



JONATHAN E. FIELDING, MD, MPH
Director and Health Officer

CYNTHIA A. HARDING, MPH
Acting Chief Deputy Director

Division of HIV and STD Programs
Mario J. Pérez, Director
600 South Commonwealth Avenue, 10th Floor
Los Angeles, California 90005
TEL (213) 351-8000 • FAX (213) 387-0912

www.publichealth.lacounty.gov

June 14, 2013

BOARD OF SUPERVISORS

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Dear Ryan White Program Service Providers:

FREQUENTLY ASKED QUESTIONS (FAQs) NUMBER 4 FOR AMBULATORY OUTPATIENT MEDICAL (AOM) AND MEDICAL CARE COORDINATION (MCC) SERVICES

Please find the above-referenced document with responses to FAQs submitted by providers concerning the implementation of MCC services. This is the fourth edition of FAQs focused on new Medical Care Coordination (MCC) and/or Ambulatory Outpatient Medical (AOM) services released by the Division of HIV and STD Programs (DHSP). DHSP will continue to address questions on a regular basis and post updates on the DHSP website as part of ongoing efforts to support successful program implementation. Please ensure all editions of FAQs are shared with your program staff and direct service providers.

You may submit additional questions regarding the implementation of AOM contracts and services via email to David Pieribone, Medical Services Section Manager, at pieribone@ph.lacounty.gov; and MCC contracts and services via email to Angela Boger, Care Coordination Services Section Manager, at aboger@ph.lacounty.gov.

Very truly yours,

Carlos Vega-Matos, Chief
Care Services

CVM:hn

F:\Divisions\Care Services\Common\Provider Meetings\FAQ to MOP MCC Letter_06152013.docx

Attachment

- c: Mario J. Pérez
- Kyle Baker
- Michael Green
- Mike Janson
- Sonali Kulkarni
- Mary Orticke

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS

**Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) Services
Frequently Asked Questions (FAQ) – Issue Number 4
June 15, 2013**

A. MCC Screening

Question 1: When does DHSP expect agencies to screen all existing clinic patients for MCC?

Answer: Agencies will have until **February 28, 2014** to screen all existing clinic patients for MCC. It is recommended that the MCC screener is done as part of the semi-annual eligibility/registration requirement for clinic patients when they come in for a routine care visit. While it is recommended that MCC providers complete the MCC screener, agencies may identify other appropriate staff member(s) to complete the screener. The staff member who completes the MCC screener is responsible for documenting this process in the patient medical chart.

Question 2: For newly diagnosed patients, should the agency complete the MCC screener before or after the medical visit with the doctor and their labs results come back?

Answer: It is recommended that the MCC screener is completed for newly diagnosed patients prior to their lab results and medical visit with the HIV medical provider to ensure that they are flagged for active MCC services. This is because newly diagnosed patients are considered a priority population for the MCC intervention. A “new diagnosis” is generally defined as a new HIV diagnosis within the last 6 months.

Question 2a: For patients who are “new” to the clinic but were previously in HIV medical care somewhere else in the past, should the agency complete the MCC screener before or after their medical visit or their labs return?

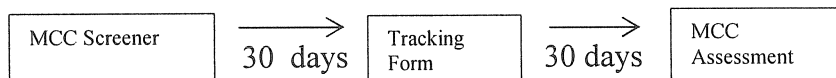
Answer: It is recommended that the MCC screener is completed for these patients after the lab results and first medical visit so the most recent information can be used to determine whether the patient needs active MCC. Some “new” patients may be switching clinics but still on medications, while others may have been in intermittent care and not on antiretroviral medication; therefore, the additional information is important to determine their need for MCC.

Question 3: How should an MCC provider track their time for completing the MCC screening?

Answer: ACMS will add a new service delivery activity called “MCC screening” that will allow MCC providers to track time spent completing the MCC screener for patients. An MCC provider may track time spent completing the MCC screener for each new clinic and self-managed patient once every 6 months for no more than 30 minutes per screening encounter.

Question 4: When are the MCC Screener, MCC Tracking form, and MCC Assessment due in Casewatch?

Answer: MCC screening for all clinic patients should occur every 6 months; if Casewatch is being used to perform the screening, it should be documented every 6 months. Once a patient is screened for MCC and identified as needing active MCC services, the MCC team has 30 days to complete the MCC Tracking form in Casewatch. The MCC Tracking form is used to designate whether a patient, who may be deemed as needing MCC by the screener or provider referral to MCC, is enrolled in active MCC or not. Once the tracking form is completed to indicate the patient is enrolled in active MCC, the MCC team has 30 days to complete and enter the initial MCC Assessment responses into Casewatch. Follow up MCC Assessments are due at intervals that vary depending on the patient's acuity on their last MCC Assessment (30 days for Severe, 90 days for High, 180 days for Moderate).



Question 5: Our team conducted MCC screening a few months prior to actually entering screening data into Casewatch. At the time the MCC screening was conducted, there was no lab data (CD4 and viral load) available. However, lab data was available at the time the MCC screening was being entered in Casewatch. Can we enter the lab data values that were available at the time the MCC screener was entered?

Answer: No. MCC teams should enter the viral load and CD4 data that was available at the time the MCC screener was conducted, not at the time the data was entered into Casewatch. This will give an accurate picture of the patient *at the time* the MCC screening was conducted. It is expected that MCC screener and other data is entered into Casewatch within 30 days of provision.

Example: The provider entered screener information in Casewatch on March 6, 2013 for a screener conducted and dated December 2012. Contractor's clinic received CD4 and viral load lab results for the patient in January 2013. The January 2013 test results will not be pulled into the screener because they are a month after the screener date of December 2012.

B. MCC Eligibility and Enrollment

Question 6: What should the MCC team do if a patient is deemed "self-managed" based on the MCC screener criteria but wants to receive active MCC services?

Answer: The MCC team should inform the patient that as a self-managed patient he/she can receive referrals from the MCC team as appropriate but that active MCC services are

intended for patients with critical and immediate medical and/or psychosocial needs. The patient can discuss their desire for MCC services with their medical provider, who can refer them to MCC based on their assessment of the patient's particular circumstances. Inform patients that their HIV medical provider and the MCC team will continue to monitor their health outcomes and will provide active MCC services to them should the need arise.

Question 7: What should the MCC team do if a patient is lost to follow up?

Answer: If the MCC team is unable to follow up with a patient within 60 days of the MCC Screening date, they should select "unable to contact patient- lost to follow up" on the MCC Tracking form in Casewatch. Selecting this option will suspend active MCC service delivery requirements.

Question 8: What should the MCC team do if a patient becomes incarcerated?

Answer: If the MCC team discovers the patient has been incarcerated and is unable to receive active MCC services as a result, they should select "unable to contact patient-incarcerated" on the MCC Tracking form in Casewatch. Selecting this option will suspend active MCC service delivery requirements. To discuss the care of patients who are known to be incarcerated in the LA Sheriff's Department's jail, please contact the HIV nurse liaison, Martha Tadesse at (213) 893-6704.

Question 9: What if a patient needs active MCC and wants the services, but he or she cannot agree to the level of commitment the service requires?

Answer: MCC is a voluntary service and patients are not obligated to participate. For a patient who wants the service, he/she should be committed to the process, in order to fully benefit from active MCC services. The MCC team should discuss with the patient the intensity of service delivery based on the patient's acuity level and work with the patient to determine how best to provide the needed service. MCC uses a patient-centered approach, so it is necessary to work with the patient where he/she is at. If, once a patient has reviewed this with the MCC team, does not feel he/she can commit to the program, he/she should be documented as "Self-managed – opts out of Active MCC" on the MCC Tracking form in Casewatch .

Question 10: How should agencies handle a clinic patient who needs active MCC but who does not/no longer falls within the eligibility criteria, e.g., >400% FPL?

Answer: If a patient does not meet the minimum eligibility requirements, including the FPL restriction, the patient is not eligible to receive Ryan White funded MCC services. Agencies should address the patient's needs with available programs and services for which they are eligible.

C. MCC Comprehensive Assessment

Question 11: Do I have to re-enter all of the information for the patient's MCC follow up Assessments each time in Casewatch?

Answer: Currently, all answers on the MCC Assessment can be copied/carried over to any re-assessment that occurs less than 6 months after the initial Assessment. At 6 months, responses to questions or fields that are used to calculate patient acuity will be erased and must be re-entered. Then the Assessment can be copied/carried over to any re-assessment for another 6 months.

Patient summary notes cannot be copied or carried over to the following Assessment. New patient summary notes must be re-entered for each Assessment.

D. MCC Integrated Care Plan

Question 12: If a patient cannot come back for another appointment to finalize the integrated care plan (ICP) after the initial visit (per the protocol), can the team briefly case conference and complete the integrate care plan during the same visit the ICP was initiated?

Answer: Yes, The MCC team does not have to schedule a separate visit with the patient to complete the ICP. This recommendation is made only to minimize the time burden for patients.

E. Interventions

Question 13: Are we required to deliver the recommended interventions for antiretroviral adherence (Adherence Enhancement Program) and risk reduction (Options/Optiones)?

Answer: The "Adherence Enhancement Program" is the required antiretroviral adherence intervention to be delivered by the MCC team. This service should be provided to all patients with high to severe acuity scores in the Antiretroviral Access and Adherence domain (section III of the Assessment). DHSP will offer additional training for this intervention in September and October 2013. Currently, the intervention manual is available for download online on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors/Appendix%20N%20-%20Adherence%20Training%20Manual.docx>

"Options/Optiones" is strongly recommended as the risk reduction intervention to be used by the MCC team. This risk reduction program should be provided to all patients with high to severe acuity scores in the Risk Behaviors domain (section X of the Assessment). Currently, the intervention manual is available for download

online on the DHSP website at:

<http://www.ph.lacounty.gov/aids/Contractors/Appendix%20O%20-%20Options-Opciones%20Manual.pdf>. If agencies would like to implement an alternate risk reduction intervention, the proposed intervention must be evidence-based and must be approved by the DHSP Program Manager prior to implementation.

Question 14: Can interventions be done over the phone?

Answer: When appropriate, interventions may be done over the phone. Interventions that require a physical demonstration or skills practice (e.g., how to put on a condom, filling/organizing a pill box) should be done during a face-to-face, in-person encounter.

Question 15: Do brief interventions and follow-up contacts have to be scheduled/conducted in separate sessions?

Answer: No, brief interventions can be delivered during follow up contacts with a patient, but MCC providers should track the time spent conducting interventions as an intervention when entering service delivery activities into Casewatch.

F. Service Delivery

Question 16: How should agencies implement MCC if MCC providers are missing from the team due to personnel vacancies, sick leave, or vacation?

Answer: The agency is responsible for designating a back-up for MCC providers in the event that an MCC provider is absent. If an MCC provider is absent for an extended period of time, the contract may be considered out of compliance and appropriate action will be taken.

Question 17: What is the relationship between MCC and:
a. Home-based Case Management?
b. Youth Case Management?

Answer: Home-based Case Management
Patients should not be enrolled in both MCC and Home Based Case Management. If a clinic patient is receiving home-based case management (whether from the same agency or a different agency), the provider should select “patient receiving home-based case management” on the “MCC Tracking” screen in Casewatch. Once this is selected, the active MCC service delivery requirements will be suspended and the patient will be considered a self-managed patient.

Youth Case Management

Youth case managers are responsible for the successful linkage of their aged-out patients to adult HIV medical care services. Once properly linked to an HIV medical

home/clinic, the Youth case manager should transition the patient to the clinic's MCC team to ensure retention and adherence to HIV medication and care. No more than three (3) months of overlap between services may occur during the transition from youth case management to MCC.

Question 18: What types of referrals should the MCC team track in Casewatch?

Answer: The MCC team should enter all referrals an MCC provider initiates (i.e., the Medical Care Manager, Patient Care Manager, or Case Worker). This may include referrals to mental health services, substance use treatment, housing, benefits counseling, oral health, etc. The MCC team should not enter and track referrals initiated by the medical provider, such as subspecialty medical referrals, as an MCC referral. However, MCC providers may track time spent following up on those referrals initiated by HIV medical providers for active MCC patients.

G. Other

Question 19: Will DHSP provide agencies a report or is there a way the agencies can run a report in Casewatch to measure their MCC outcomes success?

Answer: A report will be programmed in Casewatch to allow providers to track their outcomes. This report will include a summary of the MCC performance measures by agency. DHSP will inform providers when the report is programmed and ready for use.

Question 20: What should providers do if patients are receiving MCC services at a different agency from their HIV medical home? How should the medical provider address this situation during the screening/enrollment process?

Answer: If a patient is receiving MCC services at a different agency from their HIV medical home, it is recommended that the providers address this situation with the patient and strongly suggest that, for the optimal coordination of their care, they choose one clinic at which to receive MCC and their HIV medical care. The MCC staff should assist the patient in designating one site to receive their HIV medical care and MCC services. The providers should work together to ensure a seamless transition for the patient no matter where the patient ultimately chooses to receive his/her HIV medical care, including active MCC services when warranted. In cases where a patient's medical home does not offer MCC, a patient may receive MCC services elsewhere.

Question 21: What should a provider do if a patient is identified as needing active MCC but is not interested in receiving the service?

Answer: MCC is a voluntary service. If a patient does not wish to participate, they may opt out by choice.