Module One

Medical Case Management

Overview

Roles and Responsibilities

Medical Case Manager

Medical Case Management (MCM) services are provided under the direction of, or by referral from, a clinical provider and include client-centered services that implement the clinical treatment plan, including linking clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are key components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to complex HIV/AIDS treatments. Clients may be seen in a clinic, community-based organization, home or skilled nursing facility.

There are three specific types of Medical Case Managers (MCMs) in the Contra Costa System of Care:

- Community Based Organization (CBO) Medical Case Managers
- Medical Social Workers providing Short Term Assistance and ADAP Certification
- Nurse Case Managers (Public Health Nurses)

The pages that follow will specify the tasks, roles and responsibilities for all Medical Case Managers and highlight some additional activities unique to each type.

Roles and Responsibilities for <u>All</u> Medical Case Managers

- Work in conjunction with medical care providers (e.g. case conferencing, attending rounds); ensuring all clients are case conferenced at medical rounds at least twice per year.
- Implement the medical treatment plan by providing counseling on medication, appointment and other treatment adherence issues.
- Conduct initial pre-screening of clients to determine eligibility for services and appropriateness of case management services.
- Verify enrollment in medical care, and support enrollment of the uninsured in Basic Health Care (BHC) if eligible.
- Perform client intake and needs assessment including completion of all required paperwork. (See module 3 for specifics)
- Collect core data elements required for ARIES (AIDS Regional Information & Evaluation System) database intake.
- Complete client assessment and reassessment including the acuity scale as a standard measure for the system of care.
- Develop a comprehensive care plan jointly with the client that includes short and long term goals focused on attaining, maintaining and achieving positive health outcomes.
- At least twice annually evaluate and update the client care plan based upon changes to health status and other factors detailed in the reassessment or acuity scale.
- Conduct risk reduction counseling and partner counseling and provide referral services (PCRS) with all clients to prevent HIV transmission.
- Refer and link clients to appropriate services within the system of care that promote positive health outcomes, treatment adherence, and greater self-sufficiency. Monitor the client's follow-through with these services.
- Refer to nurse case management any client who is pregnancy or whose health status has declined. Follow-up on the referral to ensure the client was successfully linked with nurse case management.
- Provide access to Emergency Financial Assistance (EFA), (e.g. food vouchers, utility payment assistance, and transportation vouchers) as needed to promote and maintain positive health outcomes.
- Adhere to professional boundaries by not transporting clients, not having dual relationships (e.g. serve as payee or accept power of attorney), and not serving a client that is a staff member at the agency where you work.
- Evaluate effectiveness of services based upon client outcomes in the scope of work.

Additional Roles & Responsibilities for Specific Types of Medical Case Managers

Medical Social Workers:

- Staff or attend Infectious Disease (ID) clinics.
- Offer central intake for the Contra Costa HIV Services System.
- Provide comprehensive safety net services including short term case management (1 week to 3 months) for individuals who are unable to access community-based services.
- Enroll clients in the AIDS Drug Assistance Program (ADAP) and recertify them annually.
- Enroll clients in Early Intervention Services.
- Serve as a back up for general intake and referral to case management for the entire county HIV services system.
- Refer to community based medical case management those clients who are stabilized but have chronic medical needs and are at a higher functioning level.
- Coordinate entry into nurse case management, including assistance with discharge coordination and transfer from community based medical case management.
- Troubleshoot navigation of the medical care system.
- May screen emergency assistance requests.

Community Based Organization (CBO's) Medical Case Managers

- Receive referrals from Central Intake Coordinator or Medical Doctor.
- Serve Level 1 & 2 clients and possibly Level 3 if client is assessed by nurse case manager and deemed appropriate for the level of care.
- Provide MCM services to those who have chronic medical needs and/or are at a higher functioning level.

Nurse Case Managers

- Clinically assess clients for home care and home delivery of meals.
- Screen and assess Level 3 & 4 clients for Nurse Case Management.
- Provide patient consultations.
- Provide specialized health education.
- Clinically assess physical, mental and safety needs of clients at home.
- Clinically assess client's medication adherence.