Montana Ryan White Part B
Medical Case Management
Service Standard

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

Definition

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Agencies providing Part B-funded HIV case management services in the State of Montana provide services under a broad spectrum of service delivery models, including rural community-based organizational models and hospital-based settings. These standards provide a framework of quality HIV case management that may be delivered with variation in actual services provided. The model is a (1) client-centered, (2) multi-disciplinary approach for (3) chronic disease management.

Key Activities

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client’s and other key family members’ needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
  Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State

Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance
The objective of Medical Case Management services is improving health care outcomes, whereas the objective of Non-Medical Case Management Services is to provide guidance and assistance in improving access to needed services.

HIV/AIDS BUREAU POLICY 16-02
Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

HRSA Program Monitoring Standard
(*HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards, Part B, #13)*

Support for Medical Case Management (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. Activities that include at least the following:

- Initial assessment of service needs
  - Development of a comprehensive, individualized care plan
  - Coordination of services required to implement the plan
  - Continuous client monitoring to assess the efficacy of the plan
  - Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary
- Service components that may include:
  - A range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical, Manufacturers' Patient Assistance Programs, other State of local health care and supportive services)
  - Coordination and follow-up of medical treatments
  - Ongoing assessment of the client's and other key family members' needs and personal support systems
  - Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatment

- Client –specific advocacy and/or review of utilization of services

1.0 Intake

Purpose

The intake process gathers information necessary to determine a client's eligibility for benefit programs and refers clients to Case Management. The Case Manager is the first contact for new clients and plays an important role in educating the client about the HIV Case Management or other benefit programs, as well as how a client can successfully navigate the process. For new clients, the Case Manager orients the client to the HIV Case Management or other benefit programs, conducts the initial intake, and performs the Assessment, both of which can be completed on the same day. For existing clients, the Case Manager conducts the six-month eligibility review and documents outcomes.

In most agencies, Case Managers conduct an intake, which also includes eligibility determination. Some agencies utilize a Non-Medical Case Manager/Eligibility/Intake Specialist, or other staff to perform these duties. This activity is typically recorded as NMCM. (See the Non-Medical Case Management Service Standard for more detail.)

Process

The Standards provide a step-by-step process for conducting an intake and determining eligibility for services. The following steps provide additional information in implementing these roles

1. Some clients may need immediate assistance from a Medical Case Manager. The client will be referred immediately to a Medical Case Manager for assistance if the following applies:
    a. The client is taking medication, but the supply will run out within the next seven days.
    b. The client states that he/she may be a danger to himself/herself or others. In this event, the Case Manager and/or Non-Medical Case Manager/Eligibility/Intake Specialist should immediately initiate their agency emergency crisis protocol. Additional information on Suicide and Threat Management should be found in their agency's emergency crisis protocol and must be reviewed annually. In these cases, the Non-Medical Case Manager/Eligibility/Intake Specialist must complete the intake process after assisting the client to receive the needed services.
    c. Clients must be informed of their right to confidentiality and the law regarding this for the professional staff participating on the HIV Case Management team. It is important not to assume that anyone - even a client's partner/spouse or other family member - knows that the client is HIV-positive. When trying to contact the client (phone calls, letters, etc.), Case Management staff should identify themselves only by name and never give an organizational affiliation that would

imply that the client has a particular health status or receives Ryan White or other services.

2. Many of the programs and services available to assist clients have income eligibility requirements. Therefore, an important part of the intake process is determining the income level of clients and number of family members in the household. This documentation will be necessary for the client to access other programs, including Part B-funded support services managed both by local community-based organizations, by other RW service providers, and by MT DPHHS.

3. The Case Management Agency shall use the standardized Intake/Assessment forms (See Appendix A for all forms) developed by the state to determine whether a client should be referred to MCM Services. As stated in the Standards, clients shall be referred to MCM services within two working days if they answer "yes" to the referral questions.

4. Appendix A includes:
    a. Complete and dated Eligibility/Intake/Assessment Form
    b. Signed Informed Consent Form
    c. Signed Release of Information (ROI) Form
    d. Grievance Policy and Confidentiality document
    e. Client Rights and Responsibilities document
    f. Client Eligibility Determination and Eligibility Recertification Record with the standardized forms
    g. Referrals: If a client needs a referral to another provider agency, the Medical Case Manager or Non-Medical Case Manager/Eligibility/Intake Specialist will make the appropriate referrals and document them in the progress notes.*

*Progress Notes: Progress notes are a section in a client's chart or record where HIV Case Management team members document all client interactions, including direct client interactions and roles undertaken on behalf of a client. The documentation serves as a legal record of events during a client's participation in the service. It also allows Case Management team members to compare past status to current status, communicates findings and plans, and can be used to support invoicing for services. Progress notes should be updated within 48 hours of encounter or action, note the type of encounter (in-person, telephone, mail, etc.), and must be signed with case manager's full name and title (or according to agency's electronic medical record protocol).

Standard	Measure	Documentation
1.1 All prospective clients who contact the agency will talk with a RW Case Manager. within three business days of the initial client contact.	1.1 Case Manager will make contact within three business days of the initial client contact.	1.1 First contact and date of contact is documented in client's file.

1.2 Each prospective client scheduled for an intake appointment will be informed verbally and, whenever possible, in writing of date and time of intake appointment and what documents should be brought to appointment.	1.2 Conversation and written notification, when possible, about the date and time of the appointment and required documentation.	1.2 Documentation in client's file regarding appointment and how it was communicated.
1.3 Each prospective client who is referred or who requests RW Part B-funded (and other parts where appropriate) services will receive a comprehensive in-person intake.	1.3 Intake must be completed within 10 business days of the first contact for clients (see 1.4 below). Completion of an Eligibility/Intake Review Form	1.3 Completed and dated Eligibility/Intake Review form and required documentation (outlined in Eligibility below) is placed in client's file
1.4 The intake process will be expedited for clients who are newly diagnosed, pregnant, or recently released from incarceration.	1.4 Intake for expedited clients must be completed within 72 hours	1.4 Completed and dated Eligibility/Intake Review Form.
1.5 If the intake completion is delayed because of missing documents during the 30-day calendar period, the Case Manager (CM) or qualified Non-Medical staff must notify the client about what documents are missing.	1.5 Notification must occur at least three times. These three contacts need to occur on different days and can be by phone, person, and/or mail over the 30-day calendar period. The final notification must e in writing and state that the client's file will be closed without required documentation.	1.5 File/date client progress notes and a copy of the final written notification, if applicable.
1.6 RW eligibility (including income, # in household, verification of HIV+ status, Montana residency and uninsured/underinsured status) must be reviewed and recertified.	1.6 Eligibility requirements are met at time of intake, and recertification must occur every six months.	1.6 Completed and dated Eligibility and/or Recertification Form. Without the required documents, clients will be officially ineligible for any RW services.

1.7 Every client who completes the intake process will have: a signed and dated Informed Consent form, a copy of the provider's Grievance Procedures, a copy of the provider's Confidentiality Statement, a signed and dated Release of Information (ROI) form, and a copy of the Client Rights and Responsibilities. *	1.7All forms must be completed at the time of intake, with client's signature on all forms.	1.7 Copies of signed and dated forms in client file. 1
1.8 If the client answers "yes" to any of the questions in the MCM Referral section of the Eligibility/Intake Form, the client must be referred to MCM.	1.8 Referral must occur within two working days after the completion of the intake process.	1.8 Dated documentation of MCM referral in progress notes.
1.9 A minimum of one progress note must be included for each client encounter (with the client or someone on behalf of the client)	1.9 Progress note(s) must match the data entered into the database in terms of date, service, and units of service provided.	1.9 Progress notes in the client file match the service entries in the database.

*Forms may be developed by agencies to meet any unique or more specific requirements

2.0 Medical Case Management

Purpose

The MCM Assessment is an information gathering process which includes, but is not limited to, a face-to-face interview between a client and Medical Case Manager that allows for the acquisition of secondary data from health and human services professionals and other individuals. It is a cooperative and interactive process during which a client and Medical Case Manager collect, analyze, synthesize, and prioritize information which identifies client needs, resources, and strengths, for purposes of developing a Care Plan to address the needs identified.

Clients are assessed annually to evaluate progress, identify unresolved and/or emerging needs, guide appropriate revisions in the Care Plan, and inform decisions regarding discharge from HIV case management services and/or transition to other appropriate services. Assessment should also be conducted in the event of significant changes in the client's life. Assessment is directed at reaching an agreement between the client and the Medical Case Manager concerning priority needs and client strengths and limitations.

Areas of Assessment:

1. The extent and nature of client needs.
2. The capacity of the client to meet personal needs.
3. The capacity of the client's support network to address client needs.
4. The capacity of available human services agencies/organizations to address client needs.

<u>Process</u>

1. If the MCM Assessment were not completed or scheduled during the intake process, the client is contacted to schedule an appointment for the Assessment. The Assessment is conducted in face-to-face meeting(s) between the client and Medical Case Manager. Home visits are encouraged for clients who either have difficulty accessing the case management agency or where visiting the client's home would assist in the identification of need. A protocol should be in place within your agency regarding home visits that includes safety measures, standard rules, and privacy.
2. Assessments should be completed within 30 days from the intake date. Documentation of any delays in completing the MCM Assessment must be included in the progress notes.
3. The Assessment is conducted by a Medical Case Manager and is performed in accordance with the Montana HIV Case Management Standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements and confidential meeting location. The Assessment is documented on the MCM Assessment Form. The Assessment process utilizes an Acuity Scale to assist in summarizing the results of the assessment.
4. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination. Equally- important is the ongoing collaboration between the Medical Case Manager and other health and human service providers and individuals involved with the client. Case conferencing with the medical treatment team and consultation with other agencies providing services to the client should be an ongoing activity of case management and appropriate documentation of these activities should be included in a consistent way in the progress notes.
5. Adherence to medical and medication treatment must be assessed, and if identified as a need, be included in the Care Plan.
6. Client needs are systematically screened and documented. This involves the active participation of the client, health and human services professional, and

other individuals, as agreed to by the client. Client needs should be identified in the following areas (items included on Assessment):

a. Health status and history of HIV/AIDS complications and treatments, including adherence concerns/issues;
b. Health literacy;
c. Current medications and side effects;
d. Income (including benefits issued through Social Security or other sources);
e. Health coverage benefits and ability to use those benefits (health insurance, Medicaid, Medicare, veterans' benefits, eligibility for ACA services) or participation in clinical trials;
f. Housing/shelter (residential support, adaptive equipment and assistance with decision making);
g. Employment;
h. Educational status/literacy, primary language read and spoken, prognosis for employment, educational/vocational needs, appropriateness and/or availability of educational, rehabilitation and vocational programs;
i. Mental health and emotional status;
j. History of violence and abuse;
k. Cultural, ethnic, racial background, spirituality and religion;
l. Communication skills, language literacy, and/or translation requirements;
m. Social relationships and support (informal care givers, formal service providers, significant issues in relationships, and social environments);
n. Client's physical environment, as well as ability to meet activities of daily living;
o. Recreation and leisure;
p. Transportation;
q. Legal status, if appropriate (guardian relationships, child custody, pending court dates, criminal history and other involvement with the legal system);
r. Knowledge of HIV disease transmission and risk reduction strategies;
s. Accessibility of health and community resources which the client needs or wants;
t. Assessment of alcohol, tobacco, and other drug use; and
u. Knowledge of legal rights and responsibilities, including living will, health care power of attorney or durable power of attorney options.

Standard	Measure	Documentation
2.1 Each MCM client will participate in at least one face-to-face interview to assess their need while they are in active HIV case management	2.1 Initial assessment must be completed within 30 days of intake. Face-to-face interviews must occur a minimum of every 12 months. Re-assessments must occur according to acuity level assigned.	2.1 Dated, completed, and signed Initial Assessment in client file. Dated, completed, and signed MCM Assessment form within the past 12 months. *

2.2 The key findings of the MCM Assessment must be summarized at the end of the Assessment form.	2.2 Summary is completed at the time the Assessment occurs.	2.2 Summary is documented on the last page of the MCM Assessment Form.
2.3 Treatment Adherence must be assessed, and if identified as a need, included in the Care Plan. *	2.3 Included when the Care Plan is written.	2.3 Documentation on the MCM Assessment Form * and in the Care Plan if indicated as a need.

* Forms may be developed by agencies that meet their agencies' unique requirements.

3.0 Acuity Scale

Purpose

Montana's RW Part B HIV case management program strives to provide the greatest level of support to clients with the greatest need. A three-stage Acuity Scale is used as an additional part of the MCM Assessment process and is completed after the intake and MCM Assessment are complete. The Acuity Scale:

- Is a tool for the Medical Case Manager to use, which complements the MCM Assessment to determine the level of case management needed;
- Is intended to provide a framework for documenting important assessment elements and for standardizing key questions that should be asked as part of a professional assessment;
- Helps provide consistency from client to client and is a tool to assist in an objective assessment of a client's need, thereby minimizing inherent subjective bias;
- Helps develop priority need areas to be addressed in the Care Plan.

Process

1. Interview the client following the Intake and Assessment/Re-Assessment Standards.
2. Review all pertinent client documents, secondary assessments done by other professionals, and any relevant information available about the client's needs.
3. Check the appropriate indicators in each Life Area on the Acuity Scale.
4. An Acuity Level for each Life Area is assigned using professional judgment. If there are indicators that are potentially disabling to a client such as: newly diagnosed, pregnant, currently homeless, recently released from correctional facility, a higher level will be assigned to that Life Area so that higher levels of program support may be provided to stabilize the client. Use of professional judgment is used to determine the appropriate level of program support/services.
5. The score is assigned based on the number criteria checked in each Acuity Level. Multiply the number of criteria checked in each Acuity Level by the number of the Acuity Level. For example, if three criteria are checked in Acuity Level 2, then the score at the bottom of Acuity Level 2 is "6" (2 x 3).

6. Please note**:** The following criteria, at a minimum, will result in an automatic Acuity Level 3, during the first 90 days of service: (a) released from a correctional facility within the past 90 days, (b) diagnosed with HIV in the last 180 days, (c) pregnant and (d) homeless. This will ensure that the client receives the additional amount of case management service that may be warranted.
7. Clients who score a "13" or less are considered Level 1 and may receive services through a Medical Case Manager as needed, and as mutually agreed upon by the Medical Case Manager and the client (for example, periodic transportation or medication assistance services). A Care Plan is not needed. Acuity should be reassessed if clients are requesting assistance more frequently than their initially-assessed need might indicate.
8. Total the points at the end of Acuity Scale. Assign appropriate program support activities.

The Acuity Level Guidelines

The following criteria, at a minimum, will result in an automatic Acuity Level 3, during the first 90 days of service: (a) release from a correctional facility within the past 90 days, (b) diagnosed with HIV in the last 180 days, (c) pregnant or (d) currently homeless. This will ensure that the client receives the additional amount of case management service that may be warranted.

Level 1 0-13 points = low	• Initial Assessment and Acuity • Minimum contact annually • Reassessed annually • Documentation in progress notes • Reassess Acuity annually unless client situation changes or if service requests become frequent
Level 2 14-25 points = medium	• Initial Assessment and Acuity • Annual Re-Assessment • Assess Acuity every 6 months • Minimum contact (telephone or face-to-face) every six months to verify address/phone number, to check on client's current status • Care Plan update every 6 months • Documentation in progress notes

Level 3 26-40 points = high/urgent	• Initial Assessment & Acuity • Minimum Re-Assessment every 6 months • Minimum contact (telephone or face-to-face) every 30 days • Care Plan updated minimum every 3 months • Acuity updated minimum every 3 months • Documentation in progress notes

Standard	**Measure**	**Documentation**
3.1 Each MCM client will have an Acuity Scale completed and documented, indicating their Acuity level.	3.1 Signed by MCM on the date of completion.	3.1 Completed, signed, and dated Acuity Scale notes in client file.
3.2 Every active client will have her/his Acuity Scale updated as frequently as indicated in each Acuity level (1, 2, or 3).	3.2 Signed by MCM on the date of completion.	3.2 Completed, signed, and dated notes regarding updates in Acuity Scale level included in client file.

4.0 Medical Case Management Service Planning

Purpose of Assessment-Based Planning

For the most efficient use of time and for effective outcomes to occur, there must be a clear plan that directs the activities of the client and Medical Case Manager. This plan becomes the basis for evaluating what services were provided and whether they achieved the desired outcomes. Once the Medical Case Manager has gathered enough information from the intake and assessment and has identified the priority needs areas, this information will form the basis of Service Planning.

Client Involvement in Planning

Creating a Care Plan provides the basis from which the Medical Case Manager and the client work together, as partners, to access the resources and services which will enhance the client's quality of life and his or her ability to cope with the complexity of living with HIV. The client plays a vital role in the process of developing a plan of care. The process supports client self- determination and self-management of a chronic disease whenever possible and empowers a client to actively participate in the planning and delivery of services.

When developing a Care Plan, it is necessary to have concurrence on expected responsibilities and have an agreement on the tasks assignments to be completed by the Medical Case Manager and the client. Most clients will count on the Medical Case Manager to guide them through the health and human services system and to present options and help them develop contingency plans, should the initial efforts fail to produce the desired results. There should be ongoing and joint assessments of the appropriateness of the Plan.

Process

In an ongoing interactive process with the client, problems are identified and prioritized. Identified problems are addressed through a planning process that includes the mutual development of goals, assigned activities and reporting outcomes. The MCM Care Plan Form should contain the following:

- Identification of problems/primary barriers;
- Prioritization of goals and issues;
- Planning tasks and action steps to be completed to help a client meet his/her goals, keeping in mind the client's ability to attain only one goal at a time and that goal should be attainable based on the client's perspective;
- The name of the person who will be responsible for the assigned task: either the client, the Medical Case Manager, or both;
- Documentation of the target date of tasks and goals;
- The Task Completion Date to show when the task was completed;
- The Care Plan signed and dated by the client and Medical Case Manager on the date it is developed; and
- Documentation in the progress notes regarding completion of the plan and whether the client received a copy.

Standard	Measure	Documentation
4.1 After completion of the MCM Assessment, every client (except those with an Acuity Score of 13) will participate in the development of a Care Plan.	4.1 The Care Plan must be completed within 45 calendar days from the completion of the Assessment.	4.1 Completed and dated Care Plan in the client file, with client and MCM signatures. If care plan does not meet the 45-day requirement, documentation must also include notes explaining the delay.
4.2 The Care Plan will reflect that the client was included in its development and offered a copy of the Care Plan.	4.2 Client receives a copy of the Care Plan or, if it was offered, declined.	4.2 Progress notes in the client file stating the Care Plan was developed with input from the client and that the client was offered and/or received a copy.

5.0 Care Plan Implementation

Purpose of Care Plan Implementation

Activities related to Care Plan Implementation should be used as tools for helping the client resolve crises and to develop sustaining strategies to cope with his or her problems and service needs independently. This involves:

- evaluating the effectiveness and relevance of the plan;
- measuring client progress toward stated goals and activities; and
- revising the plan as needed (with minimum frequency according to Acuity level).

Process

1. The goals and activities developed during the planning process should be regularly reviewed to determine progress and whether any changes in the client's situation warrant a change in the Care Plan according to Acuity Level.
2. Case conferences with the client's medical team and other treatment teams (i.e., mental health treatment teams) can help ensure that all providers involved in a client's care and treatment work together to achieve the best mix of services, which also minimizes service duplication.
3. Clients and Medical Case Managers must at least maintain contact according to Acuity Level to build trust, communication, and rapport. Careful planning by the client and the Medical Case Manager can determine how often contact is needed to minimize crisis situations and to best meet the client's anticipated needs.
4. Clients should be encouraged to contact the Medical Case Manager when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems.
5. Follow-up and monitoring activities can occur through direct contact (i.e. face-to-face meetings, telephone communication, texting, email, instant messaging) with the client or his or her representative.
6. Indirect contact regarding the client, with the client's family or caregiver, primary medical provider, service providers, and other professionals also provides information. This can happen through meetings, telephone contact regarding the client, written reports, and letters.

Standard	Measure	Documentation
5.1 The client and MCM will work together to develop and meet Care Plan goals.	5.1. Completed annually and updated every six months.	5.1 Update progress notes in client's file regarding progress made in achieving goals. These notes must be dated

		and match the required time frames.
5.2 All clients will have their Care Plans updated as indicated by level of Acuity.	5.2 Plans are updated if/when changes in Acuity Level occur.	5.2 Completed, current, and dated notes in the client's file regarding the updated Care Plan (if applicable).
5.3 Ongoing document of Care Plan activities related to goal completion.	5.3 Progress notes must be completed within 48 hours of goal achievement(s).	5.3 Dated progress notes regarding goal completion.

6.0 Transition/Transfer

Purpose

A client is considered active within the agency when he or she actively seeks and receives services and has been seen or contacted within the time frame required by the Acuity Scale. The client's case may be closed for a variety of reasons, including:

- Client has satisfactorily met goals.
- The client moves out of state.
- The client decides to transfer to another agency.
- The client withdraws from or refuses Case Management services, reports that services are no longer needed, or no longer participates in the Case Management plan.
- The client can no longer be located.
- The client becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program.
- The client's needs are more appropriately addressed in other programs.
- The client exhibits a pattern of abuse as defined by agency's policy.
- The client is deceased.

If a client transfers to another location, agency, or service provider, (including a non-HIV/AIDS Case Manager), the Case Manager will provide a discharge summary and other requested records within five business days of request (or as soon as feasible). If a client moves to another area, the Case Manager will make a referral for case management services in the new location.

Unable to Locate

If a client cannot be located, the case management agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the Case Management case will be closed within thirty (30) days from the date on the letter if the client does not make an appointment with the Case Manager.

Withdrawal from Care

If a client reports that services are no longer needed or decides to no longer participate in the Care Plan, then the client may withdraw from services. Clients may decide to withdraw for a variety of reasons. It may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or to better identify factors that are interfering with the client's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the case management agency, Case Managers are encouraged to refer these clients to agencies which are skilled in providing the needed services.

Administrative Discharge

Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by the Case Manager's supervisor according to that agency's policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart.

Standard	Measure	Documentation
6.1 A discharge summary is written for every client.	6.1 Discharge summary must be written within 30 days of discharge.	6.1 Dated discharge summary in client file.
6.2 If applicable, a certified letter is sent to the client, informing him or her about the discharge.	6.2 The certified letter, if applicable, must be mailed to the client within two weeks of discharge.	6.2 A copy of the certified letter, if applicable, is placed in client's file.
6.3 Progress notes are included that lead up to the determination of discharge.	6.3 Progress notes are dated.	6.3 Dated progress notes are in each client's file.

7.0 Personnel Qualifications

Standard	Measure	Documentation
7.1 Medical Case Managers (MCMs) must have a minimum of a B.A. in Social	7.1.a. If licensed, a copy of the most current Montana license must be kept in the Medical	7.1.a. and b. Copies of degrees, certifications and/or licenses (as applicable) in

Work (BSW), M.A. in Social Work (MSW)—licensure preferred, or other related health or human service degree from an accredited college or university; OR current MT-licensed Registered Nurse (RN) and an Association of Nurses in AIDS Care (ANAC) Certification (preferred); or related experience for a period of two years, regardless of academic preparation.	Case Manager's personnel file. 7.1.b. Copies of degrees and/or certifications, demonstrating appropriate education and training.	personnel file.
7.2 All Medical Case Managers must complete a minimum training regimen within one year of their hire date that includes: (a) HIV Case Management Standards, (b) Counseling, Treatment and Referral Services (CTRS) training to include HIV disease processes, treatment, testing, legal ramifications to include confidentiality, counseling/referral and prevention, (c) cultural competency and (d) AIDS Drug Assistance Program (ADAP)/Insurance training.	7.2 . Copies demonstrating completion of required trainings Note: If newly hired Medical Case Managers have previously obtained all the required training, they do not need to repeat it.	7.2 Dated documentation of required/additional training should be kept in the Medical Case Manager's personnel file.
7.3 All Medical Case Managers, except Montana Licensed Clinical Social Workers (LCSW), Licensed Clinical Professional Counselors (LCPC) or nationally Certified Case Managers (CCM) must complete an MT DPHHS-approved basic case management training	7.3.a.and b. Documents that demonstration completion of training(s)	7.3. and 7.4 Dated documentation of completion applicable training(s) in the Medical Case Manager's personnel file.

program within one year of their hire date [e.g. Mountain West AIDS Training Center (MWAETC) offers a variety of trainings and consultation services.] 7.4 All Medical Case Managers are recommended to complete 12 hours of continuing education in HIV/AIDS each year. Appropriate continuing education opportunities will be identified by Case Managers		

8.0 Grievance Policy

Purpose
To ensure that consumers may voice a complaint or grievance

Procedures
All Ryan White providers must have a grievance policy that is posted in the facility. Additionally, all clients will receive a copy of the grievance procedure. The first step in filing a grievance is with the *agency providing the service*. Consumers may voice a complaint or grievance to their Case Manager. Clients are expected to attempt resolution at the local level. If, however, clients are unable to resolve the issue, they may pursue a second step—filing a grievance with the State Health Department. Within 30 days of the local determination, consumers may file the complaint or grievance in writing (See Appendix A for sample form) to:

Montana DPHHS
HIV/STD Program, Ryan White Part B
Attn: HIV Treatment Coordinator
1400 E. Broadway
Room C-211
Helena MT 59601

An applicant may submit a complaint on the following grounds:

- The client believes the sub-recipient is not treating them fairly.
- The client believes the sub-recipient is not providing quality services.
- The client was denied services.

The applicant (client) must state all the facts and arguments for the appeal in the form provided (Appendix B), include detailed descriptions of the action the client is appealing, and the relief or correction the applicant is requesting. The form *must* be signed by the client.

The Ryan White Part B Program Manager will respond in writing within 14 days of receipt of the grievance or complaint informing the client of the time and place of a meeting with the Ryan White Part B Program Manager and other appointed HIV/STD state staff.

Standard	Measure	Documentation
8.1.a. The Grievance Policy has been explained to each client. Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received. 8.1.b. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines.	8.1.a. and b. Each client is given a copy of the Grievance Policy to sign, indicating understanding of the reasons for filing a grievance, as well as the process for doing so.	8.1.a Signed and dated Grievance Policy in client file. 8.1.b. Written Grievance Policy on file.
8.2 Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.		8.2. Policy is available in languages and formats appropriate to populations served.

<u>9.0 Linguistic Competency</u>

Standard	Measure	Documentation
9.1.Health services are culturally and linguistically competent, client-guided and community based.	9.1.a. Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; 9.1.b.Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and	9.1 a and b: Documentation of cultural and linguistic experience/competence

	linguistically appropriate services; 9.1.c. List of cultural competency trainings completed by staff	9.1.c. Completed trainings documented in personnel files.
9.2 Each provider shall make available to clients the process for requesting interpretation services, including American Sign Language	9.2. Interpreter(s) is/are available.	9.2 A list of interpreters and contact information in program file.

10.0 Client Rights and Responsibilities

National Monitoring Standards: Provision of Part B-funded HIV primary medical care and support services, to the maximum extent, without regard to either: the ability of the individual to pay for such services, or the current or past health conditions of the individuals served. (*HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B, Section F, #2 April, 2013*)

Standard	Measure	Documentation
10.1 Services are available and accessible to any individual who meets program eligibility requirements.	10.1.a. Written eligibility requirements, following federal standards 10.1.b. Non-discrimination policy	10.1.a Proof of client's eligibility documented in client file 10.1.b. Non-discrimination policy on file.
10.2 All providers shall comply with all applicable federal, state, and local anti- discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting based on the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or AIDS/HIV.	10.2 Written policies, including the federal ADA policy and specific MT laws	10.2.a. Policies are on file. 10.2.b. Policies are posted for clients to view.

10.3.a. Clients understand their rights, which include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; • Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; There is possible child or elder abuse; or b) Ordered by a court of law. Client responsibilities include:	10.3.a. Client's Rights and Responsibilities policy on file 10.3.b. Policy has been explained to client.	10.3.a and 10.3.b Current Client's Rights and Responsibilities form signed and dated by client and located in client's record.

c) Treat other clients and staff with respect and courtesy; d) Protect the confidentiality of other clients; e) Participate in creating in a plan of service; f) Let the agency know any concerns or changes in needs; g) Make and keep appointments, or when possible to phone to cancel or change an appointment time; h) Stay in contact with the agency by informing the agency of change in address and phone number, as well as responding to phone calls and mail and i) Not subject the agency's staff to physical, sexual, verbal and/or emotional abuse or threats. 10.3.b. Explanation of Client's Rights and Responsibilities is provided to each client.		

<u>11.0 Secure Client Records, Privacy, and Confidentiality</u>

Standard	Measure	Documentation
11.1) Client confidentiality is ensured	11.1.a. Client confidentiality policy that includes a Release of Information (ROI) 11.1.b. Health Insurance Portability and Accountability Act (HIPPA) compliance	11.1.a. Written client confidentiality policy on file at provider agency 11.1.b.HIPPA documentation is on file and posted where clients can view it.
11.2) Client's consent for release of information is determined.	11.2 Current Release of Information Form signed and	11.2 Signed and dated ROI located in client file. Each release form indicates who

	dated by client and provider representative	may receive the client's information and has an expiration of not more than 12 months.
11.3) Electronic patient records are protected from unauthorized use.	11.3 Each client file is stored in a secure location.	11.3.a. Files stored in locked file or cabinet with access limited to appropriate personnel. 11.3.b. Electronic files are password protected with access limited to appropriate personnel.
11.4 Annual submission of Verification of Receipt of Assurance of Key Requirements	11.4. All staff that handle client-identifying information document	11.4 Signed Verification of Receipt of Assurance of Key Requirement forms on file

12.0 Quality Management

Performance Measures:

Refer to Summary of Clinical Performance Measures Part B

APPENDIX A: STANDARDIZED FORMS

Client Intake/Eligibility Determination

☐ Intake or Annual Review Date Completed:	☐ 6 Month Review – **Changes** Date Completed:		☐ 6 Month Review – **No Changes** Date Completed:
Social Security number:		Age:	DOB:
Date of HIV Diagnosis:		Date of AIDS Diagnosis (if applicable):	

PERSONAL INFORMATION:

LEGAL LAST NAME	LEGAL FIRST NAME	MIDDLE INITIAL	OTHER NAMES USED	
				☐ YES; ☐ NO
STREET ADDRESS	CITY	STATE	ZIP	OK to send mail
				☐ YES; ☐ NO
MAILING ADDRESS, IF DIFFERENT	CITY	STATE	ZIP	OK to send mail

( ) HOME PHONE #	☐ YES; ☐ NO OK to leave message	GENDER:	☐ Male; ☐ Female; ☐ Transgender (M → F); ☐ Transgender (F → M)
( ) CELLPHONE #	☐ YES; ☐ NO OK to leave message	RACE:	☐ White/Caucasian; ☐ Black/African American; ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native; ☐ Other
( ) MESSAGE PHONE#	☐ YES; ☐ NO OK to leave message?	ETHNICITY:	**☐ Hispanic/Latino; · Non-Hispanic/Latino** ☐Mexican, Mexican American, Chicano/a; ☐Puerto Rican; ☐Cuban; ☐Other Hispanic, Latino/a or Spanish Origin; ☐Asian; ☐Asian Indian ☐ Chinese; ☐ Filipino; ☐ Japanese; ☐ Korean; ☐Vietnamese; ☐Other Asian; ☐Guamanian or Chamorro; ☐Samoan; ☐Another Pacific Islander
	☐ YES; ☐ NO	PRIMARY LANGUAGE:	

MEDICAL HEALTH INSURANCE:

☐ PRIVATE	☐ MEDICARE	☐ MEDICAID	☐ OTHER	☐ NO INSURANCE
Company:_______________ ID #: __________________ ACA Enrolled:_____________ COBRA (end date): __________ Dental Insurance (name): ______________________	☐ Part A ☐ Part B ☐ Part D; ________ ☐ Enrolled in MPAP ☐ Low income subsidy ☐ Qual. Medicare Ben.	HMO ________________ Standard (Blue & White Card) ☐ Dual Eligible MCO: ________________	☐ VA Benefits #: _______ ☐ Champus #: _______ ☐ _______ #: __________	**Comments:**

KEY CONTACTS:

		( )	☐ YES; ☐ NO
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER	AWARE OF HIV STATUS
	( )		( )
PRIMARY CARE PHYSICIAN	PHONE NUMBER	PHARMACY	PHONE NUMBER
	( )		( )
HIV SPECIALIST	PHONE NUMBER	OTHER AGENCY	PHONE NUMBER

1	Client Name:____________________________ID #:________CM Initial:________Date:____________ (Form Revised March 2019)

HOUSING FAMILY/DEPENDENT CHILDREN

Do you have dependent children (including children you are paying child support for):	☐ NO ☐ YES
	If yes, how many:
	If yes, do they live with you? ☐ NO; ☐ YES

HOUSEHOLD MEMBERS:

NAMES	RELATIONSHIP	AGE	AWARE OF HIV STATUS	INCOME
			☐ YES; ☐ NO	$
			☐ YES; ☐ NO	$
			☐ YES; ☐ NO	$
			☐ YES; ☐ NO	$

ELIGIBILITY CATEGORY	DOCUMENTATION PRESENTED (Copies of all documentation are to be filed with this form and retained by the provider agency)	
HIV+ diagnosis Required only at intake. Check one:	☐ Lab test (viral load) sent from lab or physician ☐ Documentation submitted from the healthcare provider who is providing medical care ☐ Previously obtained/Is in client file.	
Verification of Identity Required annually (if document is not expired). Client must provide one of the following:	☐ Montana Driver License ☐ Tribal ID ☐ Montana State ID card ☐ Military ID ☐ Passport ☐ Student ID ☐ Social Security Card ☐ Citizenship/Naturalization	☐ Student visa ☐ Birth certificate ☐ Montana Learner's Permit or Temporary License ☐ Other official document (list):
Verification of Residency Client must provide one of the following: (Documentation must include client's full legal name and match residential address on application.) **(Required annually for eligibility and documentation)**	☐ Montana Driver License ☐ Tribal ID (current address) ☐ Montana State ID ☐ Utility Bill ☐ Lease, rental, or mortgage agreement ☐ Current property tax document ☐ Residency Verification Form ☐ Current Montana Voter Registration card (current address) ☐ Letter from lease holder[1]	☐ Court Corrections Proof of Identity ☐ Copy of public assistance/ benefits document ☐ Homeowner's association ☐ Military/Veteran's Affairs ☐ Montana vehicle title or registration card ☐ Other:

[1] Must include the lease holder's name, address that matches the client's application, relationship to the client and lease holder's telephone number.

VERIFICATION OF INCOME				
Required every 6 months for recertification				
Type of Income	**Person(s) Receiving Income**	**Monthly Gross Income**	**Annual Gross Income**	**Required Documentation**
Work income (wages, tips, commissions, bonuses)				➢ 2 months current, consecutive paystubs or earnings statements for ALL jobs ***or*** ➢ Copy of most recent tax return
Self-employment income				➢ Most recent quarterly tax returns ***or*** ➢ Business records for 3 consecutive months prior
Unemployment/ Disability benefits				➢ Compensations stubs ***or*** ➢ Award letter
Stocks, bonds, cash dividends, trust, investment income, royalties				➢ Documentation from financial institution showing income received, values, terms & conditions
Alimony/child support Foster care payments				➢ Benefit award letter ***or*** ➢ Official document showing amount received regularly
Pension or retirement income (not social security)				➢ Annual benefit statement
Social security retirement/survivor's benefit				➢ Annual benefit statement
Veterans benefits				➢ Benefit award letter
Social Security income (SSI/SSDI)				➢ Annual benefit statement or bank statement showing deposit
Public Assistance/TANF (not SNAP)				➢ Most recent payment statement ***or*** ➢ Benefit notice
Worker's Compensation or Sick Benefits				➢ Benefit award letter
Other Income:				➢ Document:
TOTAL		**Monthly Total= $**	**Annual Total = $**	

Family size:_______________________ **Federal Poverty Level: ____________________**

3	Client Name:____________________________ID #:________CM Initial:________Date:____________ (Form Revised March 2019)

Does client have a payee?	☐ NO ☐ YES
	If yes, Name: ____________________ Phone: __________________________

NO INCOME STATEMENT
I declare that my family and I have no income. I (we) get food, housing and clothing in the following ways:

I understand that I must tell my HIV case manager about any changes as part of the six-month eligibility/recertification review. I understand that if I falsify or do not give complete information, my eligibility for Ryan White-funded services may be denied.

____ __________________________________

Client (or legal guardian) Signature **Today's date (day/month/year)**

Additional Comments:

NO INCOME STATEMENT (6 Month Review)
I declare that my family and I have no income. I (we) get food, housing and clothing in the following ways:

I understand that I must tell my HIV case manager about any changes as part of the six-month eligibility review. I understand that if I falsify or do not give complete information, my eligibility for Ryan White-funded services may be denied.

____ __________________________________

Client (or legal guardian) Signature (6-month review) **Today's date (day/month/year) (6-month review)**

I know if the agency is not able to contact me, that after 90 days trying, I agree to the agency mailing me a Certified Letter to notify me of discharge from services.

____ __________________________________

Client (or legal guardian) Signature **Today's date (day/month/year)**

4	Client Name:_________________________ID #:_______CM Initial:_______Date:___________ (Form Revised March 2019)

PublicHealth IN THE 406

HIV MEDICAL CASE MANAGEMENT PROGRAM ASSESSMENT/RE-ASSESSMENT

Client:	Client #:
Initial Assessment Date:	MCM Name:
Re-Assessment Date:	MCM Name:

HIV Status: **HIV Risk Factors** (check all that apply):

☐ HIV positive (not AIDS)	dx date:	☐ MSM ☐ Heterosexual ☐ IDU ☐ Perinatal
☐ HIV positive (AIDS unknown)	dx date:	☐ Receipt of blood or tissue
☐ CDC-defined AIDS	dx date:	☐ Hemophilic coagulation disorder
☐ Unknown or not reported/identified		☐ Other:

Medical Care:

☐ None ☐ Publicly-funded clinic or HD ☐ Private practice ☐ Hospital Outpatient ☐ ER ☐ Other

CARE PROVIDER CONTACT INFORMATION (name and phone#):

Primary Care Provider		( )
HIV/AIDS Provider		( )
Pharmacy		( )
Dentist		( )

Current Medication Profile:

Date Prescribed	Medication	Dose	Frequency	Route	Date d/c'd

1	Client Name:___________________________ID #:________CM Initial:________Date:____________ (Form Revised March 2019)

HIV Medication Adherence Assessment: ☐ **No Change**

Is client currently taking antiretroviral medications? ☐ Yes ☐ Sometimes ☐ No
If no, why? ☐ Not recommended ☐ Does not want to take ☐ Wants to/considering taking
If yes/sometimes, client's understanding of meds: ☐ thorough ☐ average ☐ basic ☐ confused
If yes/sometimes, who is responsible for ordering/picking up refills? ☐ self ☐ other: ______________
If yes/sometimes, are: ☐ meds outdated? ☐ Yes ☐ No ☐ meds prescribed by multiple providers? ☐ Yes ☐ No ☐ meds properly stored? ☐ Yes ☐ No ☐ meds borrowed from others? ☐ Yes ☐ No
If yes/sometimes, are meds taken on schedule every day/every time? ☐ Yes ☐ No
If no, number of missed doses in past week:______number of late doses in past week: ______
Possible reason(s) for late or missed doses (check all that apply): Medication side effects: ☐ dizziness ☐ nausea ☐ diarrhea ☐ drowsiness ☐ headache ☐ other: ___________________________

Barriers:

☐ depression/mental health	☐ complex medication regime
☐ substance use	☐ number of pills
☐ mental status changes	☐ size pills
☐ doubts medication effectiveness	☐ taste of medication
☐ lack of information	☐ eating habits (e.g., loss of appetite)
☐ works outside the home	☐ lack of regular schedule
☐ caregiving responsibilities	☐ needs assistance with ADLs
☐ lack of social support	☐ undisclosed HIV status
☐ difficulty getting refills:	☐ other:

AVAILABILITY OF BASIC NEEDS (check if need assistance)**:** ☐ **No Change**

☐	Food; ☐ Utilities; ☐ Personal care/hygiene	
☐	Access to food programs (describe):	☐ NO ☐ YES
☐	Safe childcare available (if needed):	☐ NO ☐ YES (describe)
☐	Other basic needs (describe):	

HOUSING/LIVING ARRANGEMENT: ☐ **No Change**

☐ Permanently housed: (describe)	
☐ Not permanently housed: (describe)	
☐ Type of housing:	☐Rent home/apartment ☐ Living with family ☐ Own home ☐Transitional living facility/half-way house ☐ Nursing Home/medical facility, etc. ☐ Homeless, on street/in car ☐ Homeless, in shelter ☐ Homeless, living with others
Receiving housing assistance (HOPWA, public housing, Section 8, Ryan White):	
• At risk of losing current housing:	☐ NO ☐ YES
• Concerns about current housing:	
• Needs help finding affordable housing or shelter:	☐ NO ☐ YES

2	Client Name:_____________________________ID #:________CM Initial:________Date:____________ (Form Revised March 2019)

INSURANCE and OTHER COVERAGE: ☐ **No Change**

Have any type of insurance?	☐ NO ☐ YES ☐ Don't Know
If Yes, check all types that you currently have:	☐ Medicaid ☐ Medicare A/B ☐ Medicare D ☐ Private Insurance
☐ Other coverage:	
☐ Issues with understanding, navigating and using insurance benefits:	
☐ Needs help with health insurance enrollment:	

TRANSPORTATION: ☐ **No Change**

☐ If no problem with transportation, note "N/A":	
☐ Access to and funds for transportation (gas, bus pass, etc.):	
☐ Needs help arranging transportation (HandiRide, volunteer, etc.):	
Barriers to accessing transportation:	

EDUCATION: ☐ **No Change**

Highest grade completed in school:	
Degrees/certificates earned:	
Primary Language:	
Difficulty reading primary language: ☐ NO ☐ YES	Difficulty writing primary language: ☐ NO ☐ YES
Difficulty reading English: ☐ NO ☐ YES	Difficulty writing English: ☐ NO ☐ YES
What's the best way information is received (e.g. written, visual, auditory)?	

EMPLOYMENT/INCOME: ☐ **No Change**

Currently working/employed:	☐ NO ☐ YES, If yes, employer/position:
Barriers to employment (check all that apply)	**Give specifics:**
☐ Health related issues	
☐ Fear of losing benefits	
☐ Applying for jobs	
☐ Transportation	
☐ Childcare needed	
☐ Education	
☐ Negative past experiences	
☐ Other	
Does client need referral for Job Services	☐ NO ☐ YES

LEGAL ISSUES: ☐ **No Change**

Does client have:	☐ Trust ☐ Will ☐ Physician's Directive ☐ Healthcare Power of Attorney ☐ Living Will ☐ Durable Power of Attorney ☐ Guardian/Conservator for self/dependents
If Power of Attorney:	Name:
	Phone #:
Legal status:	☐ Arrest(s) ☐ Conviction(s) ☐ Restraining order(s) ☐ Parole/probations ☐ Fines ☐ Name change ☐ Change in legal status of relationship like marriage, separation, or divorce Describe:

SOCIAL SUPPORT: ☐ **No Change**

Relationship (spouse, partner, parent, child, sibling, friend, relative, pet, other)	**Aware of HIV Status?**	**Type of Support** (Emotional/moral, financial, transportation, shelter, medical/adherence, none, other)	**Signed Release?**
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

COMMUNITY RESOURCES: ☐ **No Change**

Organization/Agency (church, support group, community-based organization, shelter, treatment center, other)	**Aware of HIV Status?**	**Services Provided** (Support received such as transportation, shelter, financial, emotional, other)	**Signed Release?**
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

SEXUAL HISTORY/RISK ASSESSMENT: ☐ **No Change**

Current spouse or partner:	
Is partner aware of client's HIV status?	☐ Yes ☐ No
Is client currently sexually active?	☐ Yes ☐ No
When was client last sexually active?	

Are there times when it's difficult for client and partner to engage in safer sex behaviors?: ☐ Yes ☐ No
If yes, Why?

Does client have past or current experiences with sexually-transmitted infections in addition to HIV?	☐ Yes ☐ No ☐ N/A
Does client have past or current experiences about potential trauma of sexual abuse/assault?	☐ Yes ☐ No ☐ N/A
Does client inject drugs with needles?	☐ Yes ☐ No
Does client share needles?	☐ Yes ☐ No ☐ N/A
Have all needle-sharing partners been informed of client's HIV status?	☐ Yes ☐ No ☐ N/A
How does client protect self and drug-using partners?	☐ Does not share needles; ☐ N/A ☐ Uses clean needles/works; ☐ N/A
Does client have access to condoms, clean needles and other safe sex/risk reduction supplies?	☐ Yes ☐ No ☐ N/A
Does client request additional information about risk reduction?	☐ Yes ☐ No ☐ N/A

<u>SUBSTANCE USE/ADDICTION HISTORY AND SCREENING</u>: ☐ **No Change**

Substance (use/abuse/addiction)	**Use** P = past C = current	**Amount**	**Frequency** (daily/weekly/ monthly)	**Duration** (<1 yr; 1-2 yr; >2 yr)	**Last Use** (<1 mo; 1-6 mo; 6 mo-2 yr; >2 yr)	Problem for client? ✓ = yes	Wants treatment ✓ = yes
Gambling							
Nicotine (cigs/chew)							
Alcohol							
Marijuana							
Speed/Meth							
Cocaine/crack							
Heroin							
Hallucinogens							
Rx Medications							
Other							

PLAN:

Refer for substance abuse treatment: ☐ Yes; ☐ No	Comments/details/other:

5	Client Name:____________________________ ID #:________ CM Initial:________ Date:____________ (Form Revised March 2019)

MENTAL HEALTH SCREENING

☐ **No Change**

Does client report history of mental health (MH) diagnosis? If yes, describe:	☐ Yes ☐ No
Has client ever been prescribed medication for a MH condition? If yes, what conditions?:	☐ Yes ☐ No
Is client taking medications for a MH condition now? If yes, what medications?:	☐ Yes ☐ No
Has client ever been hospitalized for a MH condition? If yes, describe:	☐ Yes ☐ No

Does client report any of the following a problem in the past year?	☐ Depression ☐ Anxiety ☐ Insomnia ☐ Forgetfulness ☐ Delusions ☐ Withdrawal/isolation ☐ Dementia ☐ Suicidal thoughts ☐ Other:
How troubled has client been in the past 3 months with any of above listed problems?	☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
Is client interested in mental health counseling, therapy or support group referral?	☐ Yes ☐ No Specify:
Has client ever attempted to hurt self or others in past?	☐ Yes ☐ No COMMENTS:
Does client have currently thoughts of hurting self or others?	☐ Yes ☐ No
Does client have a specific plan?	☐ Yes ☐ No
Does client have the means to carry out the plan?	☐ Yes ☐ No COMMENTS:

If answered "yes" to any of last 3 questions, case manager must follow the agency emergency crisis protocol for appropriate response.

PLAN: Refer for Mental Health Assessment: ☐ Yes ☐ No Comments/details:

Counseling/therapy/support group referral for client:	☐ Individual counseling ☐ AA/NA ☐ MSM group ☐ HIV group ☐ HIV Prevention group ☐ Anger Management ☐ Domestic Violence ☐ Other:

6	Client Name:________________ ID #:________ CM Initial:________ Date:__________ (Form Revised March 2019)

MEDICAL CASE MANAGEMENT ACUITY SCALE *(check one level in each category – multiply number of checks by level number to calculate points per level*) If any of the following conditions apply, the acuity level is automatically 3 and the acuity must be reassessed in 90 days: ☐ Released from a correctional facility within the past 90 days ☐ Diagnosed with HIV in the last 180 days ☐ Currently homeless ☐ Pregnant				
Life Area	**1 (lowest)**	**2**	**3**	**4**
Knowledge & understanding of HIV as a medical diagnosis, transmission, & medications	Complete understanding of HIV disease process, transmission & medications	❑ Periodic education of client on HIV disease process, transmission, and/or medications	❑ Minimal knowledge of HIV, transmission, and/or medications	❑ No knowledge of HIV, transmission risks, and/or medications
Basic Needs	❑ Client can meet own basic needs. Client is able to access community assistance on their own as needed.	❑ Occasional help to access assistance	❑ Difficulty accessing assistance. Often w/o basics.	❑ Has limited access to food. Without most basic needs.
Transportation	❑ Has reliable transportation. Is able to cover costs of transportation. Bus tickets.	❑ Needs occasional assistance < 2 times per year, Ride arrangement needed	❑ No means. Under or un-served area for public transportation. Needs assistance 3-6 times per year.	❑ Serious impact on access to medical care. Needs assistance > 7 times per year.
Health Insurance/medical care coverage	❑ Has own medical insurance and payer. Able to access medical care.	❑ Enrolled in medical care benefits program. Needs occasional assistance accessing medical care < 2 times per year.	❑ Needs referral to access insurance or medical care benefits program. No medical crisis. Needs assistance accessing medical care 3-6 times per year.	❑ Needs immediate assistance to access insurance or medical care benefits program. Medical crisis. Does not have access to medical care.
Self sufficiency	❑ Independent. Can follow-up on referrals and can access services.	❑ Sometimes requires assistance in follow-up and completing forms.	❑ Difficulty with follow-up, completing forms and accessing services.	❑ Never follows-up, unable to complete forms, burns bridges.
Housing/Living arrangement	❑ Living in clean, habitable, stable housing. Does not need assistance.	❑ Stable housing subsidized or not. Occasionally needs assistance with paying for housing <2 times per year.	❑ Unstable housing subsidized or not. Housing subsidy violation or eviction imminent. Frequently accesses housing assistance 3-6 times per year.	❑ Unable to live independently. Recently evicted. Homeless. Temporary housing. Accesses assistance > 7 times per year.

1	Client Name:___________________________ID #:________CM Initial:________Date:____________ (Form Revised March 2019)

Risk Behavior	❑ Understand risks & practices harm reduction behavior.	❑ Poor understanding of risk and no exposure to high risk situations. Risks explained but continue to engage in risky behaviors.	❑ Has poor knowledge and/or occasionally engages in risky behaviors.	Lacks knowledge and/or engages in significant risky behaviors.
Substance Use	❑ No difficulties with substance use. No need for referral.	❑ Past problems- less than 1 yr. recovery, recurrent problems. Not impacting ability to pay bills or health.	❑ Current substance use – willing to seek help. Impacts ability to pay bills and access to medical care.	❑ Current substance use – not willing to seek help. Unable to pay bills or maintain medical care because of addiction.
Dental	❑ Has own medical insurance and payer. Able to access dental care.	❑ Aware of dental services offered and requires assistance accessing dental care < 2 times per year, Referral needed.	❑ Needs information and referral to access dental services. No dental crisis. Needs information or education on dental services available.	❑ Needs immediate assistance to access dental care benefits program. Dental crisis. Does not have access to dental care.
Mental Health	❑ No history of mental health problems. No need for referral	❑ Past problems and/or reports current difficulties/ stress – is functioning or already engaged in mental health care.	❑ Experiencing severe difficulty in day-to-day functioning. Requires significant support. Needs referral to mental health care.	❑ Danger to self or others, needs immediate intervention. Needs but not accessing therapy.
Points Per Level				
	Total Points:			

Overall Assessment or Re-assessment Findings Summary

(Initial Assessment)
Medical Case Manager Signature:________________________________Date:___________

(Re-Assessment)
Medical Case Manager Signature:________________________________Date:___________

2	Client Name:_________________________ID #:_______CM Initial:_______Date:___________ (Form Revised March 2019)

MEDICAL CASE MANAGEMENT CARE PLAN

Client Name		**Date Care Plan Started**	
		(Initial/Annual)	
		Date Due to be Updated	
Medical Case Manager			
Acuity Points/Level:	**Date**	**Updated Acuity Points/Level:**	**Date Updated Acuity completed:**

Is this a reassessment for Acuity Level Three ☐Yes ☐No

Prioritized Issues/Goals

Goal #	Planned Tasks/Action Steps	CM/ CL	Target Date	Task completion date and Outcome

Client's Statement and Agreement: I have participated in the creation of this plan for my care. I understand that I take responsibility for MY plan for the plan to succeed. My case manager has explained to me what portions of the plan I am solely responsible for and those with which my case manager will assist me. I agree to follow all aspects of this plan and advise case manager if there are significant changes in my life that make it necessary to change this plan. I agree to stay in contact with case manager as planned.

______________________________ CLIENT SIGNATURE & DATE

______________________________ MEDICAL CASE MANAGER SIGNATURE & D

1	Client Name:______________________ID #:__________CM Initial:___________Date:____________

HIV Case Manager/Prevention Counselor

50-18-106, MCA. **Duty to report cases**. If a physician or other person knows or has reason to suspect that a person who has a sexually transmitted disease is conducting himself in a way which might expose another to infection, he shall immediately notify the local health officer of the name and address of the diseased person and the essential facts in the case.

50-18-101, MCA. **Sexually transmitted diseases defined.** Human immunodeficiency virus (HIV), syphilis, gonorrhea, chancroid, chlamydia genital infections, lymphogranuloma venereum, and granuloma inguinale are sexually transmitted diseases. Sexually transmitted diseases are contagious, infectious, communicable, and dangerous to public health.

50-18-112, MCA. **Infected person not to expose another to sexually transmitted disease**. A person infected with a sexually transmitted disease may not knowingly expose another person to infection.

50-18-113, MCA. **Violation a misdemeanor.** A person who violates provisions of this chapter or rules adopted by the department of public health and human services concerning a sexually transmitted disease or who fails or refused to obey any lawful order issued by a state or local health officer is guilty of a misdemeanor.

Communicable Disease Checklist

_____ I understand HIV is an infectious disease without a known cure
_____ I understand HIV can be transmitted to another person through the exchange of body fluids such as sexual intercourse and the sharing of needles.
_____ I understand Montana has laws that pertain specifically to the transmission of a sexually transmitted disease (*Some, but not all, of these laws are copied above*.)
_____ I understand my personal responsibilities to:

1) Protect myself from STDs and new strains of HIV
2) Protect others from transmission of HIV
3) Disclose my HIV status to sexual and/or needle sharing partners

Client Signature: ___________________________________Date: ____________________

_____ I have counseled my client in ways to prevent the transmission of HIV to others.
_____ I have informed the client of his/her personal responsibility to:

1) Protect his/herself from STD's and new strains of HIV
2) Protect others from transmission of HIV
3) Disclose his/her HIV status to sexual and/or needle sharing partners

_____ I have provided my client with information about available services relevant to his/her health status and referred him/her to appropriate services.

Case Manager/Counselor Signature: ________________________ Date: ___________________

APPENDIX B: CLIENT COMPLAINT FORM

I, ____ (grievant), am requesting resolution of a complaint filed under the grievance procedures outlined by MT State Health Department, Ryan White Program regarding ____________________ _________________________________ ____ (name of agency), located in____(city/county).

Statement of Grievance:
Be sure to include relevant parties, action, specific occurrences—dates and times—and location(s). Attach documentation if appropriate.
____
____
____
____
____

Prior Attempts to Resolve (please include dates and parties involved): ___________________________
____
____
____

Resolution Sought (clearly describe the relief or corrective action you are requesting): ______________
____
____
____

Print Name ____

Signature ____

Contact Info (phone and/or email). Please include the best time(s) to reach you. ___________________
____
____

1. Submit the original of this form and copies of any supporting documentation to the agency.
2. Maintain a complete copy for your personal records.

APPENDIX C: DEFINITIONS

Advocacy: The act of assisting someone in obtaining needed goods, services or benefits, (such as medical, social, community, legal, financial, and other needed services), especially when the individual has had difficulty obtaining them on his or her own. Advocacy does not involve coordination and follow-up on medical treatments and should not be confused with an appropriate Nursing intervention. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Americans with Disabilities Act (ADA): A civil rights law passed by the U.S. Congress in July of 1990 to protect people with disabilities from discrimination in public and private services and accommodations. Since HIV disease is considered a disability, the ADA protections apply to PLWHA.

Broker: To act as an intermediary or negotiate on behalf of a client.

Client Record: A collection of printed or computerized information regarding a person using services currently or in the recent past.

Confidentiality: The process of keeping private information private. Information given by a client to a service provider will be protected and will not be released to a third party without the explicit written permission of the client or his or her representative. Information may be released only in the following circumstances: (1) When a written release of information is signed by the client; (2) When there is a clear medical emergency; (3) When there is a clear and imminent danger to the client, Medical Case Manager or others; (4) Where there is possible child or elder abuse; and (5) When ordered by a court of law.

Criteria: A standard, or on a or be rule, test which judgment decision can based.

Cultural Competency: Refers to whether service providers and others can accommodate language, values, beliefs, and behaviors of individuals and groups they serve.

Demographic Information: Descriptive information for an individual that may include but is not limited to, age, race, ethnicity, and gender. This information provides a profile of people receiving services from a specific agency.

Emotional Support: Emotional Support: The ability of the Medical Case Manager to listen and empathize is the essence of emotional support in the care coordination relationship. In cultivating a trusting relationship, it is important for the Medical Case Manager to strike a balance between the empathetic role--utilizing active listening skills, developing rapport, and providing emotional support--and the objective role which requires engaging and encouraging the client toward concrete actions to achieve a desired outcome. Because HIV case management is often defined as a task-oriented process, we tend to focus on the "doing" of tasks with the client and forget the importance of "being present." Being truly available to offer emotional support is particularly important in situations where the resources to meet the needs of the client are not available.22

Grievance: A real or imaginary wrong causing resentment and regarded as grounds for complaint.

HIV Disease Health Education/Risk Reduction: Activities that include information dissemination about methods to reduce the spread of HIV, HIV disease progression, and the benefits of medical and psychosocial support services. This activity does not include medication or treatment information that is part of Adherence activities.

Health Insurance Portability and Accountability Act (HIPAA): The first comprehensive federal protection of patient privacy passed by the U.S. Congress in 1996. HIPAA sets national standards to protect personal health information, standardize the way it's used, and make health insurance more portable for the public. Key provisions include: (1) guaranteed access for clients' to their medical records; (2) the ability of the client to limit the information that entities like MT DPHHS and its contractors can disclose; (3) the ability of the client to review their medical records for accuracy and to request changes; and (4) allows health information to be disclosed without authorization for certain national priority purposes, such as research or public health disease outbreaks.

May: Permissive, but not to be interpreted as an enforceable requirement.

Must: Indicates condition, action, etc., as mandatory and enforceable.

Multi-Disciplinary Team: A team that includes professionals representing the disciplines required for a holistic approach to meeting the needs of a client, as identified through the Assessment. At a minimum, a medical team for HIV care consists of the Medical Provider, Medical Case Manager, and Treatment Adherence Advocate.

Outreach/Case Finding: Activities that have as their principal purpose to identify individuals with HIV disease so that they may become enrolled in care and treatment services. Outreach activities should be coordinated with the local HIV prevention outreach program. Activities should be targeted to populations known to be at disproportionate risk; conducted at times and places where such individuals are likely to be reached; and be reportable and evaluated for effectiveness in getting new clients with HIV enrolled in care coordination and medical care.

Quality Assurance (QA): Refers to a broad spectrum of ongoing/continuous evaluation activities design to ensure compliance with minimum quality standards. An ongoing monitoring of services for compliance with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections, and adherence to state and federal laws, rules, and regulations.

Quality Improvement (QI): Generally used to describe the ongoing monitoring, evaluation, and improvement process. It includes a client-driven philosophy and process that focuses on preventing problems and maximizing quality of care. This focus is a means for measuring improvement to access quality of HIV services.

Ryan White HIV/AIDS Treatment Extension Act of 2009: Passed by the U.S. Congress in 1990, the purpose of this federal act is to provide emergency assistance to communities that are 23 most affected by the HIV epidemic and to make financial assistance available to state and other public or private nonprofit entities. This assistance provides for the development, organization, coordination and operation of more effective and cost-efficient systems for the delivery of essential services to individuals and families with HIV disease.

Service Plan: A written plan that directs the activities of the client and the Medical Case Manager. The Service Plan delineates the case management goals and objectives required to coordinate and link the client to the continuum of health and support services required to manage his/her disease.
Service Planning: An ongoing interactive process with the clients, where problems are identified and prioritized. Identified problems are addressed through a planning process that includes the development of goals, assigned activities, and reporting outcomes. Clients and their support systems also have strengths that should be incorporated into Service Planning.
Shall: Indicates condition, action, etc. as mandatory and enforceable, unless an exception is granted and/or required under funding regulations and/or MT DPHHS discretion.
Should: Indicates accepted industry or professional practice standard and/or what is expected. May or may not be enforceable but is subject to remediation.
Standard: An authoritative statement by which a profession describes the responsibilities, ethics, and behaviors for which its practitioners are accountable. A rule or basis of comparison in measuring or judging capacity, quantity, content, extent, value, and/or quality.
Therapy/Counseling: Therapy or counseling refers to professional mental health interventions aimed at reducing clinical symptoms that interfere with an individual's ability to meet the demands of daily life and participate actively in his or her own health care. It falls outside the role of a Medical Case Manager to provide mental health therapy or counseling to clients. Referring clients to appropriate mental health resources, and facilitating access to those services is the appropriate role for the Medical Case Manager
Treatment Plan: A written plan of treatment and therapy developed by a medical provider

USEFUL RYAN WHITE ABBREVIATIONS AND ACRONYMS:
ACA: Affordable Care Act
ADA: Americans with Disabilities Act
ADAP: AIDS Drug Assistance Program
MWAETC: Mountain West AIDS Education and Training Center
ANAC: Association of Nurses in AIDS Care
BS: Bachelor of Science
BSW: Bachelor of Social Work
CD4: Cluster of Differentiation 4
CCM: Certified Case Manager
DDP Division of Disease Prevention
ED: Emergency Department
GED: General Educational Development
HIPAA: Health Insurance Portability and Accountability Act
HCS HIV Care Services
HS: High School
LCSW: Licensed Clinical Social Worker
LCPC: Licensed Clinical Professional Counselor
MAI: Minority AIDS Initiative
MCM: Medical Case Management

MSW: Master of Social Work
NMCM: Non-Medical Case Management
PLWHA: People living with HIV/AIDS
QA: Quality assurance
RN: Registered Nurse
ROI: Release of Information
RW: Ryan White
SNAP: Supplemental Nutrition Assistance Program
SSDI: Social Security Disability Insurance
SSI: Social Security Insurance
TANF: Temporary Assistance for Needy Families
MT DPHHS: Montana Department of Health and Human Services
VL: Viral load