related documentation must be entered and completed in Designated HIV MIS within three business days of client contact.</td>
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<tr>
<td>21.1.</td>
<td>100% of progress notes will be entered and completed in Designated HIV MIS within three business days of client contact.</td>
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<tr>
<td>21.1.1.</td>
<td>Progress Notes</td>
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<td>21.1.2.</td>
<td>Designated HIV MIS</td>
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<tr>
<td>22.</td>
<td>Each client will receive a return call within two business days of client’s voice message requesting a return call.</td>
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<tr>
<td>22.1.</td>
<td>100% of clients will receive a return call within two business days of client’s voice message requesting a return call.</td>
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<td>22.1.1.</td>
<td>Telephone Log</td>
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<td>22.1.2.</td>
<td>Progress Log</td>
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<td>22.1.3.</td>
<td>Designated HIV MIS</td>
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<tr>
<td>23.</td>
<td>Conduct medical chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessment.</td>
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<td>23.1.</td>
<td>100% of clients’ charts are reviewed at least quarterly.</td>
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<td>23.1.1.</td>
<td>Health Assessment</td>
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<tr>
<td>23.1.2.</td>
<td>Electronic Health Record</td>
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<tr>
<td>23.1.3.</td>
<td>Progress Notes</td>
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<tr>
<td>23.1.4.</td>
<td>Designated HIV MIS</td>
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PROTOCOLS

The Disease Case Management Protocol identifies the specific ways to implement the Disease Case Management standards and processes inherent to Disease Case Management. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., HAB HIV Medical Case Management Performance Measures, etc.).

Eligibility Verification

The Disease Case Manager shall verify client’s eligibility is established by reviewing the certification in the designated HIV MIS. The purpose of the verification is to ensure 1) client’s access to all services client may be eligible for and 2) the status of Ryan White as payer of last resort.

Target Population

Individuals who are Broward County residents living with HIV/AIDS who earn less than or equal to 400% of the Federal Poverty Guidelines, are un-insured and have barriers to economic stability, have no other means or funding source to receive services, and may have difficulties achieving positive health care outcomes on their own.

Services Covered

Disease Case Management covers the services listed below. The services provided are delivered to clients through their Disease Case Managers.

- Initial comprehensive health assessment
- Development of an coordinated Plan of Care with the client, his/her primary care provider, behavioral health provider, case manager, other health care providers, and family members and/or significant others as designated by the client
- Routine follow up on the client’s Plan of Care at times designated by the client’s treatment plan, the client, and/or the Disease Case Manager
- Periodic Primary Care and Behavioral Health re-assessments
- Health care monitoring such as:
  - Coordination of medical care with the clients’ primary care provider, behavioral health provider, case manager, or other health care providers
  - Monitoring of prescription medication fulfillment and medication adherence coaching
- Client education such as information on health conditions, prescription medications, medication adherence, proper nutrition and exercise, prevention, and staying healthy
- Assistance with identifying resources in the community specific to the client’s needs

Client Health Assessment

Assessment Process

The Disease Case Manager shall assess client needs by coordinating and/or completing all sections of the Primary Medical and Behavioral Health assessment in the designated HIV MIS. The Disease Case Manager shall complete the initial comprehensive health assessment within three (3) sessions from the time of initial visit. The purpose of the initial comprehensive health assessment is to evaluate each new client’s clinical status, social/lifestyle issues, knowledge of HIV, ability to comply with medication regimens, and assign an acuity risk category. At completion of the initial comprehensive health assessment, the client is assigned one of three levels of risk, i.e., high, moderate, or low. Based on the client’s risk level and identified needs, the development of the client’s personalized Plan of Care within 30 days of the health assessment in collaboration with the client, family members, case manager, and the client’s Primary Care and/or Behavioral Health provider, as needed.

Disease Case Managers shall conduct reassessments within six months after completion of the initial comprehensive health assessment or sooner if the client’s circumstances changes significantly. Disease Case Managers update clients’ plans of care and acuity determination levels with client and physician input based on the results of the client health assessments. The Disease Case Management health
assessment should include a review of the following with clients:

- Client’s current health status, including disease co-morbidities
- Client’s understanding of HIV disease progression, risky behaviors, and prevention methods
- Current or recently developed health and wellness concerns
- Behavioral health needs
  - Current/past substance use, such as alcohol and recreational drugs
- Mental health screening
- Assessment of progress of personal and health goals identified in client’s individual care plan
- Updating of goals and care plan, if necessary
- Current medication regimen
- Adherence to medication regimen
- Adherence to provider visits (primary care physician and specialists)
- Health services utilization, such as, emergency room visits and hospitalizations
- Current health and/or social needs
- Safer sex practices and screening for sexually transmitted infections
- Preventive health measures taken since last assessment
- Nutritional needs
- Demographic update
- Housing/social issues

Plan of Care

Individualized Plan of Care (POC)

The Disease Case Manager in conjunction with the client shall complete a coordinated individualized Plan of Care that incorporates the specific needs of the client. The Plan of Care includes the needs that can be met in the time frame agreed with the client. The Plan of Care is completed within 30 days of the initial comprehensive health assessment.

Time frames

The Disease Case Manager shall assist the client to set client driven, realistic time frames to resolve the barriers to access to primary care and achievement of Primary Care and Behavioral Health goals identified in the health assessment.

Addressing Cultural Needs

The Disease Case Manager shall ensure client cultural needs are addressed by including those agreed with the client in the Plan of Care.

The client will be an active participant in developing the Plan of Care. All interested parties should agree to the plan before implementation of services. Plans of care will include:

1. Name of client Integrated Primary Care and Behavioral Health provider and Disease Case Manager
2. Date and signature of Disease Case Manager
3. Date and signature of the client
4. Description of flexible short- and long-term personal and Primary Care and Behavioral Health goals, desired outcomes and dates of target goal resolution
5. Steps to be taken by the client, Disease Case Manager, and treatment team to accomplish documented goals
6. Number and type of client contacts based on Plan of Care needs:
   - Intense Contact - one face to face and at least four telephone patient or service-related contacts per month
   - Intermediate Contact - one face to face contact every three months and at least one telephone patient or service-related contact per month
7. Recommendations on how to implement the Plan of Care
8. Contingencies for anticipated problems or complications
9. Date and signature of Disease Case Manager Supervisor
Addressing Client Needs
The Disease Case Manager shall coordinate and use the Primary Care and Behavioral Health assessment data in the development of the care plan. The Disease Case Manager, in conjunction with the client and treatment team, shall prioritize the client needs to be addressed in the Plan of Care.

Resolutions to Barriers
The Disease Case Manager shall assist the client in determining appropriate strategies to resolve barriers to access Primary and Behavioral Health care. The resolutions shall be client driven.

Goals
As a member of the clinical care team, the Disease Case Manager shall assist the client to define both personal and health goals for the needs identified in the Plan of Care. The expected outcomes shall be documented in the coordinated Plan of Care. The Disease Case Manager shall document the specific assistance provided to the client in the Progress Notes.

In making sure that the client meets their goals in their coordinated Plan of Care, the Disease Case Manager will document efforts to assist the client by documenting with progress notes in the client’s record.

Client Participation
The Disease Case Manager shall ensure client participation in the development of the coordinated Plan of Care. The client’s signature on the coordinated Plan of Care shall serve as evidence of the client’s participation.

Once all barriers are addressed and treatment goals are achieved, Disease Case Management is no longer needed and client should be discharged from services.

Primary Care and Behavior Health Provider Consultation
The Primary Care and Behavioral Health provider may be contacted by the Disease Case Manager for care coordination and/or consultation. This includes:
1. Clarification of the client’s treatment plan including gaps in care
2. Clarification of prescription medications
3. Client that is non-compliant with treatment
4. Concerns related to client safety and/or quality issues
5. Behavior or lifestyle that is detrimental to the condition being managed
6. Clients that cannot be reached and has information that could be vital to share with the primary medical provider or treatment team

The intent and role of the Disease Case Manager is to promote Primary Care and Behavioral Health provider collaboration and to alert the providers to gaps in health care, to conduct outreach to the providers and to involve them in facilitating interventions related to specific gaps in care. The Primary Care and Behavioral Health provider collaboration is designed to strengthen the relationship between the treatment team and client.

Referral Process
Purpose
To standardize the process used to provide clients with information, and referrals when appropriate, within the Ryan White system of care and to other third party providers.

Procedure
Referring Disease Case Manager shall assess client needs by completing a health assessment. The analysis of the health assessment shall assist the Disease Case Manager in determining the referrals needed.
A Plan of Care shall be developed by the referring Disease Case Manager based on the identified needs. Referrals shall be documented in the Plan of Care and the Progress Notes.

Referring Disease Case Manager shall provide client with information of available services. This shall be documented in Progress Notes.

Referring Disease Case Manager shall utilize a referral tracking system to follow-up, identify the progress of referrals, and document the results of the referral in the Progress Notes.

**Status of Referral**
Referring Disease Case Manager and provider that receives the referral shall communicate and update treatment team on the status of the referral.

**No Show**
Referring Disease Case Manager shall contact “no show” clients to assess potential barriers and/or conditions leading to “no show”.

Referring Disease Case Manager and client shall determine future steps to resolve the situations that triggered the “no show”.

Referring Disease Case Manager shall establish coordination with the agency that received the initial referral to re-activate it after client consents.

Disease Case Manager shall document all client follow-up (phone calls, mail, face-to-face and/or electronic communication) on Progress Notes as soon as information is collected.

**HIV Prevention, Education, and Counseling**
Disease Case Managers will provide health information and education to patients, their family members, or other supportive persons regarding HIV prevention, transmission, and risk behavior management.

Disease Case Managers shall provide the following education at initial presentation and at each visit or as needed.

- Importance of adherence to medications and follow-up visits
- Basic pathology of HIV/AIDS
- Disclosure of HIV/AIDS status to partners
- Prevention of disease transmission
- Reduction of high risk behavior
- Advance directives
- Signs and symptoms of HIV/AIDS progression
- Birth Control
- Diet and Exercise

In addition, Disease Case Managers shall:

- Screen patients for risk behaviors
- Communicate prevention messages to patients
- Discuss sexual practices and drug-use with patients
- Positively re-enforce changes to safer behavior
- Refer patients for substance abuse treatment
- Facilitate partner notification, counseling and testing
- Provide education on treatment options for sexually transmitted diseases
- Provide education materials for disease self-management
- Educate on the importance of maintaining treatment regimens
- Educate on techniques to manage side effects and drug interactions
• Provide support regarding adherence to recommended therapeutic regimens, medical procedures, and self-care

Access to Primary Medical Care
The Disease Case Manager shall assist the client to access primary medical care, if he/she is not in care, using information provided in the health assessment. The Disease Case Manager shall discuss with the client the necessity for accessing primary medical care and with client participation determine how the Disease Case Manager can help him/her access primary medical care. The Disease Case Manager shall discuss with the client what actions need to happen so he/she can start primary medical care. The Disease Case Manager shall coordinate a primary medical care appointment for consenting client within 2 weeks of client contact with Disease Case Manager.

The Disease Case Manager shall detail the assistance provided in the Progress Notes including any coordination conducted to get the client in primary medical care.

Retention in Primary Medical Care
The Disease Case Manager shall assist the client to remain in Primary Care and Behavioral Health. The Disease Case Manager shall assess possible barriers to continue in primary medical care and assist in the resolution of these barriers.

The Disease Case Manager shall detail the assistance provided in the Progress Notes. The Disease Case Manager shall document any coordination conducted to assist client to remain in primary medical care.

Linkages and Coordination
The term linkage involves the act or process of connecting clients to treatment organizations. Once coordinated Plans of Care have been developed, services not offered by an agency may be required. In such cases, clients will need to be linked to other agencies to receive services, and care, especially if provided at multiple service points, which require coordination. Disease Case Managers are required to coordinate services and treatments. If a linkage is to be successful, that is, providing the best opportunities for clients to obtain access to the continuum of care, then Disease Case Managers must facilitate referrals and ensure that clients complete appointments (verified by obtaining feedback from recipient service providers).

Disease Case Managers should:
• Develop individualized, coordinated care plans that will enable clients to receive needed services.
• Ensure that clients are engaged in services without becoming lost to care.
• Coordinate many services and treatment as a seamless system of care. This includes follow up of medical treatment and timely and coordinated access to medically appropriate levels of care. A main component of the coordinator role of the Disease Case Manager is the continuous interchange and exchange of patient treatment information between DCM agencies, primary medical care providers, and the rest of the treatment team.

In order to support the linkage and coordination role of Disease Case Managers, the agency in which the DCM program is housed is encouraged to identify gaps in services within their organization and reach out to form strong alliances and partnerships with other organizations to bridge these gaps according to the specific needs of identified client populations. Strong linkages include defined processes for information exchange, feedback and mutually understood methods for enrolling clients into services.

As part of information exchange for the benefit of the client, one approach is using “interdisciplinary case conferences,” during which client cases are discussed amongst their treatment team. Such should include both internal and external providers of the DCM agency, and if possible and appropriate, clients and family members or those providing close support. The goal is to provide holistic, coordinated, integrated, client-centered services across providers to reduce duplication and minimize fragmentation. It can occur face-to-face or by teleconference, at regular intervals or during significant changes in client care or situation. Case conferencing is used to identify or clarify issues regarding client needs, goals and
objectives; review activities including progress and barriers towards goals; and map out roles and responsibilities, resolve conflicts and adjust the coordinated Plan of Care.

Re-engagement of Clients into Care
Clients are considered lost to care after missing core medical service appointments for a period of six months or more. Dependent on DCM Plan of Cares, appointments may include Primary Medical Care, Behavioral Health and Substance Abuse services, Oral Health Care, etc. Albeit, reengagement is the responsibility of the entire health care community, Disease Case Managers maintain a unique relationship with clients and are well positioned to guide clients back into care. Therefore, DCM programs are encouraged to develop internal policies to re-engage clients in care and/or referrals to retention services.

Adherence to Treatment
The Disease Case Manager shall discuss with the client strategies to improve adherence to treatment. The Disease Case Manager shall detail the assistance provided in the Progress Notes. The Disease Case Manager shall document any coordination conducted to assist client to adhere to treatment.

Treatment Adherence support includes interventions or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatment. This is a core component of Disease Case Management services. The Disease Case Management program has a responsibility to directly provide, or link client to, treatment adherence services. An assessment of treatment adherence support needs and client education should begin as soon as clients enter DCM and should continue as long as the client remains in DCM and is medically recommended.

The goal of any treatment adherence intervention is to provide clients with the necessary skills, information and support to follow mutually agreed upon and evidence-based recommendations of health care professionals to achieve optimal health. This includes, but is not limited to:

- Taking all medications as prescribed
- Making and keeping appointments
- Overcoming barriers to care and treatment
- Adapting to therapeutic lifestyle changes as necessary

Viral Load and CD4 Monitoring
The Disease Case Manager will collect, plot, analyze and monitor and review with the client his/her CD4 count and viral load every six months. Each client will be assessed to determine whether multidisciplinary case staffing is warranted upon receipt and analysis of lab results.

Follow-up
Schedule of Client Follow-up
The Disease Case Manager shall provide follow-up based on the client’s coordinated Plan of Care. The Disease Case Manager shall follow-up on the progress of the coordinated Plan of Care and the client’s adherence to treatment and medications. The Disease Case Manager shall document the follow-up in the Progress Notes, including phone calls, mail, face-to-face and/or electronic communication. Monitoring lab reports (trending viral loads and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. The Disease Case Manager shall take every possible interaction with the client as a window of opportunity to assess and/or reinforce access, retention, and adherence to treatment.

Documentation
The Disease Case Manager shall document within three business days any coordination and/or intervention with the client and/or on behalf of the client.

Reassessment
The Disease Case Manager shall conduct: a) continuous client monitoring to assess the efficacy of the Plan of Care and b) Periodic re-evaluation and adaptation of the plan at least every six months. The
Disease Case Manager shall document the reassessment in the Progress Notes. The Disease Case Manager shall revise and update the coordinated Plan of Care at reassessment.

If the client chooses to receive services from a different provider, the Disease Case Manager shall ask if the client desires to have the record transferred once he/she has selected another provider. The Disease Case Manager shall document the reasons for client’s refusal of services. If the client does not express a reason, the Disease Case Manager shall document this.

**Case Closure, Transfer, and Termination**

Case closure and transfer are systematic processes for disenrollment of clients from Disease Case Management services. The processes include formally notifying clients and treatment team of pending case closures and/or transfers. In the case of transfers, the Disease Case Manager should facilitate the transfer of client information and records.

**Closure**

Client cases may be closed for one or more of the following reasons:
- All identified goals and objectives in the Plan of Care were achieved
- Clients request to end services
- Client moves out of Broward County
- Death
- Inability to contact or re-engage client after 12 months of documented, intensive re-engagement efforts
- Client is incarcerated

**Transfers**

A client may be transferred to an interagency Disease Case Manager or other Disease Case Management provider for the following reasons:
- Client request
- Disease Case Manager request
- Disease Case Manager Supervisor determines a transfer is appropriate

**Termination**

This may occur for the following reasons:
- Client exhibits patterns of abuse of agency staff, property, and/or services
- Client is unwilling to participate in service planning
- Client makes false claims about eligibility requirements or falsify documentation
- Client is admitted to a long-term or residential facility

All reasonable, well-documented efforts must be made to resolve issues before resorting to termination.

**Continuous Quality Improvement**

Disease Case Management shall conduct chart reviews at least monthly to ensure appropriate documentation of all services, including referrals, follow-up, and reassessment.

**Responsibilities of Disease Case Managers**

Ryan White Part A Disease Case Managers shall provide services to clients as indicated below:
- Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
- Provide care management and education to clients to improve self-management of their HIV/AIDS disease, any co-morbidities and overall health
- Coordinate client health care through all levels with emphasis on primary and HIV/AIDS specialist care
- Provide active care management:
Disease Case Management
Service Delivery Model

- Complete baseline health assessment
- Complete six month reassessment
- Complete Plan of Care
- Monitor adherence to Plan of Care
- Complete follow-up assessments
- Maintain contact with the client at least once every three months or more often depending upon the client’s severity/acuity level
- Collect lab values and clinical data and document them in the client’s chart
  - Review client medication regimen
  - Promote medication and treatment adherence
  - Provide client education for adherence to treatment, medications, and their side effects
  - Review medical records and service utilization
  - Assist in improving pharmaceutical utilization patterns including use of multiple pharmacies, multiple prescribers, over-utilization, and under-utilization
  - Facilitate access to primary medical care, medications, home health care, specialty care
  - Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
  - Coordinate and track referrals
  - Monitor referral status
  - Coordinate medical care and behavioral health needs
  - Ensure all non-Ryan White Part A medical clients’ verified Viral Loads, CD4 counts are available and entered into designated HIV MIS
  - Identify, refer, follow-up with social support service needs identified in the POC
  - Coordinate client care with all appropriate parties
  - Document all interventions
  - Assist client with Prescription Assistance Program (PAP) referrals

Payer of last resort
An applicant may not be eligible for services from Ryan White Part A Program if the applicant is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White may be utilized for HIV related services only when no other source of payment exists.

This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state, or federal programs, or pending determination of eligibility from other local, state or federal programs. Ryan White Part A services is the payer of last resort. All community resources should be explored with clients prior to obtaining and receiving Ryan White Part A services.

Professional Requirements and Training
Disease Case Manager
Education Requirements:
- Must at a minimum be a Licensed Practical Nurse with active license in Florida and have a minimum of one year of clinical/case management/care coordination experience

Other Requirements:
- Knowledge of community resources
- Knowledge of target population
- Knowledge of HIV/AIDS disease and treatment
- Cultural and linguistic competence
- Experience in care coordination
- Demonstrated HIV/AIDS experience
- Experience with complex medical clients
- Knowledge of infectious disease processes, HIV/AIDS patients, and antibiotics
Skills:
- Client assessment
- Written documentation
- Adherence assessment and reinforcement
- Time management
- Computer literacy
- Care Coordination

Additional requirement based on the type of setting and/or project:
- Knowledge of substance abuse
- Knowledge of women’s health
- Maintenance of clinical knowledge base

Training of the Disease Case Manager:
- HIV Basic Training
- Annual HIV Update
- Disease Case Manager must have a minimum of 12 continuing education hours of training annually on medically-related topics

Disease Case Management Supervisors
In addition to the Disease Case Manager requirements:
- Master’s degree from an accredited institution in health/human services preferred or Bachelor’s with a minimum of 3 years clinical/case management experience
- A minimum of one year supervisory experience in a healthcare or social services setting
- Knowledge of program goals, outcomes, indicators, protocols, quality improvement evaluation, staff training and development
- Experience with chart review
- Experience with assessment of staff performance

Training:
- Updates on management issues and/or skills
- Other appropriate to the position
- Disease Case Manager must have a minimum of 12 continuing education hours of training annually on medically-related topics