Minority AIDS Initiative Medical Case Management Service Delivery Model

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Definition:

MAI Medical Case Management (MCM) services support the ability of clients to remain adherent to medical care. These services have a central role in providing treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS treatments. MAI MCM includes individual therapeutic support services facilitated or guided by an individual who may be the same age, gender, or HIV status as the client, and who has experienced and resolved the same type of problems as the client. Trained peers provide MAI MCM to optimize a client’s strengths to ensure successful completion of established goals. MAI MCM draws upon the Antiretroviral Treatment Access Study-II (ARTAS-II) model. Components of MAI MCM services include: (1) treatment literacy; (2) emotional support; (3) adherence to care by attending appointments, monitoring test results, and following instructions; (4) adherence to medication regimens; and (5) encouragement of healthy behaviors and positive living enabling the achievement of healthy outcomes. MAI MCM is time-limited. MAI Medical Case Managers provide clients with information and practical solutions for systems-navigation and optimal use of program resources. This information is provided during an initial assessment visit and up to six individual sessions. This strengths-based counseling approach is used within a 90-day period. MAI Medical Case Managers serve as liaisons for maintaining regular communication between clients and their medical providers. MAI Medical Case Managers educate clients in HIV service delivery, disease progression and management, viral loads, CD4 values, and skills to achieve health literacy. MAI Medical Case Managers will provide other MCM services including face-to-face visits with the client, telephone contacts, home visits, educating clients on the MAI MCM process and expectations; accompany clients to OAMC appointments, other support services, and any other forms of communication.
### 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 (Only one required for each strategy.)</th>
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</table>
| 1. Increased access, retention and adherence to OAMC.                           | 1.1. 100% of clients will achieve session objectives by designated target dates.   | Funding Clients Staff Facilities Supplies | 1.1.1. Conduct six individual sessions in which strengths-based counseling is used                                                             | 1.1.1.1. Implementation plan documenting specific, measureable, achievable, relevant, and time-bound goals, objectives, and tasks  
|                                                                                | 1.2. 100% of clients were linked to Outpatient/Ambulatory Medical Care within five sessions. | Funding Clients Staff Facilities Supplies | 1.2.1. Conduct six individual sessions in which strengths-based counseling is used                                                             | 1.2.1.1. Progress notes                                                                                                   
|                                                                                |                                                                                     |                         | 1.2.1.2. Appointment Records                                                                                                                |                                                                                                                         |
### STANDARDS FOR SERVICE DELIVERY

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<tr>
<th>Standard</th>
<th>Indicator</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>1. Each client will receive a strengths assessment.</td>
<td>1.1. 100% of client records will have a completed strengths assessment.</td>
<td>1.1.1. Strengths Assessment Form 1.1.2. PE</td>
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<td>2. Each client will receive SMART objectives by the 3rd session.</td>
<td>2.1. 100% of client records will have SMART objectives by the 3rd session.</td>
<td>2.1.1. Strengths Assessment Form 2.1.2. POC 2.1.3. PE</td>
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<tr>
<td>3. Each client will receive six strengths-based counseling sessions.</td>
<td>3.1. 100% of client records will complete six counseling sessions.</td>
<td>3.1.1. PE</td>
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<td>4. Each client will be assessed to determine if he/she currently receives OAMC.</td>
<td>4.1. 100% of clients will have documented clients’ adherence to OAMC appointments.</td>
<td>4.1.1. Strengths Assessment Form 4.1.2. PE 4.1.3. Progress notes</td>
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<td>5. Each client’s viral load and CD4 will be collected.</td>
<td>5.1. 100% of clients’ viral loads and CD4 counts will be requested to document clients’ adherence with ordered laboratory testing.</td>
<td>5.1.1. Strengths Assessment Form 5.1.2. PE 5.1.3. Progress notes</td>
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<td>6. Each client’s use of highly active antiretroviral therapy (ART) will be assessed.</td>
<td>6.1. 100% of clients’ will be assessed for ART adherence.</td>
<td>6.1.1. Strengths Assessment Form 6.1.2. PE 6.1.3. Progress notes</td>
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<td>7. Each client that self-terminates from MAI MCM will receive a collaborative staffing with the MAI Medical Case Manager and their assigned medical case manager to ensure a seamless transition into MCM services.</td>
<td>7.1. 100% of clients who self-terminate from MAI MCM will participate in a collaborative staffing with the MAI medical case manager and their assigned medical case manager.</td>
<td>7.1.1. Progress notes</td>
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<td>8. Upon termination of active MAI MCM, a client’s case is closed and a closure summary is completed to document the case disposition and activities to be completed by the assigned Medical Case Manager.</td>
<td>8.1. 100% of closed cases include documentation stating the reason for closure and a closure summary. 8.2. 100% of MAI MCM case closure summaries are signed off by an MAI MCM Supervisor.</td>
<td>8.1.1. Case closure summary</td>
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<td>9. Each client will receive a three-month follow-up assessment following the closure of the client’s file to ensure scheduled OAMC appointments were kept.</td>
<td>9.1. 100% of clients will receive a three-month follow-up assessment to ensure scheduled OAMC appointments were kept.</td>
<td>9.1.1. PE 9.1.2. Progress notes</td>
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</table>
| 10. Each client will receive a six-month follow-up assessment following the closure of the client’s file to ensure scheduled OAMC appointments were kept. | 10.1. 100% of clients will receive a six-month follow-up assessment to ensure scheduled OAMC appointments were kept. | 10.1.1. PE  
10.1.2. Progress notes |
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<td>11. Progress notes and all program and service-related documentation must be entered into PE within three business days of client contact.</td>
<td>11.1. 100% of progress notes will be written within three business days of client contact.</td>
<td>11.1.1. Progress notes</td>
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| 12. Each client will receive a return call within one business day of the client’s voice message requesting a return call. | 12.1. 80% of clients will receive a return call within one business day of client’s voice message requesting a return call. | 12.1.1. Telephone log  
12.1.2. Progress log |
The MAI MCM Protocol identifies the specific ways to implement the MAI MCM standards and processes inherent to MAI MCM services. Culturally competent service providers shall conduct services. 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 MAI MCM services shall verify the client’s eligibility by reviewing certification in Provide Enterprise (PE). Clients eligible for MAI MCM include racial and ethnic minority individuals (as defined by the HIV/AIDS Bureau) who are Broward County HIV positive residents at least 18 years or older, earn less than or equal to 300% of the Federal Poverty Level (FPL) Guidelines, are uninsured, have barriers to economic stability, and have no other means or funding source to receive services. To be eligible for MAI MCM services, the individual must also be currently enrolled in Ryan White Part A Program-funded medical case management, missed a minimum of one scheduled outpatient/ambulatory medical care (OAMC) appointment in the last six months, and be considered at risk for falling out of OAMC.

Referral from OAMC
Ryan White Part A Program-funded OAMC providers shall refer clients meeting the criteria for MAI MCM (i.e., missed a minimum of one scheduled OAMC appointment in the last six months and at risk for falling out of medical care) to a MAI Medical Case Manager.

Strengths-Based Assessment and Counseling
MAI MCM services are based on a strengths-based counseling approach that establishes a partnering relationship between the client and MAI Medical Case Manager. The MAI Medical Case Manager shall assess the client to identify personal strengths, abilities, and skills that the client can use to access OAMC and accomplish other short-term goals. The strengths assessment focuses on the client’s ability to accomplish a task, use a skill, or fulfill a goal in a significant life domain. The strengths assessment identifies and draws upon past successes experienced by the client. A Strengths Assessment Form is used to guide the MAI medical case manager in conducting sessions. Following completion of the strengths assessment, the MAI Medical Case Manager will help the client establish short-term goals, objectives, and activities aimed at linking the client to OAMC and other short-term goals.

The MAI Medical Case Manager and the client will collaborate to assist the client in achieving goals that he or she identifies as valuable or important and emphasizes strengths as a way of achieving these goals. The strengths-based counseling approach must support the client’s current MCM plan of care. The counseling shall be conducted in no longer than a 90-day period using a maximum of six individual face-to-face client sessions that do not exceed 120 minutes per session:

- Session 1 shall focus on assessing Client’s individual needs and priorities utilizing potential strengths that the client can apply to help resolve problems or barriers.
- Session 2 should focus on reinforcing and identifying resources needed to help carry out their POC based on the client’s skills and abilities.
- Session 3 shall help the Client to develop objectives that are specific, measurable, achievable, relevant and time-bound. Objectives shall identify and resolve barriers that interfere with the goal of
adhering to their prescribed medical regimens.

- Session 4 shall develop a Client specific implementation plan that focuses on achieving the objectives and ways to resolve previously identified barriers that interfere with the progression of achieving their goals.
- Session 5 shall evaluate the Client’s success of the transferred into the medical case management Plan of Care that will ensure the resolution of any barriers in the Strengths-Based Approach.
- Session 6 is a collaborative staffing with the Client and the Medical Case Manager to ensure that the client has a seamless transition back into medical case management services.

### Follow-Up Assessments
MAI medical case managers shall perform two follow-up assessments for each client:

- **Three-Month Follow-Up Assessment 1:** shall be completed three months following the closure of the client’s file. MAI Medical Case Managers shall follow-up to ensure a scheduled OAMC appointment was kept and documented in PE. The MAI medical case manager shall follow-up with the client and the Medical Case Manager to verify achievement of the implementation plan.
- **Six-Month Follow-Up Assessment:** shall be completed after six months following the closure of the client’s file. MAI Medical Case Managers shall follow-up to ensure a scheduled OAMC appointment was kept and documented in PE. The MAI Medical Case Manager should follow up with the client and the Medical Case Manager on achievement of the implementation plan.

The follow-up assessments shall be completed after the client’s file has been closed. If appointments are missed, they are rescheduled until the sessions can be completed. If a client self-terminates from MAI MCM before completion, there will be a multidisciplinary staffing attended by the MAI Medical Case Manager and the client’s assigned Medical Case Manager to assess the client’s readiness for care, along with a referral to a more intensive treatment adherence program as applicable.

### Supervision
MAI MCM supervisors must establish a formal and intensive supervision plan, which includes weekly supervision, in-service trainings, case reviews, chart reviews as learning opportunities, continuous quality improvement activities, and health literacy training updates. Supervision shall be conducted on an individual basis or in a group setting, such as case staffing and be documented in the MAI Medical Case Manager’s personnel file.

### Continuous Quality Improvement
MAI Medical Case Managers shall conduct chart reviews at least quarterly to ensure appropriate documentation of all services, including referrals, follow-up, and reassessment.

### 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 the Ryan White Program may be used for HIV-related services only when no other source of payment exists. An applicant cannot receive services or be eligible to participate in local, state, or federal programs where the same type service is provided or available. 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 Program Part A services are 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**

**Education Requirements:**

High School Diploma or Equivalent

Requirement: Must be a consumer of services and have at least one-year of experience in the HIV/AIDS delivery system.

Other experience that would be helpful to assist clients:

- Knowledge of community resources and support groups
- Knowledge of the target population
- Knowledge of HIV disease and treatment

**Skills:**

- Client strengths assessment
- Written documentation
- Adherence assessment and reinforcement
- Time management

**Additional requirement based on the type of setting and/or project:**

- Knowledge of substance abuse
- Knowledge of women’s health
- Knowledge of medical issues

**Training of the MAI Medical Case Manager:**

- HIV Basic Training
- Annual HIV Update
- Strengths-Based Counseling Approaches
- Peer Burn-Out Prevention Support

MAI MCM must have a minimum of 8 hours of training annually on medically-related topics.

**Additional requirement:**

Mandatory case management seminars and/or training sessions required by the Grantee

Cultural and linguistic competence

**MAI MCM Supervisors**

In addition to the MAI Medical Case Manager requirements:

Master’s degree from an accredited institution in health/human services preferred or Bachelors with a minimum of three years of case management experience

A minimum of one year of supervisory experience in a health 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