Provider Reference Manual

Targeted HIV Case Management and High Risk, Negative Case Management

for

Ryan White and Medicaid Populations

HIV Provision of Care

&

Special Populations Unit

Final Version 11.15.22 V4.5

Areas of Focus:

Targeted Care/Case Management Protocol for People Living with HIV & AIDS

Targeted Case Management Protocol for People at High Risk for HIV

Revision History

Version	Date	Reason for Revisions	Sections Revised
1.0	20 January 2016	New document	
1.0	5 April 2016	Revisions	Community, providers, staff revisions
2.0	1 June 2016	Version 2	Final review of all sections and edits
3.0	3 March 2017	Version 3	Final, final draft for publication
3.1	1 June 2022	Version 3.1 working draft	Created internal working draft v3 to v3.1
4.0	10/4/2022	Version 4 Final Working Copy to Key Stakeholders	V4 represents pre-external vetting of revised document
4.1	10/18/2022	4.1 Vetted document with resolution of comments	V4.1 Reviewed as final draft to EOHHS
4.2	10/20/2022	Version 4.2 Final Working Copy to Key Stakeholders with EOHHS edits	4.2 EOHHS final edits before sending to staff for final check
4.3 & 4.4	10/20/22 – 11/1/22	Staff final revisions and edits. Inclusion of tools to document	Next step document goes to Gainwell for final review and posting TBA
4.5	11.15.22	Design and final edits	Final Copy Completed

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Section I – Rhode Island Ryan White & Medicaid HIV TCM Provider Manual Outlined

INTRODUCTION TO THIS PROVIDER MANUAL

The Rhode Island Executive Office of Health and Human Services (EOHHS), in conjunction with Gainwell Technologies, Inc. developed this provider manual for all RI Targeted HIV Case Management Ryan White and Medicaid Providers. The purpose of this guide is to assist both Ryan White Part B Medicaid providers with policy, coverage information Ryan White and Medicaid allowable costs and services, and Medicaid claim reimbursement for this program. We emphasize this manual also applies to those HIV agencies funded to provide non-medical, targeted case management for the RI Ryan White Part B program. General information is found in the General Guidelines Reference Manual. The Gain well Technologies Customer Service Help Desk is also available to answer questions not covered in these manuals.

> Pertaining to Medicaid, The Centers for Medicare, and Medicaid Services (CMS) has published interim final regulations to govern case management services under Medicaid (Federal Register, December 4, 2007, Vol. 72, No. 232, 68077-68093; 42 CFR Parts 431, 440 and 441). Under these regulations Medicaid case management services are services that will assist individuals in gaining access to needed medical, social, educational, or other services. These regulations were promulgated to implement part of the Deficit Reduction Act of 2005 (DRA, Public Law, 109-171—see the Bazelon Center's March 2006 Mental Health Policy Reporter) and are CMS' interpretation of Section 6052, Reforms of Case Management and Targeted Case Management. The rule covers case management services and targeted case management services and seeks to clarify the situations in which payment will and will not be made by Medicaid.

Summary of New Federal Targeted Case Management Final Regulations – Effective March 3, 2008, | MES.

The language above specifically references Medicaid definition of Targeted Case Management. You shall notice that in this document there is a clarification between the terms "Targeted HIV Care Management for People Living with HIV/AIDS" and "Targeted Case Management for People at High Risk for HIV." It is important to acknowledge that while we present two areas, one for people that are living with HIV, and the other for people at high risk for HIV, the terms care and case management within this manual, **may be used interchangeably.**

For specifics regarding the difference in the nature of these terms (care and case management) as they apply to the populations to be served by either function, and for practice details see page 4-5, Scope of Service. For simplicity, we shall refer to care management as it applies to people living

with HIV, and case management to those at high risk for HIV. Essentially, the practice components are the same, and each area whether it be case, or care management must fulfill the Intake, Assessment/Reassessment (Severity Indexing is found here), Care Planning (Care Planning shall be required even for people at high risk for HIV), and Documenting HIV Quality Performance Measures (metrics). The general rubric of case management will apply to both areas, but we felt it important to clarify and distinguish so the readers understand the perspective of working with people at high risk for HIV versus those living with HIV. ***Please also know that Medical Case Management for people living with HIV is yet another concept and has distinguishable features for clinical care and practice.***

Medicaid, non-medical, targeted case/care management services are defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational, and other services, such as housing and transportation.

For Medicaid, the preamble to the CMS regulation clarifies that targeted case management cannot be furnished to an individual who is not yet determined eligible for Medicaid. However, Medicaid administrative costs can include assisting individuals in applying for or obtaining eligibility, re-determinations of eligibility, intake processing, preadmission screening for inpatient care, prior authorization and utilization review, and outreach. States may not claim costs for administrative activities if the activities are an integral part or extension of a direct medical service.

For the purposes of this Provider Manual, we seek to more clearly define the allowable expenses and services associated with HIV Targeted Case/Care Management for both Medicaid and non-Medicaid (Ryan White) populations. The functions of RI Medicaid HIV Targeted Case/Care Management reimbursed must assist persons eligible for Medicaid to access needed medical, social, psychosocial, educational, financial, and other services required to encourage the enrollee's maximum, independent functioning in the community. ***Case/Care management provides access to services but does not include the actual provision of the needed services.***

Case/Care Managers providing services within this framework must be well versed in all of the Rhode Island Medicaid benefits for beneficiaries (transportation, home, and community health services, etc.), so that they can maximize the full potential of the benefits package for the clients they serve. Same for Ryan White providers.

RI Medicaid HIV Targeted Case/Care Management (RIMTCM) has the following unique characteristics among Medicaid services:

- It is targeted to people living with HIV/AIDS who will benefit from a focused effort to improve access to a wide range of medical, human, and social services.

- A State Medicaid Plan Amendment is prepared by the RI Executive Office of Health & Human Services for each targeted population. Each state plan amendment (SPA) and targeted case management program may be tailored to the needs of the

target population. Case/Care Management already exists in the State Plan, Amendment.

- RIMTCM Provider entities, are enrolled as Medicaid providers of HIV targeted case/care management for people living with HIV/AIDS and/ or for people at high risk for HIV (HIV negative individuals) on the basis of the approved proposal and designation by the statewide supervising authority. *Providers may serve only the population for whom they are designated*; and monthly contact requirements, case/care manager qualifications, service standards, reimbursement methodology and resulting billing rules may be specific to the approved State Plan Amendment (i.e., target population).

RI HIV TCM Assessment: Case Manager Survey Results Summary and Analysis

Rhode Island Executive Office of Health and Human Services, HIV Provision of Care & Special Populations, Non-Medical Targeted Case Management Survey, June 2022

The HIV Provision of Care & Special Populations Unit proceeded to revise and update this manual with the assistance of case managers and senior level HIV providers funded by Medicaid and Ryan White. We proceeded by developing an internal, working draft document of the assessment, via share and framing this first draft with new thoughts, edits, comments, and a list of citations regarding research performed.

Then we distributed a brief survey for active HIV Targeted Case Managers and their supervisors. Our intent was to find out if case managers and their supervisors used the Provider Manual and if they had suggestions for improvement or other thoughts.

We estimated there were approximately 60 case managers including their supervisors, and that was the anticipated denominator for the survey. 15 individuals completed the survey and sent back responses after three attempts to receive 100% completion. In short, our 25% response rate accounted for active case managers and some supervisors who are actively performing targeted case management for Medicaid and Ryan White.

Here is the survey and a summary of the input we received regarding the use of the previous Provider Manual for HIV case management. Please note after the survey was done, we then proceeded to the analysis phase and intended to make changes to the Provider Manual from the thoughts and comments we received. The survey is below:

In June 2022, the anonymous, 12-question survey below was given to all non-medical (targeted) case managers with the following instructions:

The following 12 question survey is anonymous, and no answers will be drawn back to your agency. This 5–10-minute survey will ask questions regarding your use of the Case Management Provider Manual and your regular practice as a Targeted Non-Medical Case Manager funded by Ryan White in the State of Rhode Island. The information you provide will be used to inform our new revisions that are currently being made to the Provider Manual in order for it to be an up-to-date resource for your reference. All results will be analyzed in an aggregate fashion. Please take your time and answer all questions honestly. Thank you!

* Required

1. Have you read the RI EOHHS Case Management Provider Reference Manual?*

- Yes
- No

2. If you answered yes to the question above, how often do you refer to the Case Management Provider Reference Manual in your daily job?*

3. Do you currently use severity and/or acuity indexing with your clients?*

- Yes
- No
- Other:

4A. If you answered yes to the previous question; do you believe using severity indexing prohibits your flexibility in providing the correct treatment to your clients?

- Yes
- No
- Other:

4B. If you answered yes to the previous question (4A), please explain why. If you answered no, please explain what you like about the acuity/severity index you use:

_____
_____
____

5. Please select all the choices that are relevant and best describe the acuity/severity levels of your clients:*

- More than 50% of the clients I work with are high on the index
- More than 50% of the clients I work with are moderate on the index
- More than 50% of the clients I work with are low on the index
- I have more clients that fall under high and moderate index levels than low on the index
- I have more clients that fall under moderate and low index levels than high on the index
- The clients I work fall equally among the three categories, where about 33% are low, moderate and high
- I have no idea where my clients fall on the index

6. Based on your previous answer in #5, do you believe you are able to devote enough time to manage your client caseload effectively?*

- Yes
- No
- Other:

6A. If you answered no to question #6, please list the primary barriers that interfere with you devoting enough time to your clients:

_____
_____
____

7. Below are some challenges and barriers that we have heard from case managers. Please check all that apply to you:*

- I have too many clients
- I don't have enough tools or resources to perform my job
- COVID-19 altered the way that I practice
- My clients have very severe needs and it is really difficult for me to attend to all of those needs
- My clients are not responsive to advisory and/or the Care Plan that we have created
- My job description and my duties are often not clear to me
- Issues like substance use disorder and mental illness get in the way of care planning
- My salary
- I'm rather new at this, and therefore do not have a lot of the skills and/or experiences that my colleagues have
- I have been working for so long and the HIV field is becoming more difficult to work in
- I'm being asked to do many more things than just case management
- Virtual or tele case management is challenging for me
- Other:

8. What opportunities are available to you as a non-medical case manager? Please check all that apply to you:*

- I have on the job flexibility to care for and manage my clients
- I have all the tools and resources I need to perform well in my job
- COVID-19 provided more tools for me to manage my clients
- I have ample training and development for me to do my job
- My salary is adequate
- I see the pathway to advancement in my agency and feel that I can advance professionally
- My job description and duties are clear and provide me with the guidance I need to get the job done
- Virtual or tele case management provides me with more opportunities to meet with clients
- Other:

9. The official provider manual for HIV case management outlines several processes and steps regarding case management intake, assessment, and care planning. Please check all the areas found in the manual, that are integral to case management:*

- Assessing all clients for the B.A.L.L.O.O.N. Criteria
- Intake, Assessment, and Care Planning
- Understanding your clients insurance provider and how to bill for that client
- Integrating Acuity/Severity Indexing for client care
- Understanding what is an allowable and unallowable costs for Medicaid and Ryan White case management
- Engaging and reengaging clients in care

10. Please identify the quality measures below by checking all those that apply:*

- Viral load suppression
- Face to Face visits with clients
- Number of Complaints Clients have toward the agency
- Client is on ARVs
- Client has a Care Plan
- Client is in Unstable Housing
- Client is Homeless
- Client is in Care
- Client has children

11. Do you believe that extra guidance provided in the case management manual regarding emergency preparedness (i.e. COVID-19, Monkeypox, Natural Disasters, etc.) would be a helpful resource to have?*

- Yes
- No
- Unsure

12. Please add any additional comments!

2022 HIV TCM Survey Case Manager Results Summary/Analysis

The purpose of this survey was to better understand how non-medical case managers, under RI EOHHS Ryan White Part B, currently interact with the current targeted case management manual published in 2017. The questions addressed case managers' knowledge of the manual, as well opinions around current practices including caseload size and severity indexing.

Out of the 40 people, including non-medical case managers and their supervisors, asked to complete the survey, we received 15 responses. Close to 75% of respondents said that they have read the Case Management Manual before; however, of those who have read it they seldom refer to it. One respondent said that it would be extremely helpful to have more training on the manual in team meetings for refreshers. 86.7% of respondents use severity indexing with their clients, and of that percentage only 25% feel as though this system prohibits their flexibility to provide the correct treatment. Most who gave explanations for their opinions felt as though the severity/acuity index gives better information to inform the case manager's process moving forward with the client. One respondent recorded that they feel as though severity indexing does not give an accurate picture of the client.

When asked about where most of their clients fall on the severity index, most case managers responded that most of their clients are either low or moderate severity levels. Only one person responded that most of their clients are high on the index, and one responded that they had no idea where their clients fall. 73.3% of case managers responded that based on their caseload they can devote enough time to each client, while 13.3% feel as though they cannot. Barriers for the 13.3% include high case load and too much paperwork.

Most case managers responded that the biggest barriers to doing their job is their salary, and the high rates of substance use and mental health that can complicate care planning. Case managers also responded that they feel they have too many clients, and many of them feel that COVID-19 has severely altered the way that they practice. 26.7% feel as though they are being asked to do many more things than just case management, and often clients do not respond to the care plan that has been created. On the other hand, most case workers responded that they feel they have on the job flexibility to care for clients, as well as all of the resources that they would need to care for their clients. There were also high responses for having ample training opportunities and clear duties in their job descriptions.

The last questions in the survey asked supervisors and case managers to identify all areas found in the manual that are integral to case management. Almost all respondents said that the manual covers intake, assessment, and planning and integrating acuity/severity indexing. There was one false answer that discussed the B.A.L.L.O.O.N. measure (which was a trick question, as there is no such measure!) and one person responded that this was in the manual. Another question discussed the quality measures that are used and most responded correctly. One person responded that they did not understand what this question (number 10) was asking.

Majority of respondents said that more information and training on how to deal with emergency preparedness would be helpful. Respondents added additional comments explaining that they were grateful for taking the time to receive their input. Other challenges that case managers are concerned about is high case manager turnover rate and working with undocumented clients who are at risk of deportation. Respondents asked for the Provider Reference Manual to be implemented in more Case Manager training from RI EOHHS.

After the survey was analyzed, input from the case managers was used to revise Version 4 of the Provider Manual. There were changes made to training requirements, resources for emergency management and the 8 dimensions of wellness, and more information on the impact/importance of case management. More information was added to the manual about chronic disease management and best practices regarding a case manager's role in building rapport with clients. Survey questions about caseload size were considered. The final, working draft was sent out to supervisors of case managers (of Medicaid and Ryan White Part B agencies we find) for their final comments before the final copy was published.

Why is Case Management Essential for People Living with HIV?

According to CDC, more than 1.2 million Americans are living with HIV, and approximately 13% are unaware they are infected with the virus. For those infected with the disease, the medical outlook is vastly different today than it was in the early days of the epidemic, when treatment was largely palliative, and life expectancies following diagnosis were relatively short. Today's treatments have transformed HIV from what was once an acute, fatal condition to a chronic, manageable disease. Individuals with the virus have the potential to live long, productive, fulfilling lives. However, many face barriers that prevent them from receiving the full benefit of available treatment options.

A high percentage of PLWH come from populations historically underserved by traditional health care systems. Many struggle with substance abuse problems, homelessness, and mental illness. Men who have sex with men, youth, and people of color (men and women) are disproportionately affected.[1]

1. Ryan White Part B Client Services Manual - Iowa Department of Public Health. https://idph.iowa.gov/hivstdhep/hiv/support. Accessed July 7, 2022.

The Effectiveness of Case Management

Studies have found a high level of need for care and support services among PLWH. Research suggests that case management is an effective approach for addressing the complex needs of chronically ill clients. Case management can help improve client quality of life, satisfaction with care, and use of community- based services.

Case management also helps reduce the cost of care by decreasing the number of hospitalizations a client undergoes to address HIV-related medical conditions. On the behavioral front, case management has been effective in helping clients address substance abuse issues, as well as criminal and HIV risk behavior.

Clients with case managers are also more likely than those without to follow their drug regimens. One study found that use of case management was associated with higher rates of treatment adherence and improved CD4+cell counts among PLWH who were homeless and marginally housed. More intensive contact with a case manager has been associated with fewer unmet needs for income assistance, health insurance, home care and treatment. Recent studies have found that even brief interventions by a case manager can improve the chances that a person newly diagnosed with HIV will enter care.[2]

2. Ryan White Part B Client Services Manual - Iowa Department of Public Health. https://idph.iowa.gov/hivstdhep/hiv/support . Accessed July 7, 2022.

A Case Manager's Role

It is apparent that optimal care for HIV clients requires a comprehensive approach to service delivery that incorporates a wide range of practitioners, including doctors, mental health professionals, pharmacists, nurses, and dietitians, to monitor disease progression, adherence to medication regimens, side effects, and drug resistance. Regarding support services, most programs serving those with HIV provide or have referrals to HIV prevention programs, mental health counseling, substance abuse treatment, housing, financial assistance, legal aid, childcare, transportation, and other similar services, both inside and outside HIV systems of care. Case managers perform a critical role in facilitating client access to and use of these services, in part, by ensuring they are well coordinated.

Case management services should reflect principles of service delivery that affirm a client's right to:

- A quality life
- Privacy
- Confidentiality
- Self-determination
- Freedom from discrimination
- Compassionate non-judgmental care
- Dignity and respect
- Culturally competent service delivery
- High-quality case management services.[3]

3. Ryan White Part B Client Services Manual - Iowa Department of Public Health. https://idph.iowa.gov/hivstdhep/hiv/support . Accessed July 7, 2022.

The roles of the case manager are varied and require that case managers assist clients in addressing problems in all facets of their lives. Case managers often act in, but are not limited to the following roles:

- Advocate

- Counselor
- Problem solver
- Coordinator with Service Providers/Planners
- Prudent Purchaser[4]

4. 2021 Georgia Ryan White Part B Case Management Standard Operating Procedures - Georgia Department of Public Health. Georgia Ryan White Part B Case Management Standard Operating Procedures. Accessed July 7, 2022.

What is HIV Chronic Disease Management?

HIV TCM case managers have an array of skills and experience. Some are licensed, clinical social workers, some have specific experience with people living with HIV, behavioral health concern, etc. People living with HIV that are virally suppressed are now in a chronic disease management phase. The disease is undetectable and untransmissible. HIV Chronic disease management is an approach to health care that involves supporting individuals to maintain their independence and to stay as healthy as possible. It involves wellness and well-being, and case managers are at the core of this approach of helping people stay healthy and continue to assist them navigate the health and human services system. HIV Chronic disease management relies on early diagnosis and effective management of chronic conditions to prevent progression, reduce risk of complications, prevent associated illnesses, and enable people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes, and access appropriate support are all factors that influence successful management of an ongoing illness.

Improving the health of people with chronic illnesses requires transforming a health care system that is now essentially reactive – responding when a person is sick and/or in crisis – to one that is proactive and focused on keeping a person as healthy as possible. This requires not only determining what care is needed, but also spelling out roles and tasks in a structured, planned way. This helps to ensure that everyone involved as a part of the client's care team understands their role. It also requires making coordinated follow-up a part of the standard procedure, so that clients are not left on their own once they leave the doctor or case manager's office. Clients with complex needs require more intensive case management for a period to optimize their clinical care, the effectiveness of their treatment regimen, and their self-management behavioral skills.[5]

5. Ryan White Part B Client Services Manual - Iowa Department of Public Health. https://idph.iowa.gov/hivstdhep/hiv/support Accessed July 7, 2022.

Effective Self-Management of HIV

For certain, RI HIV targeted case managers have continually demonstrated that they put the client first, and center care plans around the immediate and current needs of the client. PLWH

need support and information to become effective managers of their own health. Chronic conditions require not just medical interventions, but behavioral interventions as well. Clients with chronic conditions such as HIV, play a large role in managing their conditions. Each client is at a different place in the process and appropriate interventions are driven, to a large extent, by each client's desired outcomes. To meet these needs, it is essential for clients to have the following:

- Basic information about HIV, prevention, care and treatment
- Understanding of and assistance with self-management skill building
- Ongoing support from members of the health care and case management team, family, friends, and community
- Affordable, accessible, and available resources available in the state to meet a myriad of needs

Our case managers have informed us and do practice the concept that "effective self-management support does not mean telling clients what to do." It means acknowledging the client's central role in their own care and fostering the client's sense of responsibility for their own health. Case managers are encouraged to begin each session with the client needs of today. To focus upon well-being and wellness and to also practice trauma informed approaches.

It also includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. But self-management can't begin and end with a class. Using a collaborative approach, case managers and clients work together to define problems, set priorities, establish goals, create care plans, and solve problems along the way.

Below are the key components of chronic disease management & client self-management:

- **An emphasis on the client's role** - What will, or can they do to make identified change occur? Here is where TAVIE Red is an essential tool in assisting clients get to where they want to be from a health outcome perspective as well as from a wellness perspective.
- **A standardized assessment** - Agencies use a variety of assessments to determine what a client needs may be, how they will approach those needs, and what action steps need to occur to make change happen. Many times, clients are faced with crisis and case managers assist in addressing and managing the crisis at hand.
- **Effective, evidence-based interventions** - Again agencies have a list of such effective methods to assist a client, like Motivational Interviewing, TAVIE Red, crisis intervention and trauma informed approaches, etc.
- **Consistent assessment and care planning (goal setting) and problem solving** – Often, HIV case managers know how important it is to update the client Assessment and relate that newly revised Assessment to the Care Plan. Things change and the more we check in with the client about those changes the more we understand what care planning actions and activities need to occur. Case managers are required to use the TAVIE Red platform dashboard or console to understand where each of their clients are in terms of the "quests, rituals and outcomes" they are achieving with TAVIE Red.
- **Active, sustained referrals and follow-up** - A case management is always in the referral and follow-up mode. To work properly, case managers have reported the follow-up to a session must be immediate, active, and sustained, so that the client is successful. Now with tele case management approaches available in RI, case managers can often and

consistently follow-up. Clients can fell as though they can contact case managers more readily, such that when in crisis there is a direct link to someone who may help them.

Follow-up is an essential product of quality performance measures in Rhode Island. The high success rate of attaining viral suppression among people living with HIV enrolled in Ryan White, is due to many factors including the active follow-up, and the Ryan White program's ability to allow case manager's the flexibility to perform follow=up activities. The local scene for effective follow-up during case management really depends on the referrals that are out there for your client. In addition, a procedural approach to follow-ups requires record keeping, a network of reliable, consistent resources and programs/agencies accessible and available to your client. If a client doesn't have the resources to access some referrals or to perform the follow up you as a case manager desire, then the outcome may be inferior.

TAVIE Red, An Essential, Required Component of HIV Case Management in Rhode Island

TAVIE Red 4th Generation (TAVIE Red) is the third iteration of a mobile application (formerly TAVIE HIV, TAVIE RX). TAVIE Red utilizes gamification to increase health and psychological self-management and assists case managers with connecting with clients. Gamification keeps clients engaged, assists with behavior, and increases gain knowledge through elements of game mechanics, such as working through scenarios where challenges are presented (i.e., Quests) and earning rewards for completion of activities. The TAVIE Red intervention aims to improve linkage and retention in care while addressing social determinants of health among people with HIV.

Rhode Island Executive Office of Health and Human Services (RI EOHHS), in partnership with 360 Medlink, administers TAVIE Red and has reached over 330 people with HIV. We expect all people living with HIV within the state will have full access to TAVIE Red by the end of 2023.

Clients who participate in the intervention are eligible for RWHAP services. In 2017, RI EOHHS received an RWHAP Part B supplemental grant from HRSA to provide services to clients enrolled in RI EOHHS's over 60 RWHAP-funded agencies. TAVIE Red features include treatment and symptom management, treatment reminders, a CD4 and viral load charting tool, health-related self-assessments, GPS resource mapping (e.g., locate food, housing, transportation), gamification and personalized health coaching to develop behavior change, and the ability for clients to achieve rewards (e.g., tokens, leadership board). TAVIE Pro, the case manager online portal, is used in conjunction with TAVIE Red. TAVIE Pro acts as a mechanism for case managers to send announcements, schedule appointments, and monitor client self-assessment progress.

Case managers performing HIV case management for Medicaid and/or Ryan White must be trained on TAVIE Red, assist with outreach and coordination of their clients using TAVIE Red and use the data within the TAVIE Red platform to assess their clients' progress.

The TAVIE On-the-Ground Training proves to be a valuable asset within the Case Manager's toolbox, serving as a training that provides credits towards the Pathways to Advancement. This four-part series contains modules relating to the introduction, training, and operational aspects of the TAVIE Red and TAVIE Pro Programs.

Click HERE to access the TAVIE On-the-Ground Training.

Also included is **the TAVIE RED Intervention Guide**. This guide made in conjunction with NASTAD, 360 Medlink, and cleared with HRSA to provide the user a much more in-depth look at the practical uses of TAVIE Red and TAVIE Pro in order to greater understand the evidence-based practices that have gone into further developing and polishing this tool for Case Managers and Clients to use.

Click HERE to access the TAVIE Red Intervention Guide.

Creating a Client Centered Approach to Case Management

The client-centered model was originally developed by Carl Rogers and contains these key elements of a helping relationship: empathy, respect, and genuineness. The fundamental principle of the approach is that all people have an inherent tendency to strive toward growth, self-actualization, and self-direction. A client-centered approach places the needs, values, and priorities of the client as the central core around which all interaction and activity revolve. Understanding how the clients perceive their needs, their resources, and their priorities for utilizing services to meet their needs is essential if the case management relationship is truly going to be client centered. [6]

Each client has the right to personal choice, although these choices may conflict with reason, practicality, or the case manager's professional judgment. The issue of valuing a client's right to personal choice is a relatively simple matter when the case manager and client's priorities are compatible. It is when there is a difference between the priorities of the case manager and the client that the case manager must make a diligent effort to distinguish between her or his own values and judgments and those of the client. One of the most difficult challenges for a case manager is to see their client making a choice that will probably result in negative outcomes, and which opposes the case manager's best counsel.

In these situations, case managers must be willing to let the client experience the consequences of their choices, and hope that the relationship with the case manager will be a place to which the client can return for support without being judged. The important exception is when the client is planning to harm themselves or others.

It is the case manager's responsibility to:

- Offer accurate information to the client
- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions

- Present options to the clients from which they may select a course of action or inaction
- Offer direction when it is asked for, or when withholding it would place the client or someone else at risk for harm
- Follow through with the care plan as actively as possible by engaging with such things as the TAVIE Red console (dashboard), texting, emailing and calling clients.

6. The Psychology of Carl Rogers | Center for Studies of the Person (centerfortheperson.org)

PROVIDER PARTICIPATION GUIDELINES

Qualifications of Provider Entities and Case Managers

Provider Entity Qualifications

For Medicaid, case/care management services may be provided by social services agencies, facilities, persons and groups possessing the capability to provide such services that are in compliance with the Medicaid provider qualifications. **Providers must be approved to become HIV Targeted (non-medical) Case management entities under both RI Ryan White and Medicaid programs (see below for more details).** ***Claims will be rejected if entities are not approved to be HIV CTM providers for whether Medicaid or Ryan White. Note that Ryan White TCM agencies are selected via an RFP process.*** Prospective providers of Medicaid Targeted HIV Case Management services may include, but are not limited to:

- Facilities licensed or certified under Rhode Island Law or regulations
- Health care or social work professionals licensed or certified in accordance with Rhode Island state Law;
- State and local government agencies

Selected Entities

Providers under Medicaid expansion shall have direct provider agreements with the Managed Care Organizations participating in expansion. Providers selected to perform HIV case management for targeted case management services must have specific, documented experience working with people living with HIV and/or people who are qualified as high risk, negative individuals. Ryan White HIV targeted case/care management providers will be selected based on an RFP process and once an agency is selected they will sign an agreement with the RI EOHHS, HIV Provision of Care & Special Populations Unit..

The following qualification requirements apply to potential providers of HIV

targeted case/care management for both Ryan White and Medicaid:

PROVIDER (AGENCY) QUALIFICATIONS: Applications will be accepted from certified home health agencies, community health centers, community service programs, and other community-based organizations with:

- At least two years' experience in the case management of persons living with HIV and AIDS; or
- At least three years' experience providing community based social services to persons living with HIV and AIDS; or
- At least three years' experience providing case management or community based social services to women, children and families; people living with behavioral health conditions (substance users, mental health); homeless persons; adolescents; parolees and other high-risk populations *and includes one year HIV related experience.*

CASE/CARE MANAGEMENT STAFF QUALIFICATIONS: ***Individual case managers must meet the education and experience qualifications listed below:***

STAFF QUALIFICATIONS: *To qualify immediately as an eligible Medicaid (Ryan White as well) Targeted Case/Care Manager, upon entry, case managers must have:*

- *A bachelor's degree, and a one-year case management experience a college degree in a health or human service field;* ***or***
- *At least two years of case management experience and an additional year of experience in other activities with the target population and an associate's degree;* ***or***
- *At least one year of case management experience, a high school diploma, and a case* management certification from an accredited institution, and, additionally, at least two years of H I V experience or/ other activities with the target population; ***or***
- A bachelor's or master's degree which includes a practicum encompassing a substantial number of case management activities, including the performance of assessments and development of case management plans.

OR

- A minimum of an Associate's Degree from an accredited college or university; and · A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness preferred; and/or
- State or National certification from a recognized state/national certification organization and/or licensing organization preferred (i.e. LBSW, LMSW, LCSW,

LPC, LMFT, LCDC, etc.,); or

- Case managers employed prior to March 1, 2009 and who did not meet the minimum qualifications listed above may be granted a waiver from these qualifications by the Administrative Agency (pending three letters of recommendation from an employer or a supervisor attesting to their length of employment and qualifications to perform HIV case management services) ; and
- Knowledge and training in assessment of needs, formulation of care plans, monitoring of care plans and evaluation of case pro files; and
- Extensive knowledge of community resources and services.
- Each agency staff person who provides direct services to clients shall be properly trained in case management. Supervisors will be a degreed or licensed individual (by the State of RI) in the fields of health, social services, mental health, or a related area, preferably Master's Level.
- Ongoing training is required for all case management staff.
- At least one year of case management experience and a college degree in a health or human service field.

Within 18 months of entry (not to exceed 18 months) as a case/care manager:

All case/care managers (Medicaid and Ryan White, must have a case management certification from a reputable, accredited, college/university. While the waiting process is in place, case/care managers that do not have a certificate must be closely supervised under an experienced case manager (an experienced case manager with a certificate and the credentialed skills listed above).

- **CASE/CARE MANAGER TRAINING AND ADVANCEMENT**

Training: Qualified providers must ensure that all case managers within this discipline are trained accordingly, and they must provide ancillary training and updates at least sixteen hours per year (in addition to any case management, continued certification requirements). Although sixteen hours of training is required, it is up to the agency if they would prefer to provide more to their case managers. (Current Agency Range: 16 to 40 hours per year)

Pathway to Advancement: In the interest of creating a sustainable, equitable and well-trained workforce, providers must submit a plan/schedule of advancement for case managers that includes apprenticeship, entry and senior level case management opportunities with pay and responsibilities reflective of these advancements. ***The program is called Pathway to Advancement and will be present in every HIV Targeted Case Management Ryan White provider agency agreement and a part of the HIV TCM for Medicaid providers doing case management for people living with HIV.*** This will apply to both Medicaid and Ryan White HIV targeted case/care management providers and their staff.

This plan/schedule should be based upon the credentials of a case manager when entering the TCM system (see above) as well as advancement determined by the agency. For example, a case manager with the least experience and academic credentials may be classified as an apprentice for a limited time, so determined by the provider, with all the benefits, privileges and pay scales associated with this level. Pathway to Advancement will be an integral part of provider agreements and clearly detailed goals and objectives are required for this initiative.

PROVIDER ENROLLMENT

Providers who wish to enroll with RI Medicaid, should view the instructions in the RI Medicaid Provider Reference Manual – General Guidelines. Ryan White contractors are selected via an RFP process that is locked in for three to five years depending upon the cycle.

SCOPE OF SERVICES FOR HIV TARGETED HIV CASE/CARE MANAGEMENT FOR MEDICAID AND RYAN WHITE PROVIDERS

In general, HIV Targeted Case/Care Management services consist of the activities listed below. They include an **Intake Process, Assessment/Reassessment (Severity Indexing is found here), Care Plan and Documenting HIV Quality Performance Measures (metrics).** The Medicaid fee for service program has a rate methodology resulting in quarter hour units of service, such that all HIV targeted case management activities use a procedural code to bill for services that are allowable. Case/Care Managers must present allowable items for billing only. ***Expansion providers shall be instructed as to their rate structure and shall work closely with the assigned MCO plans. Prior to performing services for case management contact your Managed Care Organization representatives to receive billing instructions.***

HIV Targeted Case/Care Management Services Outlined

To be eligible for RI Medicaid/Ryan White HIV Targeted Case/Care Management services, enrollees must be Medicaid or Ryan White eligible (eligibility for both Medicaid and Ryan White are different, and it is the provider responsibility to screen applicants/clients appropriately) and a member of one of the following groups:

1. **HIV infected persons;**

2. **HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established, or;**

3. **Individuals deemed to be at 'high risk" for HIV until tested and HIV status is confirmed.** Once HIV conversion takes place the person will qualify for

care management.

High risk individuals are those individuals who are members of the following populations:

- Men who have sex with men (MSM),
- Active substance users and/or those individuals with documented mental illness,
- Persons who have Hepatitis B or C,
- Persons with a documented history of sexually transmitted diseases,

People recently released from prison and/or the training school (TCM services may be delivered within one year post release),

- Sex workers,
- Transgender individuals,
- Bisexual men and woman,
- Sexually active adolescents engaging in unprotected sex, or
- Persons who engage in unprotected sex with HIV+ or high risk individuals.

Individuals at High Risk for HIV must be evaluated upon entry via a specific HIV negative, high risk severity assessment. The assessment shall yield a Severity/Acuity Index for each client.

Specific Targeted Care Management Protocol for People Living with HIV & AIDS, and for Targeted Case Management Protocol for People at High Risk for HIV

Intake Screening

Parameters for enrollee eligibility at the Intake Screening are outlined in the Rhode Island Standards for HIV Case/Care Management. Intake Screening must be offered within 3 days of referral **to the program.** Intake procedures are established by the provider agency and must involve specific financial screening tools to confirm Medicaid eligibility, as well as a brief Intake Service Plan must be completed at the time of Intake to address immediate needs (triage of needs), ***general*** severity index and generally outline action steps. This brief Intake Service Plan shall be transferred to the Care Plan. *An enrollee may be enrolled, and an intake completed during institutionalization in a hospital or long-term care facility as long as discharge is imminent [within 180 days (per ADA, Olmstead v. L.C.)]. The case manager should actively incorporate Intake into the encounter with the enrollee.*

This activity may be different from the agency's specific, more comprehensive process of Intake. Intake shall result in acceptance or denial of the client as an eligible participant in the benefit. When possible, basic trauma informed care shall be employed from the onset of client intake. Concepts relatable to trauma, like safety, violence, environment, substance use, sexual abuse, mental illness are difficult to gauge at intake and agencies are encouraged to

use their discretion as to when to assess trauma by using standardized, credentialed assessments.

Establishing Rapport & Trust with Clients during the Intake Screening Process:
https://www.mastersincounseling.org/counseling/client-rapport/

Six major areas of a client's life for consideration when conducting an intake include the following:

1. Clinical/Medical – This includes discussion of the client's health status, diagnosis, possible treatments, the client's right to refuse care or insist upon a different approach and access to primary care.

2. Psychosocial – This includes discussion of the client's level of coping or functioning and past coping strategies that were tried. A review of available resources for client support, an assessment of the client's strengths/weaknesses, support groups and barriers to care should also be addressed.

3. Social – This includes discussion of the client's family structure, significant others, and cultural background. The case manager should meet with the client's family members and significant others only when deemed appropriate for continuum of care and treatment and at the agreement of the client wishes. The client's history of family, friends, spouses, domestic partners, and others are essential to the client's well-being. This network can provide a range and depth of services which can only be enhanced.

4. Economic – This includes the current financial resources and insurance coverage, and financial assistance that has not been explored (i.e., food, housing, transportation, etc.). Budget counseling and debt management should be provided as an option. All resources including but not limited to employment and disability coverage vigorously be explored continuously documented in chart records. The client and family should be educated about insurance and terminology.

5. Cultural – This includes assessing culturally specific needs of the client and ensuring that case management services are provided in the preferred language of the client. Please note that it is not encouraged to rely on children or family to interpret for the client.

6. Linguistic - Language assistance must be provided by the agency when an interpreter is required to communicate effectively with staff to translate key information including, but not limited to, the consent for services, consent for release of medical/psychosocial information, grievance policy and any other similar documents that a provider might typically use during service provision to clients.[8]

7. 2021 Georgia Ryan White Part B Case Management Standard Operating Procedures - Georgia Department of Public Health. Georgia Ryan White Part B Case Management Standard Operating Procedures. Accessed July 7, 2022.

ASSESSMENT AND REASSESSMENT (SEVERITY or ACUITY INDEX)

Assessment and Referral must take place within 30 days of Intake.

During this process, information about the enrollee and the resources available to the enrollee are gathered to develop a care plan specific to the enrollee's needs. The case/care management process must be initiated by a written assessment of the enrollee's need for case/care management in the areas of medical, social, human services, behavioral health services, psychosocial, educational, financial, and/or other services. This process should include information from the enrollee and, with the enrollee's permission, from any collateral sources whose information is necessary to make a comprehensive assessment.

Assessment provides verification of the enrollee's current functioning and continuing need for services. The following are intrinsic to the Assessment/Reassessment process:

- **Severity/Acuity Indexing**

Is a measurement instrument used to assess a client's level of functioning, severity of illness, poly morbidities, social determinants and other risk factors? It involves questions or probes that evaluate elements like behavioral health (substance use and/or mental illness), homelessness, ability to work, severity of HIV, risk associated with transmitting the HIV virus, risk of getting the virus, etc. *All providers who assume the responsibilities associated with HIV TCM services must use a standardized Severity Index issued by the Executive Office of Health & Human Services.* Creating a solid and usable Severity Index assists both the client and the case/care manager in determining action steps and achievable goals. Severity Indexing is a vital part of Assessment and shall be monitored throughout the Reassessment phase.

- **Essential Assessment/Reassessment**

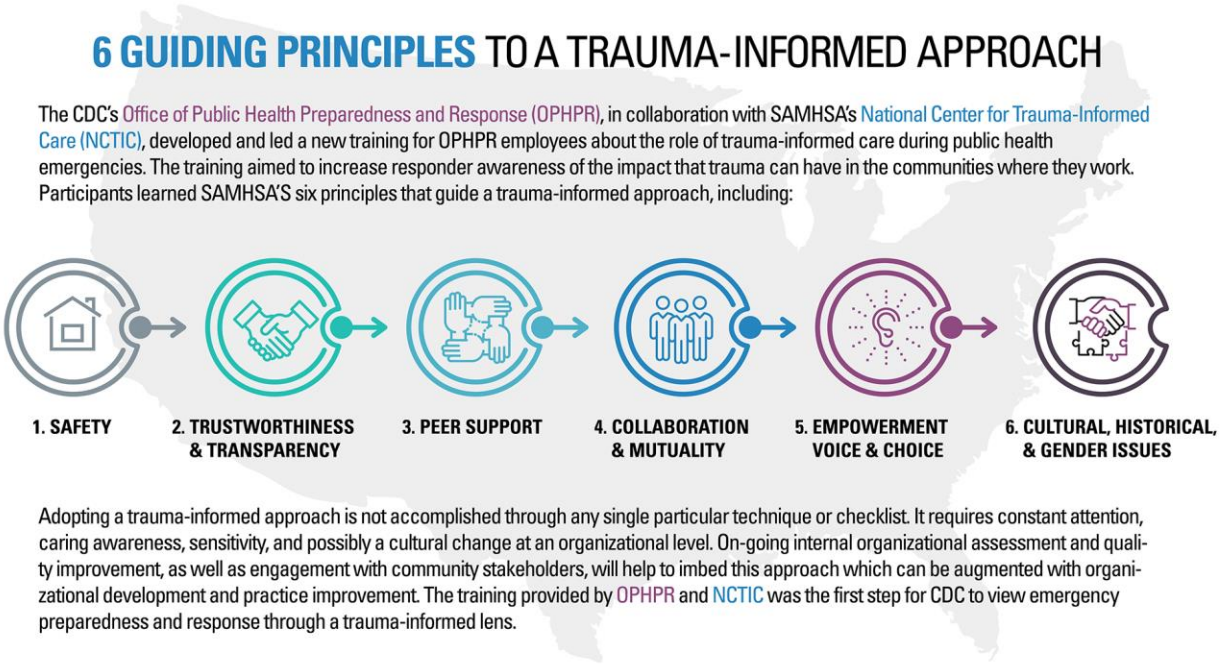
Defines the service priorities and provides an evaluation of the enrollee's ability to benefit from such services. A dedicated effort must be documented relating to the client's baseline Severity Index score and specific plans that will address and enable improvement over time. **Goals must be clearly set in the client file that document when and how transitioning can occur from a high state of severity to lower states of severity.**

- **Transitioning Documentation**
  Also intrinsic to this process of assessment/reassessment is the transitioning from case/care management, when the client no longer requires the service. Upon the enrollee's acceptance of case/care management services, an initial assessment must be completed by a case/care manager within 30 days of referral or within 30 days of the enrollee's acceptance of services. Transitioning may include referrals and other tools to maintain and sustain positive behavior change and health outcomes.
- **Reassessment**
  Assessment is a continuous process, which is the result of each encounter with the enrollee and the dialogue between the enrollee and case manager. However, a reassessment of the enrollee's need for case/care management and other services must be completed by the case manager every six months, or earlier if

required by changes in the enrollee's condition or circumstances.

- **An evaluation of any functional impairment**
  On the part of the enrollee and, if necessary; a referral for a medical assessment should be made as well as a determination of the enrollee's functional eligibility for services.

- **An evaluation of trauma, and implementation of trauma informed approaches**
  A standardized, credentialed, trauma informed assessment should be in place and used for every client. When applicable and necessary, the case manager must implement trauma informed approaches into the care plan. Implementing a Trauma-Informed Approach - United States Department of State." 28 Jun. 2018, https://2017-2021.state.gov/implementing-a-trauma-informed-approach/index.html.
  "Trauma-Informed Approach and Trauma-Specific Interventions." 12 Nov. 2015, https://www.mentalhealth.org/get-help/trauma.
  "Infographic: 6 Guiding Principles To A Trauma-Informed Approach." 17 Sept. 2020, https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm.



9. VanDillen L. The 3 "E's", 4 "R's" and 6 principles of trauma informed care - part 2 in a Series. CompAlliance. https://www.compalliance.com/the-3-es-4-rs-and-6-principles-of-trauma-informed-care-part-2-in-a-series/. Published June 18, 2020. Accessed July 26, 2022.

- **Utilization of the 8 Dimensions of Wellness assessment and tools**
  The 8 Dimensions of Wellness assessment provides case managers and client opportunities to establish wellness goals that round out the care plan and offer critical understanding of life balance and how to process well being. [10]

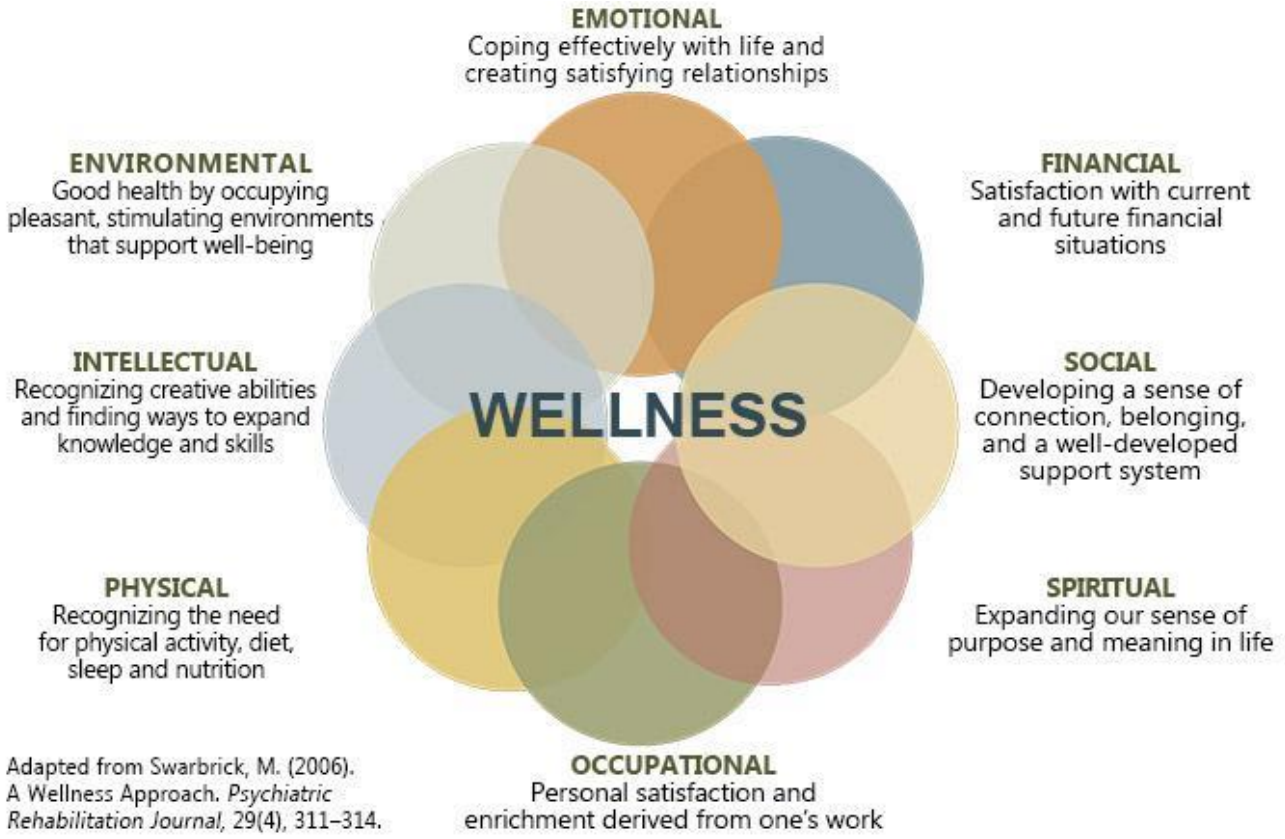
10. Promoting Wellness for Better Behavioral and physical health. MFP. https://mfpcc.samhsa.gov/ENewsArticles/Article12b_2017.aspx. Accessed July 26, 2022.

CSPNJ_Wellness_Planning_Tool_Interact

8D Slides_Aug 4 2022.pdf

CAS-019_Daily_Self-Care_Plan_Interactiv

The following represent the 8 Dimensions of Wellness. This can be used to create a wellness plan for clients:



- Review and process information
  From other agencies/individuals required to identify the barriers to care and existing gaps in service to the enrollee; and,
- **A comprehensive assessment**
  Of the individual's service needs including medical, social, psychosocial, educational, financial and other services. An assessment must be completed on all minor children living in the household and/or those minor children of the index enrollee who are dependent on the enrollee.

Specific Targeted Care Management Protocol for People Living with HIV & AIDS, and Targeted Case Management Protocol for People at High Risk for HIV

CARE PLAN AND DOCUMENTING HIV QUALITY PERFORMANCE MEASURES AND OTHER CRITICAL INFORMATION

After all of the preceding elements occur a detailed process of enrollee/client engagement begins. Often this is described as the case/care management planning and coordination stage, and the **Care Plan** is officially engaged. The case/care manager, with the enrollee, identifies the course of action to be followed, the informal and formal resources that can be used to provide services, and the frequency, duration and amount of service(s) that will satisfy the enrollee's needs. **Crisis management (see Crisis Management description below) may be employed at any time during the process of managing a client's care. For example, if a client is homeless, it is understood that many factors of success for their health outcomes rely on finding a safe home. Severity and acuity may shift because of an emergent circumstance like homelessness.**

An initial, written care plan must be completed by the case manager for each enrollee at the time of the Assessment. A complete care plan must be written within 30 days after the date of assessment.

The **Care Plan** includes, but is not limited to, the following activities:

- **Identification of the nature, amount, frequency, duration and cost of the case management services** to a particular enrollee.

- **Severity or acuity Index monitoring: (Severity indexing can be documented in the initial assessment as a baseline measure associated with client needs. Severity indexing must always be clearly documented in the care plan. Severity will change over time and must be monitored according to the circumstances.)**

- **Selection of the services** to be provided to the enrollee, with specific evidence that a referral was made (whenever possible action steps associated with referrals is requested, and if upon subsequent visits;

- **Identification of the enrollee's informal support network and providers** of services.

- **Specification of the long term and short-term objectives** to be achieved through the case management process;

- **A primary program goal**, such as self-sufficiency, must be chosen for each enrollee of targeted case/care management. Additionally, the enrollee's personal goal for the coming year should be specified. Intermediate objectives leading toward these goals and tasks required for the enrollee to achieve a stated goal should be identified in the plan with the time period within which the objectives and tasks are to be attained.

- **Performance Measures: If the person is living with HIV/AIDS specific documentation of**

performance measures across the HIV Continuum of Care must be initially documented (Baseline) and followed throughout the reassessment phase (every six months). Some elements we shall expect to be documented and reported upon are 1) Documentation that reveals the enrollee is in care and receiving medical treatment for HIV, 2) Evidence that the enrollee has been offered Antiretroviral Medications (ARVs), 3) Document ARVs and other medications, 4) Document viral suppression using laboratory test confirmation, 5) Document that enrollee visits the medical care provider at least twice per year, 5) Document if the enrollee drops out of care, is taking ARVs, and is not virally suppressed. **(See specific metrics/performance measures framework below).**

For People at High Risk for HIV a series of performance measures relating to referrals (e.g., behavioral health services, medical visits, housing, etc.), HIV Testing, STI testing, Vaccinations, other testing, outcomes associated with diversion from emergency room visits, hospitalization, housing, incarceration, sexually transmitted infectious disease documentation, etc. must be initially documented (Baseline) and followed throughout the reassessment phase (every six months). Enhancing positive behavior change and selection of healthy choices is an important outcome for high-risk negative clients. **(See specific metrics/performance measures framework below).**

Specific Targeted Care Management Protocol for People Living with HIV & AIDS, and Targeted Case Management Protocol for People at High Risk for HIV Evaluation

METRICS REPORTING FRAMEWORK

Why Metrics and Performance Measures?

For both people living with HIV as well as people at risk for HIV, we seek to measure specific events and outcomes. ***We seek to establish two phases of measurements (metrics) each year.*** The first phase of metric collection can be achieved at Intake or upon Assessment (baseline shall be established for all clients and so noted upon data collection) and the second phase is six months thereafter for post measures. The purpose of developing and collecting metrics related to documenting performance measures for people living with HIV is to monitor the progress of the client in care management. For this population we seek performance measures across the HIV Continuum of Care as well as other indicators of success/failure. Our Ryan White providers will access a data management system called CAREWare for specific quality performance measures. Medicaid providers must collect this information in a manner that allows for timely reporting to EOHHS.

Expected and Required Metrics

1. Beneficiary/Patient Participation Measures

· Newly identified HIV+ enrolled in case management (less than 1 year diagnosis; specific date of diagnosis)

· HIV + beneficiaries that feel out of case management care based upon agency out of case/care management data

· HIV+ adults who were lost to HIV medical care greater than 1 year specify when loss to care and re-engagement occurred

· HIV- , high risk enrolled in case management

· HIV-, high risk who were lost to HIV high risk case management based upon the agency out of case management data

2. Beneficiary/Patient Process Measures

- HIV + and HIV - : Unduplicated HIV tests/results for negative and positive tests (date of test and number of tests per year)
- Newly diagnosed HIV+ adults who are identified through HIV screening
- Newly identified HIV+ adults linked to HIV medical care
- HIV + : Months from first HIV+ test to linkage to care for newly diagnosed HIV+
- HIV + : Three- and six-month retention rates of HIV+ adults at baseline and after linkage, twice per year
- HIV + and HIV - : Newly identified/recurring STIs, HBV and HCV screen, HBV other Immunizations
- Acuity/Severity Index of HIV- and HIV+ enrollees

Please note once a patient is deemed HIV +, laboratory measures on file with clinical documentation is necessary.

3. Quality of Care Measures

- HIV+ adults who completed two or more medical visits
- HIV+ adults prescribed ART
  - HIV - : **Document baseline during Intake and Assessment**; 6 month and 1 year post in Care Plan. Note significant components: behavioral health services, medical visits, housing, emergency room visits, hospitalization, incarceration, sexually transmitted infectious disease documentation, etc. For HIV- , case management is dependent upon the need and severity of the client's situation. To repeat, all events pertaining to metrics must be documented in the Care Plan every 6 months.

4. Beneficiary/Patient Outcome Measures

- HIV + : Baseline and six month trends in ART outcomes, as measured by longitudinal changes in viral suppression (viral load labs provide this measure)

- HIV + and HIV - : Adherence to Quality Management performance measures ○ Track linkage to care (HIV-: primary care, etc. for HIV+: Linkage to an HIV provider, PCP, etc.)
  - ○ Track retention in care (For HIV +: Two visits per year, two viral loads per year)
  - ○ For HIV+: On ART, viral suppression
  - ○ For HIV+: Out of Care event documented (date, reason, etc.) and re-engagement documented
- Documentation for non-medical (Social/human services events) management for HIV+ and HIV- enrollees

➢ **For HIV Negative, High Risk Enrollees:** This population of enrollees must be referred to providers that offer consistent HIV, HBV, HCV and STI testing, and/or other services deemed critical to potentially prevent disease, and/or enhance the beneficiaries' health outcomes. Monitoring risk behaviors and assuring the enrollee in this category receives follow up services directly related to the care plan, identified factors that put them at risk for HIV, and other issues related to high risk categorization, must be specifically addressed.

➢ **For People Living with HIV and HIV, High Risk Negatives:** Collaboration with social services, health care providers and other formal and informal service providers, including discharge planners and others as appropriate. ***This may occur through case conferences or other means and is intended to encourage exchange of clinical information and to assure:***

➢ Integration of all clinical care plans throughout the case management process;

Continuity of service;

➢ Avoidance of duplication of service (including case management services); and

➢ Establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the enrollee.

➢ For enrollees temporarily hospitalized in acute care general hospitals, case management should concentrate on the needs of the enrollee once discharged from the hospital. It should not duplicate the efforts of the hospital social service worker or discharge planner, but should concentrate on implementing and monitoring the plan for the enrollee. The case manager should meet with the hospital social service worker and/or discharge planner to review their recommendations, medical orders and follow-up care and to advise them of plans for ongoing case management of the enrollee.

The Care Management Plan must be reviewed and updated by the case manager as required by changes in the enrollee's condition or circumstances, but not less frequently than every six months after the initial plan. Each time the care management plan is reviewed, the objectives established in the initial case management plan must be maintained or revised, and/or new objectives and new time frames established with the participation of the enrollee.

Those activities which the enrollee or the case/care manager is expected to undertake within a given period toward the accomplishment of each case management objective follow:

- The name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- The type of program or service providers to which the individual will be referred;
- Those activities to be performed by a service provider or other professionals to achieve the client/ patient related objectives; and
- The type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.
- Note: The above elements are to be documented in the client/patient's file.

Summary of Care Plan

The details of the care management plan are relatable to the management of **people at risk for HIV (HIV-)** and elements of the care plan will be used interchangeably for people living with HIV and those at high risk for HIV. In this document the case/care management plan is called a **Care Plan**, and should be completed by the case manager for each enrollee **(HIV+, HIV-).** It is highly recommended that an initial (this may be partial if the case/care manager is unable to verify information or facts, and/or if an emergent issue takes precedence over a series of action items. For example, if a client is homeless and many factors of success rely on finding a safe home; then the care plan can be initial in nature) written care plan must be completed by the case manager for each enrollee at the time of the Assessment. A complete care plan must be written within 30 days of the date of assessment. It must be signed by the enrollee to indicate that the enrollee has agreed to the plan. It should include information on needs of those collaterals/family members/children who have a direct bearing on the enrollee's ability to adhere to care and treatment. A copy of the plan must be offered to the enrollee.

For any enrollee in an institutional setting (nursing home, drug rehabilitation, or supportive housing) a joint treatment plan must be developed specifying why the enrollee is being "jointly case managed", what case/care management needs are being addressed

and by whom, and the goal to move toward case closure and/or transitional plans. (E.g. The client is transitioning from a nursing home to the community).

Implementation of the Care Management Plan

Implementation ***means marshaling available resources to translate the plan into action.*** **This includes:**

- Becoming knowledgeable about community resources, including the various entitlement programs and the extent to which these programs are capable of meeting enrollee needs;
- Working with various community and human services programs to determine which tasks/functions of the care plan will be carried out by the case manager and which by other community and human services agencies. This activity may involve negotiating functions. The case manager is responsible for service/program coordination;
- Securing the services determined in the care management plan to be appropriate for a particular enrollee, through referral to those agencies or persons who are capable of providing the identified services;
- Assisting the enrollee with referral and/or application forms required for the acquisition of services;
- Advocating with all providers of service when necessary to obtain/maintain fulfillment of the enrollee's service needs; and
- Developing alternative services to assure continuity in the event of service disruption.

Case Management Conferences are required at reassessment and also as needed to implement the service plan. Service plans should be amended/updated as the status of the enrollee/family changes and as new needs become apparent.

Those client/patient's with ongoing mental health and/or substance use issues may need more intensive case management to redirect the care plan and to address specific barriers and complex issues that impact the client/ patient's ability to adhere to care and treatment.

Crisis Intervention

- It is recommended that all case managers be trained in crisis intervention.

A case/care manager may be required to coordinate case management and other services

in the event of a crisis. Crisis intervention includes:

- Assessment of the nature of the enrollee's presenting circumstances;
- Determination of the enrollee's emergency service needs;
- Securing the services to meet the emergency needs;
- Revision of the care management plan, including any changes in activities or objectives required to achieve the established goal.

Emergency services are defined as those services required to alleviate or eliminate a crisis.

Monitoring and Follow-Up of Case Management Services

Monitoring the acquisition/provision of service and following up with enrollees guarantees continuity of service. Monitoring and follow-up includes:

- Verifying that quality services, as identified in the case management plan, are being received by the enrollee and are being delivered by providers in a cost conscious manner;
- Assuring that the enrollee is adhering to the case management plan and ascertaining the reason for the decision not to follow the agreed upon plan;
- Ascertaining the enrollee's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by another practitioner;
- Collecting data and documenting in the case record the progress of the enrollee (this includes documenting contacts made to or on behalf of the enrollee);
- Making necessary revisions to the case management plan;
- Making alternate arrangements when services have been denied or are unavailable to the enrollee; and
- Assisting the enrollee and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

Enrollee contact and monitoring are expected to be frequent and proactive to ensure the enrollee achieves goals defined in the Care Plan.

Counseling and Exit Planning

The counseling referred to in case management is that which is provided to a TCM enrollee enabling him/her to cooperate with the case manager in carrying out the objectives and tasks required to achieve the goal of TCM services. It is **not** the provision of an actual service such as employment counseling.

Counseling as a function of case management includes:

- Assuring that the enrollee obtains, on an ongoing basis, the maximum benefit from the services received;
- Developing support groups for the enrollee, the family and informal providers of services;
- Mediating among the enrollee, the family network and/or other informal providers of services to resolve problems with service provision;
- Facilitating access to other appropriate care if eligibility for the targeted services ceases; and
- Assisting enrollees to anticipate the difficulties which may be encountered subsequent to admission to or discharge from facilities or other programs including case management.

Section II - Requirements for Participation in Medicaid

Participants in the case management services offered by RI Medicaid must be Medicaid beneficiaries for either fee for service or Medicaid expansion. Some characteristics of the system associated with billing are important to consider:

(1) Because Medicaid is claiming based, RI Medicaid will link one provider of case management services to one enrollee, (2) Providers must assure that the enrollee is an appropriate member of the target population, and (3) Providers must assure the enrollee has freely chosen to participate in a particular case management program. Agencies should always verify the client is enrolled in Medicaid before billing case management services to Ryan White. ***Failure to do so may result in the recuperation of agency funds inappropriately billed to Ryan White and a sanctionable offense.***

The effective date of registration/authorization may be retroactive to the date on which the enrollee accepts case management services (if this date does not precede the date of the provider's enrollment in the Medicaid Program). In general, initial registration for case management can occur while an enrollee is residing in the community or when discharge from an acute care general hospital is imminent. For institutionalized enrollees (i.e. settings other than acute care general hospitals), the initial registration date must be after the institution discharge. When a Medicaid eligible individual is referred to the case management provider, whether by an agency or by self-referral, the individual has free choice to accept services from that case management provider, to seek services from any other approved case management provider or to reject case management services.

If the individual decides to change providers, the registration/ authorization will be changed to the new provider, effective the first day of the following month. The first provider will no longer be able to bill for services, which might be rendered to that individual after the effective date of the change. In this situation the care management plan shall be transitioned to the new provider with the knowledge of, and consent of the beneficiary.

Case Management services must not duplicate case management services that are provided under any program, including the Medicaid Program. There are times when clients enrolled in Medicaid may receive Ryan White benefits. The rule of thumb for Medicaid enrollees is Ryan White services may be offered only when Medicaid does not provide the services.

Some current examples of services Medicaid does not offer, but Ryan white does, are emergency relief and housing. Therefore it is possible for Medicaid clients to receive housing and emergency relief from Medicaid. Also, some Medicaid recipients living with HIV may not have oral health benefits. If a Medicaid beneficiary has oral health benefits, Ryan White may not be able to offer oral health services. Before enrolling Medicaid clients into Ryan White Oral health services, the case manager must verify whether the client has Medicaid oral health benefits.

Agencies should always verify the client is enrolled in Medicaid before billing oral health services to Ryan White. ***Failure to do so may result in the recuperation of agency funds inappropriately billed to Ryan White and a sanctionable offense.***

Since case management/coordination services may be a component of a Federal Home and Community Based Services (HCBS) waiver program, *individuals who are participating in an HCBS waiver program that includes case management/service coordination are* ***not eligible*** *to*

participate in the HIV case management program. If an individual is participating in such an HCBS waiver they may choose to be disenrolled from the waiver and enrolled instead in the HIV case management program.

In short, the case management agency and the case managers must verify all payers associated with the clients they service. Attending to benefits and what funding sources are allowed is essential to understanding the billable funding source. Always consider Ryan White the payer of last resort and that translates to if there is another payer for a services that payer is to be the primary source fo funding that service.

Record Keeping Requirements

A separate, tabbed case record must be maintained for each enrollee (Medicaid beneficiary) served and for whom reimbursement is claimed.

Intake/Eligibility Record Keeping

- the enrollee characteristics which constitute program eligibility;
- a notation of program information given to the enrollee at intake; the date and manner of the enrollee's voluntary acceptance of HIV case management services;

Assessment Record Keeping

- the initial enrollee assessment and any reassessments done since that time;

An initial designation of client acuity/severity

- Documentation of the initial care management plan and subsequent updates, containing goals, objectives, timeframes, etc. as agreed to by the enrollee and the case manager; progress notes are to be included in the Assessment
- a statement on the part of the enrollee of the acceptance of case management services
- copies of any releases of information signed by the enrollee
- past/present written referrals made
- correspondence, and a record of enrollee, and
- collateral contacts

Care Plan Record Keeping

Care Plans are an essential part of the overall management associated with client care. The RI HIV TCM care plan template can be used to organize the plan. It allows the listing of the identified needs, responsible party, linkages to be made etc. A completed sample can be found in the Care Management Plan Appendix to this Manual. This Appendix offers a

template and an outline of the components necessary to develop, maintain and review a HIV TCM Care Plan. Please follow those guidelines in the template, and note:

The TCM care plan is a client-centered health and social services plan that details the client's needs and goals and documents an action plan to achieve these goals. The identified needs in the plan are based on the findings from the assessment and the Acuity Scale. The TCM service plan provides the basis from which the case manager and the client work to address the client's needs.

TCM service plans are intended to facilitate optimal health outcomes, therefore metrics and performance measures are an integral portion of the care plan, so that tracking progress/failure is well documented and reported to the state. **Process Record Keeping**

In developing the plan the case manager should use a "SMART" approach so as to monitor and document the process.

Specific: Identified deficiencies during assessment should be addressed one by one. Every issue identified needs a specific objective and activities for direct intervention. Issues should not be grouped. Specific means that the objective is concrete, detailed, focused, well defined, and straightforward, emphasizes action and clearly communicates what the medical case manager and the client wants to happen.

Measurable: The TCM care plan should have measurable outcomes. If the objective is measurable, it means that the measurement source is identified and medical case manager will be able to track the results of his/her actions and/or interventions and track the progress towards achieving the objective. Measurement is the standard used for comparison. Measurement allows one to know when the objective has been achieved. An important "measure" involved in the care plan is the severity/acuity index.

Achievable/Attainable: The objectives need to be achievable. If the objective is too far in the future, when a client thinks the goal is too ambitious, he/she will find it difficult to keep motivated and strive towards its attainment. When the goal seems too unreachable, clients become frustrated and lose motivation. Little increments could be made as reassessments are done. For example, when a client has been abusing alcohol for many years it will be unattainable to stop using alcohol completely in a week. Here we suggest using Motivational Interviewing and/or Stages of Change to isolate concerns/problem areas/behavior change aspirations, and work towards achievable/attainable, realistic objectives.

[References related to creating achievable/attainable objectives -The following references are meant to guide case managers in developing skills and a toolbox approach to creating achievable/attainable objectives for their client's care plan:

Case Management and best and effective practices are important to consider and integrate when possible as ways for clients to **achieve and attain results**. Two techniques and practices

used by Ryan White and Medicaid Targeted Case Managers are **Motivational Interviewing and Stages of Change**. These are both useful in discussing options with clients and in helping them prioritize behavior change.

Motivational Interviewing (MI) References:

http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf,
http://www.ncbi.nlm.nih.gov/books/NBK64964/,
http://www.motivationalinterview.net/clinical/whatismi.html

Stages Of Change References:
http://peer.hdwg.org/sites/default/files/3b%20StagesOfChangeVersion2-PeerRole Peer_Training.pdf,
http://www.stepupprogram.org/docs/handouts/STEPUP_Stages_of_Change.pdf]

Result-oriented/Realistic: The client is involved in the planning and development of the TCM care plan and should understand his/her abilities and limitations. The case manager should take into consideration whether the objective is realistic given available resources, skills, and time to support the tasks required to achieve the objective. Using MI and/or Stages of Change may help here as well.

Time-limited: For effective implementation of intervention a clear timeframe for evaluation is required. Shorter time frames and deadlines will ensure that objectives are followed up actively. Failure of the case manager to set a deadline might reduce the motivation and urgency required to execute the tasks. Deadlines create the necessary urgency and prompt action.

More Care Plan Record Keeping

- The case manager should contact the client within five working days after the development of the TCM care plan to begin implementation of the plan.
- The case manager should develop a TCM care plan with the active participation of the client. It should describe the recommended interventions for at least three barriers to care identified during assessment.
- The TCM care plan should include at least one goal and objective of treatment adherence to help clients achieve or maintain suppressed viral load if the client is on antiretroviral treatment. Following all of the contemporary HIV Continuum of Care performance measures is advised.

Examples of Elements within a Care Plan

- Plans for communication with the client's primary medical team and an identified mechanism of feedback to ensure adherence;
- Documentation of laboratory results and documented (lab reports) viral load and other relevant lab reports recommended by the physician;

• Strategies to optimize adherence and assist with disclosure of HIV status for social support;
• Plans for minimize competing needs, such as obtaining housing, access to social services and transport; A housing plan, if needed, should be incorporated into the TCM service plan;
• Case management programs are expected to assist clients in need of housing to develop housing plan and make appropriate referrals to housing opportunities available in the community;
• Client education on relevant topics, e.g., management of medication side effects, general health literacy;
• Linkages to prevention with positives programs, needle exchange programs and plans for co-management for mental health and substance abuse clients.

The TCM service plan template can be used to organize the plan. It allows the listing of the identified needs, responsible party, linkages to be made etc. A completed sample can be found in the Appendix.

The **case record entries associated with the Assessment and Care Plan, which record the enrollee and collateral contacts** must contain at a minimum:

- the date of service
- name of the enrollee or other contact
- place of service
- the nature and extent of the service provided
- name of the provider agency and person providing the service
- All associated metrics, quality management performance measures, and key data outputs related to the HIV Continuum of Care, and
- a statement of how the service supports the enrollee or advances a particular task objective or goal described in the care management plan
- document the current (post the initial assessment) client severity/acuity index

Other Required Records

The provider of case management services shall maintain other records to support the basis for approval or payment for the case management program, including but not limited to:

- referral agreements
- provider agreements
- work plans
- records of costs incurred in providing service
- employment and personnel records which show staff qualifications, and
- time worked, statistical records of services provided, and any other records required as a result of any agreements

All records must be maintained for at least six years after the service is rendered or six years after the enrollee's 18th birthday, whichever is later.

Section III - Basis of Payment for Services Provided

Payment for case management services will be made through the Medicaid Program's fiscal agent. Payment will be enrollee specific and available only for Medicaid eligible members of the target population. **Payment will be negotiated via provider agreements rates for Medicaid expansion.**

> **Note: Please note that the MCO expansion rate structure is set with each provider by the participating plans.**

Section IV – Billable (Allowable) and Non-Billable (Non-Allowable) Services

Certain activities, which are necessary to the provision of case management services, cannot be billed as a service.

Billable (Allowable) Activities

- Documentation of care plans and assessments are billable as their own services; Phone calls are allowable given that they occur while providing a case management (service in support of the execution of a care plan or assessment) and they follow the unit structure described above;
- Case recording, monitoring and re-assessing acuity/severity, completion of progress notes, monitoring of quality performance measures, and other administrative reports;
- Training workshops and conferences not to exceed four total hours per year;

For enrollees who are temporarily hospitalized/ institutionalized for a period anticipated to be **over 30 days**, it is expected that there would be no Medicaid billing for the period of the hospitalization/ institutionalization. *When the admission is initially expected to last **30 days or less**, the case manager/enrollee relationship may be continued, and Medicaid billing is allowed only for HIV TCM services provided in the first 30 days of hospitalization. The basis for the initial expectation should be documented in the HIV TCM record for audit purposes.*

Non-Billable (Non-Allowable) Activities

The following activities are considered a necessary part of a case management program and may be included in the development of the rate methodology (unit cost structure), **but may not be billed for separately:**

- Supervisory conferences, meetings unless specifically for the purpose of advancing the case or making changes to the enrollee's case management plan;
- Intake and screening activities for Medicaid enrollees who while meeting program participation criteria do not accept services;
- Administrative work, including interagency liaison and community resource development related to serving enrollee;
- Pre-discharge TCM engagement activities for enrollees in institutional settings other than acute care general hospitals;

Certain other activities, while they may be closely related to case management, or necessary to the achievement of the enrollee's case management goals and objectives, are not included in the definition of case management services and, therefore, may not be either billed or funded through the rate methodology. These activities are:

- Outreach to non-eligible populations when the enrollee does not accept case management services;
- Enrollee transportation;
- Employment counseling;
- Drug and alcohol counseling;
- Discharge planning;
- Social work treatment;
- Preparation and mailing of general mailings, flyers, and newsletters;

child care;

- Medical Assistance eligibility determinations, redeterminations, intake processing and prioritization;
- Nursing supervision;
- Fiduciary activities related to the TCM enrollee's personal funds;
- Any other activity which constitutes or is part of another Medicaid or non-Medicaid service.

Note on Transportation: *It may be necessary for a case manager to escort an enrollee to a service provider to help them negotiate and obtain services specified in the enrollee's care*

management plan. At the same time, the case manager should be encouraging the enrollee's maximum independent functioning in the community. If this exception is justified, then, documentation is essential and consultation with the RI EOHHS overseeing the program is always recommended.

- The ongoing need to escort the enrollee should be well documented in the enrollee's case record.

Furthermore, if the case manager is escorting the enrollee to medical appointments or services, the case management should document why the enrollee was unable to obtain needed medical transportation services from Medicaid or from Ryan White. In these instances, enrollee medical transportation may be a billable case management activity.

Section V - Definitions

For the purposes of the Medicaid program and as used in this manual, the following terms are defined to mean:

Active

Active means that the enrollee who is enrolled in intensive case management is seen in face to-face contacts at least four times a month.

Targeted Care/ Case Management

Targeted Care/Case management is used interchangeably to describe a process, which assists persons to access necessary health and human services in accordance with goals contained in a written case management plan.

- **The "target" group for this area consists of people living with HIV** and in a specific section of this manual you will also see an area devoted to h**igh-risk negative individuals that are "HIV negative."** is important to note this manual focuses upon HIV Targeted Case Management which is not a medical case management service. Rhode Island Medicaid continues to support medical case managers and they are found within clinical settings for a variety of categorical conditions. Are receiving case management services from Medicaid/Ryan White providers. Are eligible for Title XIX Medicaid Coverage either as categorically eligible or medically needy only.

Engagement

Engagement means that the case manager is working with the enrollee to determine viability to become an active enrollee. **TAVIE Red is an ideal way by which HIV case managers can effectively engage clients in their care and wellness.**

Enrolled

If an enrollee is enrolled in case management, then the enrollee has been selected from a roster to be serviced by the case manager.

Other resources that are important for case managers to reference are:

Optimizing HIV Care for People Aging with HIV: Incorporating New Elements of Care, Reference Guide for Aging with HIV (hrsa.gov)

Optimizing HIV Care for People Aging with HIV: Putting Together the Best Health Care Team, , Reference Guide for Aging with HIV (hrsa.gov)

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