Medical Case Management Services (including Treatment Adherence)

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1. Service Definition

Medical case management (MCM) services (including treatment adherence) are a range of client-centered services that link clients with health, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. MCM 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 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. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) continuous client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan at least every six months as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and other forms of communication.

Service components may include: (1) a range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers’ Patient Assistance Programs, and other State or local health care and supportive services); (2) coordination and follow up of medical treatments; and (3) client-specific advocacy and/or review of utilization of services (HRSA 2013).

As used herein, the term “client” encompasses the terms “patient” and “service consumer.”

1.1. Key Services

1.1.1. Include initial assessment of service needs.

1.1.2. Include development of a comprehensive, individualized service plan.

1.1.3. Include coordination of services required to implement the plan.

1.1.4. Include client monitoring to assess the efficacy of the plan.

1.1.5. Include periodic reevaluation and adaptation of the plan as necessary over the life of the client.

1.1.6. May include client-specific advocacy and/or review of utilization of services.
1.2. Eligibility

Agencies shall, upon intake, document in client’s chart proof of HIV status, including but not limited to:

1.2.1. A diagnosis note signed by a physician; a photocopy of HIV-positive Western Blot or IFA result with client’s name; or a copy of a CD4 and viral load test with client’s name.

Agencies shall, upon intake and biannually thereafter, document in client’s chart all of the following with regard to client eligibility:

1.2.2. Proof that client resides in the Baltimore eligible metropolitan area (EMA), including but not limited to: (1) a copy of a signed lease with client’s name and address; (2) a copy of a current or previous month’s utility bill or rent receipt with client’s name and address; (3) a copy of an Supplementary Security Income (SSI) award letter with client’s name and address; (4) a notarized letter from a friend or family member, naming clients and attesting to his or her address; or (5) a support letter on official letterhead from a shelter, recovery house, transitional housing facility, or other similar housing facility.

1.2.3. Proof of annual income that is no more than 300 percent of the federal poverty level, including but not limited to: (1) a copy of a current pay stub with client’s name; (2) a copy of client’s most recent W-2 form; (3) a copy of client’s SSI award letter; (4) a signed, notarized “letter of support” from someone providing clients with financial support; or (5) documentation of active Medicaid benefits, such as client’s managed care organization (MCO) card.

1.2.4. An assessment by the intake staff of client’s third-party payer capacity, including but not limited to: (1) a copy of client’s insurance card; or (2) documentation, with initials/signature, that provider staff have checked client’s status in the Eligibility Verification System (EVS) of the State of Maryland; or (3) verification from private insurance company that includes the date and results, with initials/signature of provider staff securing verification.

For Medicaid-billable services only:

1.2.5. Documentation, with initials/signature, that provider staff has checked client’s status in the Maryland EVS.

Alternatively:

1.2.6. In the case of a referral, a signed eligibility form on the referring agency’s letterhead attesting to client’s HIV status and eligibility under items 1.2.1-1.2.4 (as applicable). Biannual documentation of items 1.2.1-1.2.4 (as applicable) is still required.

2. Service Standards of Care

Case-management services are directed toward ensuring the timely and coordinated access to medically necessary and appropriate levels of care and support services that enhance continuity of care across the continuum of service providers. The following are the minimum standards for the provision of case-management services. Agencies and individuals may exceed these
minimum standards. The level of case-management service is determined by the case manager and the client, beginning at assessment, and should be changed as needs change.

2.1. Baseline Evaluation

The baseline-evaluation period has four principal phases, as follows: identification, intake, psychosocial needs assessment, and care-plan development.

2.1.1. Identification

Identification is defined as the process used to determine if an individual is eligible for services by virtue of pre-established criteria developed by the service provider.

2.1.1.1. The agency shall screen all the individuals who call, walk in, or schedule an appointment for case-management services to determine the appropriateness for agency services, including verification of HIV status.

2.1.1.2. The agency shall make suitable referrals for those individuals who are not appropriate for agency case management, but who are in need of services.

2.1.1.3. The agency shall assess individuals in crisis to determine what agency interventions are appropriate.

2.1.1.4. The agency shall assign a case manager to eligible clients within five business days of the completion of the initial screening.

2.1.2. Intake

Intake is defined as the process to formally enroll an eligible client into the system for further assessment and the development of the client’s plan of care; it is required to collect all information about the client for subsequent planning, intervention, and/or intake.

2.1.2.1. The agency shall complete an initial assessment of each eligible client at the time of intake, collecting all information as outlined on the service provider’s intake forms within two business days. Completion of these forms is required for all levels of case management.

2.1.2.2. Eligible clients presenting with emergency needs should have these needs addressed by the conclusion of the intake appointment. Emergency needs are defined as needs that will have serious immediate consequences for the client unless these needs are met.

2.1.2.3. Clients will be seen for the first case-management appointment within five working days after assignment to a case manager. Individuals requiring an off-site visit must be seen within 10 working days after assignment to a case manager. Exceptions are made if clients initiate cancellations.

2.1.2.4. The agency shall assist clients in identifying and making appointments with medical providers as early as possible during the initial intake or the case-management intake appointment for those clients not already connected to a primary medical care provider. Clients are to schedule their own appointments if they are able.
2.1.3. Bio-Psycho-Social Assessment

After intake, agencies must provide a bio-psycho-social (BPS) assessment in the following manner:

2.1.3.1. The case manager shall complete a comprehensive written BPS assessment for each client within 30 days or by the conclusion of the third case-management appointment, whichever comes first.

2.1.3.2. Areas to be covered in the BPS assessment:

- Presenting problem(s).
- Living situation.
- Nutritional status history.
- Spirituality issues.
- Social community supports.
- Emotional/behavioral status.
- Financial status/entitlements.
- Health insurance/prescription plans.
- Sexuality issues.
- Medical history, including date of first positive result and list of major diagnosed health problems is also required for the bio-psycho-social assessment.
- Legal history.
- Physical, emotional and sexual abuse history.
- Knowledge of HIV.
- HIV disclosure concerns.
- Literacy concerns.
- Smoking history.
- A history of access to health care.

Note that it is recommended that children, ages 13 and under, be tested for HIV if either parent is HIV positive.
2.1.3.3. The case manager shall ensure that each chart contains complete written indications that the current needs have been discussed and/or identified at the time of the BPS assessment. Case managers should review the listed areas of needs when performing the BPS assessment.

2.1.4. Development of the Plan of Care

Once the bio-psycho-social assessment has been completed, the development of the plan of care follows.

2.1.4.1. With the active participation of the client and possibly others (e.g., partners, parents, guardians, and/or medical-care givers), the case manager shall develop an appropriate course of action to access the identified resources required to meet the needs and resolve the problems.

2.1.4.2. The case manager shall, with the active participation of the client, identify which needs are to be addressed through the development of goals and objectives. Time frames for meeting the goals and resolving the problems should be established. These written objectives and goals are to be incorporated into the plan of care, which is a permanent part of the client’s chart. Development of the plan of care shall be started by the third case-management appointment or within 30 working days of the date of the assignment to a case manager. All plans of care should be signed and dated by the client and the case manager.

2.1.4.3. This care plan will be arrived at by mutual agreement during the assessment phase of service. The plan must be completed within two months of the first interview. Written reevaluation of the care plan will occur every six months. The agency will continue with the current client plan for one year if the client’s needs have not changed.

2.1.4.4. The agency shall, together with the client, identify the appropriate resources needed to attain the stated goals and objectives. This resource identification shall be written in the plan of care.

2.1.4.5. The agency shall provide written verification that the client is either in agreement or disagreement with the goals and objectives contained in the plan of care.

2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

2.2.1. Implementation and coordination of the plan of care

Implementation and coordination of the plan of care should be conducted in the following manner.

2.2.1.1. The case manager shall provide support, advocacy, consultation, and crisis intervention to the client and others involved in the implementation of the plan.

2.2.1.2. The case manager shall proactively attempt to contact the client after the development of the plan to implement those parts that were not executed at the
time of the plan development. The plan will establish priorities among the identified needs.

2.2.1.3. The case manager shall advise the client on making arrangements with service providers selected and on ways of gaining access to those services. The case manager will assist clients who cannot successfully access services on their own.

2.2.1.4. The case manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client and other identified people and the outcomes resulting from these actions also shall be incorporated in the record one week after the referral or appointment.

2.2.1.5. The case manager shall be in communication with the client once every three months to provide support, advocacy, consultation, and crisis intervention throughout implementation of the client plan.

2.2.1.6. The case manager shall communicate with the client as necessary.

2.2.2. Monitoring of the Plan of Care

 Monitoring of the plan of care shall continue after the plan has been developed and implemented.

2.2.2.1. Monitoring is performed to routinely review the success in achieving services as outlined in the care plan, to measure progress in meeting goals and objectives, to intervene as appropriate, and to revise the plan as necessary.

2.2.2.2. The case manager shall monitor the goals and objectives contained in the plan, as the needs of the client require, to decide what steps need to be taken, if any. Documentation of the monitoring process shall be recorded in the record.

2.2.2.3. If a client cannot be located, after several attempts to reach him or her by telephone and/or letter for two months, a referral shall be made to case finding (if available) to assist in locating the client. If the case finder cannot locate the client within 90 days, the case-management record shall be closed.

2.2.2.4. The case manager shall monitor the referral services provided and the service delivery to verify that the services are being received and are of sufficient quality and quantity.

2.2.2.5. The case manager shall provide written documentation in the progress notes of difficulties encountered in achieving the goals and objectives and provide strategies in writing for resolving the difficulties.

2.2.2.6. The agency shall make available professional supervision or consultation to all case managers while the care plan is being monitored. A minimum of one hour of formal supervision once a month is required per case manager, with additional case consultations on an as-needed basis.

2.2.3. Reevaluation of the Plan of Care

Reevaluation of the plan of care will occur periodically.
2.2.3.1. The purpose of reevaluating the plan of care is to review the success of the implementation of the care plan and to determine if the client’s needs have significantly changed since the previous needs assessment. If the needs have changed, then a new plan should be developed. If the needs are the same, then the current plan shall be continued for one year.

2.2.3.2. Each agency shall assess the client’s records a minimum of once every six months to determine the client’s status and progress and to ascertain if any revision is needed in the care plan or in the provision of services. This review shall be recorded in the progress notes. The case manager supervisor, peer review, or formal audit personnel may undertake the record review.

2.2.3.3. The case manager shall develop, with the active participation of the client, new goals and objectives if the client’s needs have changed since the previous needs assessment. All new plans should be signed and dated by the client.

2.2.4. Case Closure

The process for case closure shall be as follows:

2.2.4.1. Closure of the case may occur at the request of the client, at the request of the agency (provided that the pre-established procedures are followed), or due to death.

2.2.4.2. Prior to closure (with the exception of death), the agency shall attempt to inform the client of the reentry requirements into the system, and make explicit what case closing means to the client.

2.2.4.3. The agency shall close a client’s file according to the written procedures established by the agency, including, but not limited to: death, relocation, transition to another provider, or at the request of the client.

2.2.4.4. In Maryland, adult records will be kept for a minimum of 10 years after the last entry (that is, records of those over 18 years of age). For children (those aged 18 and under), records must be archived either until the child reaches the age of 24 or for 6 years after death, whichever occurs first.

3. Administrative Standards of Care

This section describes the agency’s minimum administrative requirements.

3.1. Licensing, Knowledge, Skills, and Experience

Providers should be able to document the following in terms of licensing, knowledge, and experience.

3.1.1. Licensing

The agency/organization will show evidence of being licensed by an appropriate body.

3.1.1.1. Licenses must be current and available.
3.1.1.2. Where applicable, staff will have licenses that are current and appropriate for providing case-management services.

3.1.2. **Maintenance of Documentation**

The agency will be required to:

3.1.2.1. Maintain documentation that demonstrates that case-management services are provided directly by, or under the supervision of, or in consultation with, a licensed social worker and/or registered nurse case manager. The minimum set of qualifications for supervision of case managers shall be: registered nurse or licensed certified social worker status, with a minimum of three years’ experience. One year of experience may be substituted by an equivalent in additional academic preparation.

3.1.2.2. Maintain documentation for each staff person of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS.

3.1.2.3. Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.

3.1.2.4. Create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

3.2. **Patient Rights and Confidentiality and Agency Responsibilities**

Providers should be able to document the following in terms of clients’ rights and confidentiality:

3.2.1. **Policies and Procedures**

3.2.1.1. The agency shall have policies and procedures that protect the rights and outline the responsibilities of the clients and the agency.

3.2.2. **Included Provisions of Policies and Procedures**

The agency shall have policies and procedures that include these provisions:

3.2.2.1. The agency shall have written policies regarding eligibility, confidentiality, grievance procedures, rights and responsibilities of clients, referral and linkage, agency expectations of clients, and termination policies.

3.2.2.2. The agency shall have documentation, with client signature, that such policies have been offered/read and explained to the client seeking service.

3.2.2.3. The agency shall have a system for ensuring that case-management records are protected and secured.

3.2.2.4. The agency shall have a written, informed, signed consent for the delivery of case-management services.

3.2.2.5. The agency shall ensure that, when appropriate, agency staff will refer and link clients with other needed services.
3.2.2.6. The agency shall ensure that each client has received an intake screening, an eligibility determination, and an initial assessment for eligible clients.

3.2.2.7. The agency shall have documentation of the provision of information and referrals to clients as necessary when case-management services are not available. If a waiting list exists, the agency must show evidence of a plan to communicate on a regular basis with the client regarding waiting-list status.

3.2.2.8. The agency shall have evidence of referrals to other resources and information, based on client need.

3.2.2.9. The agency shall have documentation of mutual goal setting between the client and the case manager delivering the service.

3.2.2.10. The agency shall have evidence of client progress toward meeting established goals by documentation of activity through the case-management plan of care.

3.2.2.11. The agency shall have evidence of a monitoring process, to reflect that:

3.2.2.11.1 The plan of care should be monitored and revised, as necessary, on a periodic basis, at least every six months, with the client, to determine whether client and agency service goals are being met.

3.2.2.11.2. Services should be reviewed periodically, at least annually, to ensure that information given to the client is current.

3.2.2.12. The agency shall have documentation of a formal review instrument, and evidence that the record has been reviewed by a supervisor, peer reviewer, or formal audit.

3.2.2.13. The agency shall have documentation of written criteria for services, fee structure as defined within the CARE Act, intake process, discharge, transfer, and closing procedures.

3.2.2.14. The agency shall have evidence of orientation for new staff and documentation of on-going continuing education for staff.

3.2.2.15. The agency shall have a written process for supervision of case managers.

3.3. Quality Assurance

Quality assurance is described below.

3.3.1. Quality Assurance or Quality Improvement Plan

There must be a quality-improvement or assurance plan designed to monitor both the appropriateness and effectiveness of all services delivered.

3.3.2. Delivery of Direct Services

The delivery of direct services must be monitored and documented for professional accountability through the following: regular and on-going team meetings, case conferences at least monthly, individual professional evaluations at least annually, and formal supervision (which may be peer supervised).
3.3.3. *Grievance Process*
There must be a formal written grievance or appeal process for clients.

3.3.4. *Distribution of Agency Policies*
Agency policies should be given to all enrolled clients.

3.3.5. *Client identification*
There must be a process for identifying clients who qualify for case-management services.

3.3.6. *Formal Advisory Board*
There must be documentation of the existence and meeting of a formal advisory board held at least quarterly made of agency clients.

3.3.7. *Client Satisfaction*
There must be a process to solicit client satisfaction at least annually.

3.3.8. *Site Visits*
There must be documentation of periodic site visits by the administrative agent, the Baltimore City Heath Department (BCHD), or a designee.

**Treatment Adherence**

4. *Treatment Adherence Key Services*
Three services are covered under this subcategory: first, the support activities that help clients to keep medical appointments; second, the support activities that help clients appropriately follow their medication regimens; and third, the support activities that help clients successfully follow through on their care plans.
4.1 Treatment Adherence History

Treatment adherence was first introduced in the Ryan White Treatment Modernization Act of 2006 as part of medical case management services. Treatment adherence was also a subcategory under early intervention services until FY 2009, when funding for that service category was shifted into psychosocial services.

4.2. Appointments

In terms of appointments, the service contemplates working with those HIV-positive individuals who are known to the Ryan White Part A service continuum but who have identified problems with keeping appointments with primary medical care providers.

4.3. Medication Regimens

In terms of medication regimens, individuals who keep health-care appointments but do not follow the agreed-upon treatment regimen are a target group for this project.

4.4. Care Plans

In terms of care plans, individuals who do not successfully follow through on their care plans are a target group for this project.

5. Treatment Adherence Service Standards of Care

The following are minimum standards for the provision of adherence services. Agencies and individuals may exceed these standards.

5.1. Baseline Evaluation

After an intake process is completed, a baseline evaluation is performed per the medical case management guidance set forth in section 2.1.

5.1.1. Intake

The intake process must include:

- 5.1.1.1. Completion of agency-required intake forms.
- 5.1.1.2. Collection of demographic information.
- 5.1.1.3. Documentation of eligibility to ensure that the client is within Ryan White income guidelines for the uninsured and underinsured. See section 1.2 for detailed information about eligibility requirements.

5.1.2. Eligibility for Treatment Adherence

This portion of the assessment includes identification of individuals who:

- 5.1.2.1. Have missed half of their scheduled medical appointments over the previous 12 months, or
- 5.1.2.2. Have difficulty consistently following the planned medical regimen, or
- 5.1.2.3. Have difficulty following through on care-plan goals, and
5.1.2.4. Demonstrate a level of investment and willingness to participate in treatment adherence services in order to address identified barriers to adherence.

5.1.3. Assessment of Barriers

Identification, assessment, and documentation of barriers to keeping medical appointments should be done in addition to the intake BPS assessment and should include screening for and/or identification of the client’s:

5.1.3.1. Active psychiatric illness, especially depression.
5.1.3.2. Active drug and/or alcohol use.
5.1.3.3. Lack of education about HIV treatment and medications including potential side effects.
5.1.3.4. Unstable living conditions.
5.1.3.5. Social support network.
5.1.3.6. Comfort with disclosure of HIV status.
5.1.3.7. Access to adequate health care.
5.1.3.8. Language and/or literacy skills.
5.1.3.9. Other personal or familial matters such as financial status, childcare, or other immediate life needs that impact adherence.

5.1.4. Referrals for Service

5.1.4.1. Referrals may be made from within the health-care provider facility, from outside the health-care provider facility, or through client self-referral.
5.1.4.2. Possible referring entities include primary medical care facilities, community-based agencies, and substance-abuse or mental-health service agencies.

5.2. Further or Continued Services

Follow-up measures or visits should adhere to the following protocols:

5.2.1. Adherence Intervention Plan

The adherence intervention plan must be developed with the client and should be based on the cooperation of and collaboration between the client and the primary care provider and/or adherence team. Clients must sign the intervention plan as proof of agreement. The plan should include:

5.2.1.1. A description of the client’s barriers.
5.2.1.2. Strategies to help the client overcome the specified barriers.
5.2.1.3. Where appropriate, a description of referrals for other services that address barriers.
5.2.1.4. Follow-up plans, which include specific measurements for assessing improvement with a timeline for monitoring progress.

5.2.2. Evaluation of the Implementation Plan

Evaluation of the implementation plan should be performed periodically — at minimum, quarterly.

5.3. The Service Model

The service model may include either of the following. The same services are to be offered in both models.

5.3.1. Sole Support Model

This model involves a nurse, social worker, and case manager or other professional providing adherence services.

5.3.2. Team Support Model

This model involves a nurse, social worker, and case manager or other professional, such as the primary care physician or a pharmacist partnered with a trained peer counselor, providing adherence services.

6. Treatment Adherence Administrative Standards of Care

This section describes the agency’s minimum administrative requirements. Agencies and individuals may exceed these standards.

6.1. Licensing, Knowledge, Skills, and Experience

Agencies may elect to have a team-support model of service delivery or sole-support model of service delivery. Regardless of the service model, a care facilitator is essential.

Providers shall document the following in terms of licensing, knowledge, and experience.

6.1.1. Sole Support Model

A care facilitator with, at minimum, a bachelor’s degree in social work (B.S.W.) and five years of HIV experience, or a master’s degree in social work (M.S.W.) with two years of HIV experience. Staff also should have experience working with the client’s racial/ethnic populations and be culturally sensitive to the norms and attitudes that could affect adherence.

6.1.2. Team Support Model

A care facilitator with the same qualifications as for the previous option. A peer counselor will work with the care facilitator to provide services to the client. The peer counselor must be HIV positive, have experience working with HIV-positive consumers, and be able to appropriately model adherent behavior. The peer counselor must have completed high school and training through at least one DHMH-sponsored HIV training program.

6.2. Client Rights and Confidentiality

Providers shall document the following in terms of clients’ rights and confidentiality.
6.2.1. Confidentiality Policy
A written agency policy on client confidentiality.

6.2.2. Client Knowledge
Client knowledge of policies and procedures for maintaining confidentiality. This evidence must be present in existing records and files.

6.2.3. Client Records Protection
The security and protection of existing records/files containing client information.

6.2.4. Release of Information
Client consent for release of information to other service providers and, if appropriate, release forms authorizing information to be requested from other providers. This evidence must be present in existing records and files.

6.2.5. Grievance Policy
Copies of the agency grievance policy and procedures having been given to clients.

6.3. Access, Care, and Provider Continuity
Not applicable.

6.4. Agency Responsibilities
The provider agency also shall adhere to certain service standards, as follows:

6.4.1. Adherence Project Reporting Form
At minimum, the adherence project reporting form should include the following elements in addition to the elements of the agency’s standard intake and assessment forms:

- 6.4.1.1. Medical status.
- 6.4.1.2. Barriers and co-morbidities.
- 6.4.1.3. Planned interventions.

6.4.2. Client Progress
The client’s progress through the planned program must be documented in case notes.

6.4.3. Client Services
Client services should include:

- 6.4.3.1. Intake.
- 6.4.3.2. Assessment.
- 6.4.3.3. Service planning.
- 6.4.3.4. Care coordination.
- 6.4.3.5. Follow up.
6.4.3.6. Referral.

6.4.3.7. Other interventions that lead to the goal of becoming fully adherent.

6.4.4. Service Monitoring

Services should be monitored at least quarterly to determine whether the client and/or the agency’s service goals are being met.

6.4.5. Oversight

The agency is responsible for ensuring that staff members providing adherence services are overseen by a licensed or certified professional and/or that staff members consult with practitioners who have extensive HIV experience.

6.4.6. HIV Training Program

The agency will have a training program on HIV and HIV-related topics for all staff members who will be responsible for services to HIV-positive clients.

6.4.7. Required Documentation

The agency will show evidence of:

6.4.7.1. Being a legal entity able to do business in Maryland. Certification must be current and displayed.

6.4.7.2. The existence of an advisory board, with representation from the clients receiving adherence services, that meets at least quarterly.

6.4.7.3. Written criteria for services; fee structure; and procedures for intake, discharge, transfer, and closing. The case file must contain documentation that the client received this information.

6.4.8. Agency Policy

The agency shall have a policy that is shared with each client regarding:

6.4.8.1. The closure of treatment-adherence service cases based on client inactivity for nine months.

6.4.8.2. Client transfer to another primary care provider.

6.4.8.3. Behavior of the client that demonstrates chronic non-adherence or unwillingness to participate in the service despite of efforts by agency staff to engage the client.

6.4.8.4. Client request to end services.

6.4.9. Agency Policy on Transitioning

The agency shall have a policy that is shared with each client regarding transitioning from the intensive treatment adherence service into other ongoing agency services. Transitions shall occur when:

6.4.9.1. The client achieves and maintains an improved adherence rate for the five most recent medical and referral appointments.
6.4.9.2. The client achieves and maintains an improved adherence to the medication regimen as demonstrated by CD4\textsuperscript{1} and viral load.

6.4.9.3. The client, with support from the multi-disciplinary care team, follows through on 80 percent of the tasks set out in the care plan.

6.5. **Quality Assurance**

Providers should have a written quality-assurance activity that identifies areas for improvement and the subsequent actions taken. The agency must show:

6.5.1. **Quality Assurance Plan**

Each funded agency must have a quality-assurance plan that identifies areas for improvement and the subsequent actions taken.

6.5.2. **Quality Assurance Monitoring**

The agency’s quality-assurance mechanism or plan must be designed to monitor both appropriateness and effectiveness of all services provided, and must include documentation of:

6.5.2.1. A process to solicit client satisfaction with services at least annually.

6.5.2.2. The agency’s compliance with the service category standards and/or any applicable professional or federal practice standards.

6.5.2.3. Care plan reviews, both peer and supervisory.

6.5.2.4. Utilization reviews.

6.5.2.5. The most recent site visit by the administrative agency.

6.5.2.6. Action plans that address corrective actions and/or improvement in outcomes based on best practices.

6.5.2.7. Periodic data and narrative reports to the administrative agency.

7. **Summary**

Not applicable.

8. **Recommendations**

Not applicable.

9. **References and Further Reading**

9.1. **References**


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\textsuperscript{1}CD4 count tests determine the number of CD4 cells (T-helper lymphocytes with CD4 cell surface marker) present in the body. A client’s CD4 count is used to determine the progression of HIV infection and determine the course of action for medication therapies (Bartlett and Gallant 2008).