POLICY AND PROCEDURE NOTICE: PPPN-015
TRANSITIONING CLIENTS FROM MEDICAL CASE MANAGEMENT

Summary and Purpose of PPN: To guide the administration of the Ryan White Part A Program in ensuring a process for graduating clients who no longer need medical case management.

Authority:

- Fulton County Ryan White Part A Program Manual
- Atlanta EMA Quality Management Standards and Measures for Medical Case Management

Policy and Procedure:

Subrecipients who receive case management funds through Ryan White Part A must implement a policy and procedure for closing cases or graduating clients who no longer need medical case management. These clients would continue to be "active clients" of the agency, but would not be enrolled in medical case management services. In e2Fulton, Clients in this category must be identified as "discharge" in the medical case management status field on the client intake screen.

1. Clients discharged from medical case management would remain as active clients of the agency and maintained in the e2Fulton database.

2. Subrecipients and subcontractors funded for medical case management must establish criteria for determining when clients transition from medical case management.
   A. The policy must include specific criteria used to determine when clients fit into the categories of: (1) no longer needing any services or assistance from the agency (thus discharging them completely from services) to meet individualized care plan goals, or (2) no longer needing medical case management, but still requiring non-medical case management or (3) no longer needing case management, but still requiring minimal assistance from the agency (e.g., only needs assistance for ADAP/HICP re-enrollment)..
   B. The criteria in instances above must include financial, psychosocial, and medical stability and adherence to HIV care standards.
   C. The methods utilized to determine the criteria above, includes a thorough needs assessment (at a minimum: assessment of housing situation, financial stability, adherence to medical and dental treatment plans, medication adherence, access to transportation, social support systems, mental health status and need for substance abuse treatment or counseling), and identification of standard tools used for screenings.

3. Procedures and timeframes must be clearly defined in the policy, and must include:
   A. Procedure for identifying clients no longer needing case management (e.g., evaluation of care plans; no need for assistance demonstrated over a 6 month period, etc.).
   B. Procedure for conducting the needs assessment and screenings (from Section 2 above).
   C. Procedures for oversight and approval of graduating clients by a supervisor.
   D. Procedure for notifying client of graduation from case management with clear instructions of how to notify the agency of any changes, as well as education about local resources.
   E. Procedure for quality assurance of these files to ensure policies/procedures were followed.
   F. Procedure for connecting clients who only need assistance with ADAP/HICP re-enrollment to ADAP Coordinators/staff. These clients are stable and not in need of any Case Management services.
   G. Timeframes for any of the procedures detailed in the policy, including notifying client of change in status, updating files, approval by supervisor, etc.

4. Procedures must be established for managing agency-level clients, and must include:
   A. Procedure for notifying the client of his/her change in status with the agency – including that the client must notify the agency of any change in their circumstances, as well as any changes in contact information and/or insurance status.
   B. Documentation procedures, including how you will identify/document agency-level clients, both in the chart and in e2Fulton, and documenting services provided to the client.
   C. Procedures must be established to reassessing client's needs (this should include a standard re-assessment to determine if anything has changed and if the client needs to re-enter case management) upon request for any assistance. The reassessment must examine all needs and areas of the client's life relating to the client's ability to remain in care (including categories of assessment from 2.C. above – housing, financial, psychosocial, etc.). The reassessment cannot merely be a case note indicating that there are no changes.
   D. Procedures for maintenance of agency-level clients' files, including where they will be kept, who is responsible for adding eligibility information and any updated case notes to the file, as well as filing re-assessments, and who ultimately bears responsibility for these clients (e.g., supervisor, or a specific CM).
   E. Description of the support service thresholds, a client receives before CM is mandatory. For example, if a client receives only assistance for co-pays but does not need anything else, vs. a client who receives assistance for multiple services such as transportation, food, medical care, and medications.

Verification:

- Review of policies.
- Evidence that case managers are aware of the policies.
- Chart review.

Approved August 2016

Reviewed: April 2021