# BROWARD COUNTY
# RYAN WHITE PART A PROGRAM

## Disease Case Management
## Service Delivery Model

Revised by HIVPC on 3/25/2021
Last Reviewed on 4/1/2021

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# I. Service Definitions

**HRSA Definition**[1]

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities undertaken in this service category may be provided by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication), as well as activities taken on behalf of the client (e.g., multidisciplinary case conferences, referrals to other personnel or agencies).

Key activities include:

- Initial assessment of service needs
- Develop a comprehensive, individualized care plan (ICP)
- 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 ICP
- Re-evaluate the ICP plan at least every six 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 service utilization

In addition to providing the medically oriented activities above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. Such programs may include Florida Medicaid Managed Care Organizations (MCOs), Medicare Part D, Florida AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's Patient Assistance Programs (PAPs), other state or local healthcare and supportive services, and insurance plans through the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), Marketplaces/Exchanges.

**Local Definition**

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) funds the Disease Case Management (DCM) model of MCM. DCM provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications stemming from co-morbid chronic disease conditions. DCM includes assessment of client needs, development of a coordinated plan of care, and care coordination. Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Coordinating essential medical and support services and making referrals when indicated
- Providing adherence counseling to treatment regimens and healthcare, and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

## II. Key Service Components and Activities

In addition to the DCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. DCM providers must refer to their individual contract for service-specific client eligibility requirements. DCM providers must comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

**Coordination of Medical and Healthcare Improvement Services**

Providers must ensure coordination of medical and healthcare improvement services to support clients in meeting their ICP goals and maintaining their engagement in care. Case coordination and case conferencing includes communication, information sharing, and collaboration that occurs regularly with case management and other providers serving the client within and between agencies in the community. Coordination includes, but is not limited to:

- Managing HIV and co-morbid condition (chronic and acute) treatments
- Communicating with the client's primary care and behavioral health providers and other service providers to support client adherence, understanding, motivation, access to services and optimal engagement in care to include case coordination and case conferencing activities
- Coordinating medical and support service use within the RWHAP system of care, addressing barriers to obtaining services, and linking the client to services
- Coordinating specialty medical services outside the RWHAP system of care

Case conferences include multi-disciplinary service providers, including providers within the agency and those from other agencies when possible and relevant. Case conferences must be face-to-face or via conference call and must be held at routine intervals or during significant care changes or transitions. High acuity levels established by the Acuity Scale informs the frequency of case conferences. The client and their family members, significant others, or designated caregiver(s) should also be included in case conferences when possible and appropriate. These activities must be recorded in the client's progress notes in the designated HIV Management Information System (HIV MIS). Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals
- Resolve conflicts or strategize solutions

**Adherence Counseling to Support Medical Care and Treatment**
DCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions
- Documenting all adherence counseling activities in the designated HIV MIS

**Client-Centered Education and Training on HIV Self-Management**
DCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression
- Retention in HIV and primary medical care, including health promotion activities
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning
- Recognizing the signs of stress, distress, anxiety, and depression and strategies to access emotional support services
- Adequate nutrition, regular exercise, and the benefits of stress reduction and self-care.

## III. Broward Outcomes and Indicators

**Table 1. Outcomes, Indicators, and Measures**

| Outcome | Indicator(s) | Measure |
|---|---|---|
| 1. Increased access, retention, and adherence to primary medical care. | 1.1. 85% of clients achieve one (1) or more action plan goals by the target resolution date. | 1.1.1. Client action plan in designated HIV MIS. |
| | 1.2. 90% of clients are retained in primary medical care. | 1.1.2. Client appointment record in designated HIV MIS. |

## IV. Assessment and Individual Care Plan

**Comprehensive Health Assessment**

DCMs must assess client needs by conducting a CHA within 14 days of the client's initial visit. The CHA must be completed within the designated HIV MIS. The CHA is used to evaluate each client's access to medical care, health status, health maintenance, health knowledge, treatment adherence, behavioral health needs, and environment. Assessment findings are used to inform the acuity scale component.

**Acuity Scale**

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. DCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

**Table 2: Acuity Scale Scoring and DCM Management Levels**

| Management Level | Points | Health Status/ Medical Condition | Client Contact Frequency | Chart Review Frequency |
|---|---|---|---|---|
| **Self-Management** | 24-34 Points | Medically stable without need of DCM assistance and is virally suppressed | Face-to-face or telehealth visual follow-up at least once every six months for reassessment | Once every six months |
| **Basic Management** | 35-49 Points | Medically stable with minimal DCM assistance and is virally suppressed | Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months | Every 3 months |
| **Moderate Management** | 50-73 Points | At risk of becoming medically unstable without DCM assistance including documented detectable viral load or risk for viremia | Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month | Every 3 months |
| **Intensive Management** | 74-96 Points | Medically unstable and in need of comprehensive DCM assistance with an accompanying detectable viral load | Face-to-face at least once a month with phone contact weekly | Monthly |

**Reassessment**
Reassessments provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous timeframe of activities. Providers must reevaluate the client's unmet needs and related barriers by conducting reassessments every six months after completion of the initial assessment, or sooner if the client's circumstances change significantly. Reassessment findings are used to update the ICP.

**Individual Care Plan (ICP)**
Providers must develop an ICP within 30 days of completing the initial client visit. DCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The DCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. DCMs must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV MIS.

## V. Standards for Service Delivery

**Table 3. DCM Standards for Service Delivery**

| Standard | Measure |
|---|---|
| 1. Provider completes a CHA with each client within 14 days of their initial visit. | 1.1. Completed CHA in the designated HIV MIS. |
| 2. Provider develops an ICP with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client. | 2.1. ICP signed and dated by the provider and client in the designated HIV MIS. |
| 3. Provider completes a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change. | 3.1. Completed CHA in the designated HIV MIS.<br>3.2. Progress notes in the designated HIV MIS. |
| 4. Client health needs are assessed and reassessed using the Acuity Scale as outlined in *Appendix A*. | 4.1. Acuity Scale completed and scored in the designated HIV MIS. |
| 5. Client has contact with the provider at the frequency specified by client's management level as detailed in *Appendix A*. | 5.1. Documentation of client communication in the designated HIV MIS. |

| Standard | Measure |
|---|---|
| 6. Provider conducts healthcare monitoring as specified by the ICP. | 6.1. Documentation of the ICP and progress notes in the designated HIV MIS. |
| 7. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care. | 7.1. Documentation of the ICP and progress notes in the designated HIV MIS. |
| 8. Provider conducts adherence counseling to support treatment regimens and medical care. | 8.1. Documentation of the ICP and progress notes in the designated HIV MIS. |
| 9. Assistance provided to client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client. | 9.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV MIS. |
| 10. Provider follows up with clients within two business days of the client's requested communication. | 10.1. Documentation of client communication in the designated HIV MIS. |
| 11. Provider conducts medical chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in *Table 2*. | 11.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV MIS. |
| 12. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 2*. | 12.1. Documentation of client case management conference in the designated HIV MIS. |

# VI. Appendix A

## The DCM Assessment Model