Practice Standards & Administrative Guidelines for HIV Related Non-medical Case Management

WISCONSIN AIDS/HIV PROGRAM
Bureau of Communicable Diseases and Emergency Preparedness
Division of Public Health
Department of Health Services

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FORWARD

This document is the result of the efforts of several groups that, over the course of many years, were committed to developing quality services for persons with HIV infection in Wisconsin. The focus of their efforts was defining HIV psychosocial case management practice standards and administrative guidelines in order to establish a framework for statewide HIV-related case management services.

In 1991, The Wisconsin AIDS/HIV Program established a Case Management Workgroup to develop case management practice standards to be utilized by Wisconsin AIDS service organizations in providing case management services to persons with HIV infection. Recognizing the importance of administrative support and supervision of case management services in local ASOs, the Workgroup developed administrative guidelines that identify specific administrative components of case management.

In 1993, the *Practice Standards and Administrative Guidelines for HIV-Related Case Management* underwent minor revisions and expanded to include standard case management forms. Since that time, case management services have evolved to include a broader array of agencies providing case management services and ever-increasing numbers and diverse groups of persons receiving these services.

In 2001, the Wisconsin AIDS/HIV Program convened a Case Management Standards Revision Workgroup for purposes of reviewing and revising the *Practice Standards and Administrative Guidelines for HIV-Related Case Management*. This Workgroup focused on differentiating levels of case management services based on consumer need and case management resources. As a result, the Workgroup developed an acuity tool to be used as part of a comprehensive assessment. The Workgroup also developed assessment questions for adolescent and youth to target services to meet changing psychosocial needs.

In 2009, the Wisconsin AIDS/HIV Program again convened a review committee to revise the *Practice Standards and Administrative Guidelines for HIV-Related Case Management.* This group focused on revising the acuity scale and the standardized forms as well as updating the definitions of case management and enhancing the specificity of standards to better direct agencies in developing policies and procedures for service provision.

The Wisconsin AIDS/HIV Program gratefully acknowledges the efforts and commitment of the following members of the most recent Standards Revision Workgroup:

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The current standards are available electronically on the Wisconsin AIDS/HIV Program website: http://dhs.wisconsin.gov/aids-hiv/

For more information or to submit comments, contact the AIDS/HIV Program by phone at (608) 267-5287 or by fax at (608) 266-2906.

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INTENT

This document establishes universal core standards for HIV/AIDS non-medical case management services funded by the Wisconsin AIDS/HIV Program. The standards set a minimum service level for programs providing HIV case management regardless of setting, size or target population.

Universal standards of care for HIV non-medical case management were developed to:

- Clearly define non-medical case management
- Clarify service expectations and required documentation across HIV/AIDS programs providing non-medical case management
- Simplify and streamline the case management process
- Encourage more efficient use of resources
- Promote a high quality of case management services

The overall intent of the Wisconsin AIDS/HIV Program is to assist providers of case management services in understanding their responsibilities and the responsibilities of their counterparts in other programs to promote cooperation of case management efforts.

The revised *Practice Standards and Administrative Guidelines for HIV Related Case Management* describes the non-medical (psychosocial) model of HIV/AIDS case management only. Neither nursing case management nor medical case management standards are outlined in this document.

WISCONSIN CONTINUUM OF CARE: PREVENT, TEST, LINK, TREAT

In 2004, the Wisconsin AIDS/HIV Program developed the framework *Prevent-Test-Link-Treat* to organize and plan for HIV services. *Prevent-Test-Link-Treat* is a comprehensive approach to organizing and summarizing HIV-related services that are addressed through statewide community planning by focusing on the integration of effective and efficient HIV-related services. It is important to note that in planning HIV services an array of factors influence the health of individuals and communities. Some of the determinants of health include:

- the biology of HIV
- individual knowledge, attitudes, and behaviors
- access to health care
- education
- literacy
- economic opportunities
- employment
- working conditions
- housing and food
- family and social support

HIV prevention and care services focus on factors and behaviors that directly impact transmission as well as other forces such as discrimination, marginalization, and stigma that limit opportunities, diminish aspirations, and reinforce disparities. The Prevent-Test-Link-Treat framework for HIV community planning focuses on these and other factors which support, promote, and protect the health and well-being of individuals and communities that are at risk (including those unaware of or denying risk) and those living with HIV. Social, political, economic, behavioral and biologic factors contribute to the health and wellbeing of individuals and communities. These factors can also contribute to the development of health disparities.

Wisconsin's Prevent-Test-Link-Treat Framework

<table>
<tr><th colspan="9">PREVENT</th></tr>
<tr><td colspan="2">Individual Level Interventions</td><td colspan="2">Group Level Interventions</td><td colspan="2">Community Level Interventions</td><td colspan="3">Structural Level Interventions</td></tr>
<tr><th colspan="9">TEST</th></tr>
<tr><td colspan="3">Routine Testing</td><td colspan="3">Targeted Testing</td><td colspan="3">Partner Services</td></tr>
<tr><th colspan="9">LINK</th></tr>
<tr><td colspan="2">Outreach</td><td>Partner Services</td><td colspan="2">Case Management</td><td colspan="3">Other Support Services</td><td>Testing</td></tr>
<tr><th colspan="9">TREAT</th></tr>
<tr><td>Primary Medical Care</td><td>Case Management</td><td>Early Intervention Services</td><td>Medical Nutrition</td><td>Meds</td><td>Oral Health</td><td>Mental Health</td><td>Substance Abuse</td><td>Health Insurance Premium & Cost Sharing Assistance</td></tr>
</table>

Source: Wisconsin HIV Comprehensive Plan March 2009

CASE MANAGEMENT SERVICE DEFINITIONS

The following definitions are an expansion of the Health Resources and Services Administration (HRSA) definitions for case management services.

Non-Case Managed/Brief Services Consumers are those who score below 12 points on the Wisconsin Acuity Index and are therefore ineligible for Ryan White/Mike Johnson Life Care Services funded case management services. No proactive contact with consumer by case management staff is required. Services are provided to consumer as requested following verification of eligibility.

Case Management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. 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) consumer monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the consumer. It includes consumer-specific and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. This type of case management is proactive and must involve regular, case manager initiated contact.

Medical Case management services (including treatment adherence) are a range of consumer-centered services that link consumers with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component 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 consumer'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. 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) consumer monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the consumer. It includes consumer-specific and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. This type of case management is proactive and must involve regular, case manager initiated contact. It is the most intensive form of case management.

GOALS AND CORE FUNCTIONS OF CASE MANAGEMENT

GOALS

The ultimate goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the consumer in decision-making and supports a consumer's right to privacy, confidentiality, self-determination, dignity and respect, non-discrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

The major goals of case management include:

- integration of services across an array of service settings, supported by interagency collaboration when appropriate
- early access to, and maintenance of, comprehensive health care and social services
- continuity of care
- enhanced independence
- increased self-advocacy and personal empowerment
- increased knowledge of HIV disease
- prevention of disease transmission and delay of HIV progression
- increased quality of life

CORE FUNCTIONS

The case management process involves seven core functions that assess consumer needs and assist the consumer in gaining access to needed services. These include:

- **Intake/Acuity Index**: Screening and evaluating eligibility, disseminating program information, agency capacity and service limitations.

- **Assessment**: Evaluating and prioritizing consumer needs.

- **Service Plan Development**: Outlining both short and long term goals for engagement in care and facilitating consumer access to services.

- **Care Coordination**: Communication, information sharing, and collaboration, facilitated by the case manager on behalf of the consumer within and between agencies and/or providers in the community.

- **Monitoring and Evaluation**: Collecting and monitoring data to ensure that services provided are effective and consistent with the service plan.

- **Reassessment**: Reevaluating consumer needs and the service plan annually (minimum) or when there are changes in consumer's life circumstance.

- **Discharge/Transfer**: Formal notification that a consumer can no longer obtain case management services from the current service provider.

REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS

Each agency providing case management services must establish written policies and procedures specific to each of the services they provide. In addition general agency operation policies must be established and documented. The Policies and Procedures manual should be reviewed on an annual basis and updated as appropriate. A sample policy that may be used as a template can be found in Appendix I.

DEFINITIONS

Standard: an established norm or requirement. It is usually a formal document that establishes uniform criteria, methods, processes and practices.

Standard of Care: established norms or requirements that direct service providers to adhere to industry standards of practice.

> *Interpretation*: The standard of care for HIV case management in Wisconsin is outlined in the Wisconsin AIDS/HIV Program document "Practice Standards and Administrative Guidelines for HIV Related Case Management" available online at http://dhs.wisconsin.gov/aids-hiv/Resources/CMPracticeStandards021203.pdf.

Policy: a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body.

> *Interpretation:* A policy outlines the general practice for a particular area of service that will direct how an agency will meet the established standard of care. Policies should be established at a minimum for each service area and for general agency activities that contribute to the successful provision of service.

Procedure: a specified series of actions, acts or operations which have to be executed in the same manner in order to always obtain the same result under the same circumstances. Less precisely speaking, this word can indicate a *sequence* of activities, tasks, steps, decisions, calculations and processes, that when undertaken in the sequence laid down produces the described result, product or outcome.

> *Interpretation:* Procedures should exist for each policy that directs staff members on how to specifically complete a task in order to establish a standardized and equitable level of service for all consumers.

MINIMUM REQUIREMENTS FOR ESTABLISHING POLICIES AND PROCEDURES

All policies and procedures should be reviewed and updated on an annual basis. This date as well as the original effective date should be on the written policy along with the supervisory staff position responsible for monitoring compliance with the policy. Each of the policies should include a description of appropriate documentation, eligibility criteria for recipients and limitations or established caps on services (if applicable). The guidelines below are in the following format:

Description: a brief explanation of what the policy should outline
Instructions: guidelines for drafting the policy and procedures and what needs to be included.

Policies should exist for the following areas where applicable to the grantee agency:

Service Eligibility and Enrollment Procedures
Description: requirements for eligibility for case management and all other services (i.e. Income restriction, resident of WI) with the purpose of ensuring equity across consumer base.
Instructions: taking into account the eligibility requirements of the funding source, list documentation and process required to verify consumer eligibility. Outline the process and requirements for enrolling in services, including staff position(s) responsible for approval of service provision.

Crisis Intervention
Description: protocol for addressing consumer crises during business as well as non-working hours as it relates to mental health, AODA, or other emergency issues.
Instructions: include specific crisis intervention services available to consumers during off hours, and process for informing them of these services. Describe processes for assessing consumers to determine the need for individual crisis plans, and for providing relevant information. Describe staff training to be provided by agency.

Documentation
Description: procedures for establishing consumer case records and recording on-going activities (i.e. Assessment, reassessment, service provision, problem logs).
Instructions: describe which documentation will require supervisory review and signature verifying approval (i.e. assessment forms, reassessments, case closures, transportation). Indicate where specific information should be documented both in the paper chart and in the electronic record.

Consumer Confidentiality
Description: policy detailing compliance with Wisconsin State HIV confidentiality law and the federal HIPAA privacy rule (if applicable).
Instructions: include requirements for written consent to release HIV information and the prohibition against further disclosure without specific written consent of the consumer. Policies and procedures should include a general description of other safeguards to insure confidentiality (i.e. securing case records, meeting privacy, waiting areas, return addresses on agency correspondence, caller ID). The AIDS/HIV Program Confidentiality Policy is located in Appendix C.

Consumer Grievance Procedure
Description: the steps a consumer may take to file a grievance and the process program staff must take to respond to a grievance.
Instructions: include staff member(s) responsible, required documentation, review process, appeal process, time frames, policy regarding maintenance of confidentiality, and process for advising consumer and staff of outcome. Agency grievance procedures must be in compliance with the Wisconsin AIDS/HIV Program Grievance Standards (see Appendix B).

Consumer Input
Description: process for soliciting consumer views and feedback on current and planned program services including activities such as a Consumer Advisory Board, focus groups, and consumer satisfaction surveys.
Instructions: include time frame and frequency of activities as well as procedures for consumers to follow in order to provide on-going input.

Data/Reporting
Description: procedure for entering data into electronic records for the purposes of internal tracking and state/federal required reporting.
Instructions: include person(s) responsible, frequency and timeframe for data entry, the process for internal review of data and for reporting data to the state and federal government.

Quality Improvement/Quality Assurance
Description: process agency will use for measuring quality of case management and other services and making improvements.
Instructions: describe quality assurance plan including internal processes for regular, random or peer review of case records, and for administrative review of the case management program. Outline quality improvement program including responsible individual(s), staff and consumer involvement in quality activities, development and measurement of key indicators, review of results, and execution and quality Improvement projects. A comprehensive, written quality management plan must be in place and reviewed on an annual basis. For assistance in developing a plan, please contact the Quality Assurance Coordinator at the Wisconsin AIDS/HIV Program.

Fiscal and Billing
Description: protocol for documenting and tracking expenditures including the maintenance of paper receipts for services, sub-contracts for services, and internal fiscal monitoring practices (i.e. payroll, travel expenses, rent).
Instructions: technical assistance for agency fiscal planning and management is available at the Target Center website http://careacttarget.org/librarysearch2.asp and information on the types of audits that the Wisconsin AIDS/HIV Program staff will conduct please consult the following document http://dhs.wisconsin.gov/grants/PAAG/paag99.pdf. Information on Wisconsin Department of Health Services audit policy can be found at http://dhfsweb/fiscal/contractadmin/resources/manuals/oa-policy.htm.

Staffing
Description: protocol for hiring, training and supervision of case management staff members.

Instructions: see instructions as they relate to specific areas below.
Staff Qualifications
Description: description of qualifications necessary for all agency staff positions, utilizing the Practice Standards and Administrative Guideline for HIV Related Case Management.
Instructions: indicate what criteria should be in place for each member of the case management staff in accordance with the established Practice Standards and Administrative Guidelines.

Staffing Structure
Description: staffing plan for the delivery of case management and peripheral services.
Instructions: indicate model(s) of case management to be delivered (i.e. psychosocial, medical, nursing, etc.), individual or team approach to staffing and line(s) of supervision. Include a job description for each position, and organizational chart of agency and case management program.

Staff Supervision
Description: description of on-going supervision of case management staff and their activities.
Instructions: include staff responsible for supervision, type and frequency of supervisory activities (including evaluations of staff job performance), and requires documentation.

Staff Training
Description: description of how staff will be trained, including orientation, required training topics, and frequency of training.
Instructions: training must include annual confidentiality training, with an attestation signed by each staff person agreeing to abide by confidentiality requirements. New employee orientation must be outlined including timeframe for completion. Staff training records must be maintained by supervisors and are subject to review by the Wisconsin AIDS/HIV Program staff. Case manager training and certification must comply with the training requirements put forth by the Wisconsin AIDS/HIV Program on page 15 of this document.

Disciplinary Action
Description: description of agency response to the mismanagement of professional responsibilities by staff members.
Instructions: indicate the process for identifying incidents that require disciplinary action including how any mismanagement of professional responsibilities by staff members will be handled by supervisory staff.

GUIDANCE FOR POLICY DEVELOPMENT IN SPECIFIC SERVICE AREAS

A. Case Management:

1. Consent for Case Management
Description: policy assuring that case management services are voluntary, and that each consumer consents to receive case management.
Instructions: outline the process for obtaining written consent for case management services at intake. Include consent form to be used. Consent must include description of case management services offered, and right to decline any or all of case management services.

2. Rights and Responsibilities
Description: an outline reviewed with consumer upon initiation of services establishing the mutual expectations of the program and consumer conduct when engaged in case management and other services.
Instructions: agency intake and enrollment policies should include the right and responsibilities form and its purpose as well as appropriate signatures required on the document.

3. Intake
Description: protocol for assigning and conducting intakes including necessary paper work.
Instructions: outline the time frame for completion and which staff members are responsible for making appointments and referring to needed services.

4. Assessment and Acuity Level
Description: protocol for conducting an assessment including required documentation as stated in the Practice Standards and Administrative Guidelines for HIV Related Case Management.
Instructions: outline the timeframe for completion, staff responsibilities and required documentation.

5. Service Plan
Description: protocol for drafting a service plan in compliance with the standards established by the Wisconsin AIDS/HIV Program in the Practice Standards and Administrative Guidelines for HIV Related Case Management.
Instructions: outline the steps for implementation and systematic review/update of plan by case manager and supervisor. Also include consumer role in the process.

6. Reassessment
Description: protocol for conducting a reassessment in compliance with the standards established by the Wisconsin AIDS/HIV Program in the Practice Standards and Administrative Guidelines for HIV Related Case Management.
Instructions: outline the time frame for completion, the required documentation, the review process, and the consumer's role in the process.

7. Case Conferencing
Description: process, documentation, and frequency of required case conferencing with a consumer's providers in order to facilitate care coordination.
Instructions: describe the requirements for completing case conferencing according to service level including frequency and mandatory participants.

8. Consumer Contacts
Description: the minimum expected type and frequency of case management contacts with consumer as outlines in the Wisconsin Practice Standards and Administrative Guidelines for HIV Related Case Management.
Instructions: outline the process for documenting and tracking these contacts as well as internal supervisory oversight and quality assurance.

9. Referrals and Follow up
Description: process for making, monitoring, and following up on consumer referrals to other providers (as well as intra-agency referrals) and services.
Instructions: outline the process for assigning referrals and for pursuing subsequent required follow up including required documentation. List any preferred or regular referral agencies and contact information.

10. Case Closure
Description: protocol for closing case management cases, including criteria for determining closure, closure process, and required documentation.
Instructions: outline the time frame and process for case closures including appropriate documentation. For consumers who are lost to follow up, clarify expectations regarding staff efforts to locate and communicate with consumers who have not appeared for or engaged in case management services in accordance with the Wisconsin Practice Standards and Administrative Guidelines for HIV Related Case Management. Identify supervisory position(s) that will review and approve case closures.

B. Transportation
Description: protocol for approving and distributing transportation assistance
Instructions: outline the process for documenting and tracking assistance as directed by the policy guidance drafted by the AIDS/HIV Program effective April 1, 2009. Include eligibility criteria for consumers and staff responsible for approval and distribution.

C. Dental
Description: protocol for approving and distributing assistance for dental services and/or providing on-site care services.
Instructions: outline the process for verifying and documenting dental expenditures at the rates established by the Wisconsin AIDS/HIV Program in February 2009. Include eligibility criteria for consumers and staff responsible for approval.

D. Mental Health
Description: protocol for approving and distributing assistance for mental health services and/or providing on-site care services.
Instructions: outline the process for securing and distributing mental health services to consumer base either in house or through referral including eligibility criteria for consumers and staff responsible for approval.

E. AODA
Description: protocol for approving and distributing assistance for AODA services (including support groups) and/or providing on-site care services.
Instructions: outline the process for securing and distributing AODA services to consumer base either in house or through referral including eligibility criteria for consumers and staff responsible for approval.

F. Nutritional Services
Description: protocol for approving and distributing assistance for nutritional services including counseling and/or supplements.
Instructions: outline the process for determining eligibility for services and if providing nutritional counseling, process for documenting and tracking appointments and any prescriptions (for supplements, vitamins, etc.) issued by practitioner.

G. Food Pantry
Description: protocol for approving and distributing assistance with securing food items either in house or through agreement with a local pantry.
Instructions: outline the process for determining eligibility for services and if providing services in house, process for documenting and tracking frequency of distribution.

H. Support Groups
Description: protocol for establishing and maintaining agency sponsored support groups
Instructions: outline the process for tracking and documenting attendance and indicating staff responsible for monitoring support group meetings.

I. Legal
Description: protocol for provision of on-site legal services including documentation of utilization of services.
Instructions: outline the process for tracking and documenting the distribution of legal services including staff responsible for follow up.

J. Early Intervention
Description: protocol for provision of early intervention services, which include testing and counseling, referral to case management and care services and community outreach.
Instructions: including the scope of work to be conducted and staff position(s) responsible for provision of early intervention services.

CASE MANAGER QUALIFICATIONS AND TRAINING

QUALIFICATIONS

Case Manager

Either:

1) Bachelor's or Master's degree in health, human or education services and one year of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence.

or

2) Associate's degree in health or human services and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence.

The above requirements may be waived on a case-by-case basis if one of the following criteria is combined with the Professional HIV Case Manager Certification administered by the Wisconsin AIDS/HIV Program:

- Two years experience providing case management services or HIV-related care services

- An Associate's Degree in health or human services and one year of case management experience

- One year case management experience and an additional year of experience in other activities with HIV+ persons (including internship or volunteer work)

- A bachelor's degree or master's degree in health or human services

Case Manager Supervisor

Either:

1) Master's degree in health or human services and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. One year of supervisory experience preferred, however, this can be substituted for an additional year of direct case management experience.

or

2) Bachelor's degree in health or human services and three years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. Two years of supervisory experience preferred however, this can be substituted for two additional years of direct case management experience.

TRAINING REQUIREMENTS

Each agency is responsible for providing new case management staff members and supervisors with job-related training that commences within 15 working days of hire and is completed no later than 90 days following hire. Training should include provision of agency policies and procedures manual and employee handbook as well as job shadowing for core case management activities and performance monitoring during probationary period. Included in the probationary period, new case managers should be monitored for satisfactory completion of case management specific tasks such as assessments, service plan completion and client counseling sessions. These activities should be monitored in person by appropriate supervisory staff at least once before case manager is approved to provide services independently. A record of the training provided must be included in each case manager's personnel file. The record should indicate specific training topics, completion date and the employee's initials next to each training topic.

Beginning January 2009, each case manager hired by a Ryan White/LCS funded case management agency must complete the Professional HIV/AIDS Case Manager Certification Program, sponsored by the Wisconsin AIDS/HIV Program within 12 months of hire date. For current Certification requirements, contact the Life Care Services Coordinator at the Wisconsin AIDS/HIV Program.

Beginning in January 2010 each case manager must complete a minimum of 24 hours of continuing education annually in order to maintain certification. Pre-approved trainings are provided through the University of Wisconsin HIV Training System (http://www.wihiv.wisc.edu/trainingsystem/). Trainings offered outside of the HIV Training System can be applied toward the requirement if they meet the following criteria:

- training related to enhancing job performance of case managers/social workers, specifically in the HIV field (including conferences and workshops)
- training that offers CEUs or equivalent

Case managers must also attend an annual Case Managers Meeting (8 hours) hosted by the Wisconsin AIDS/HIV Program. Individual agencies and/or case management supervisors are responsible for monitoring case manager compliance with on-going training requirements and certification maintenance, including authorizing appropriate training opportunities to satisfy the maintenance requirements. Personnel records related to training and certification are subject to review during routine audits.

PERFORMANCE EVALUATIONS

Following completion of a probationary period (length determined by individual agency) each staff member (including case management supervisors) must have written and documented performance evaluations every 12 months at a minimum. Performance evaluations should be conducted by an immediate supervisor who can attest to the performance of the individual. Any individual who displays deficiencies in an area should be put on a corrective action plan and monitored for progress.

For the purposes of auditing, AIDS/HIV Program staff may request a record of performance evaluations for current employees.

GUIDANCE ON STANDARDIZED FORMS

Samples of the standardized forms for performing core case management activities and completing documentation are included in Appendix J. Forms included are:

- Intake
- Wisconsin Acuity Index (WAI)
- Comprehensive Assessment
- HIV Verification
- Service Plan
- Comprehensive Reassessment
- Brief Reassessment
- Case Closure

Any of the forms can be modified to include additional information that an agency deems necessary however the information included on each of these forms is a required minimum for collection. Utilizing the specific paper form is not necessary for agencies who wish to convert the information into fields in their electronic data bases. However none of the information requested on the paper form should be omitted from the electronic record. Furthermore, beginning April 1, 2010, all Ryan White and LCS funded agencies must maintain electronic records for consumer information as detailed in the "Documentation" section (p.18) of this document. Therefore paper forms should either be scanned or converted into an electronic document, with the exception of the forms listed in that section.

DOCUMENTATION

Consumer charts and electronic files are legal documents and must be maintained for the purposes of internal organization and auditing and external auditing. For legal and auditing purposes, if no record of an event or incident is found, then the event/incident did not occur. Accurate record keeping not only ensures a higher quality of care but also protects the service provider by documenting every action taken on the consumer's behalf. The following guidance has been drafted from established social work standards for chart documentation and etiquette.

a. Electronic record keeping

Beginning April 1, 2010, all Ryan White and Life Care Services funded agencies must maintain electronic files in addition to any paper charts for their consumer base with the exception of paper work that requires original signatures (HIV Verification, Release of Information, Rights and Responsibilities, Service Plans, etc.).

The following information **MUST** be kept in an electronic database for the purposes of reporting and auditing:

- Demographic information
- Assessments/reassessments
- Acuity Index information
- Progress notes
- Problem logs
- Appointments
- Referrals
- Case closures

b. Chart organization

Paper charts should be organized in a logical manner and paper information should be converted to an electronic format, if possible, either through transcription or scanning. The checklist in Appendix J can be used as a guideline for information that should be present in each consumer record. For the purposes of auditing, beginning in April 2010, paper charts will only be examined for the following documentation:

- Forms requiring a signature
- Copies of photo IDs, insurance cards or other pertinent information

c. Progress notes and other subjective information

The content of a progress note is subject to the following guidelines:

2. Keep the note brief and to the point
3. Define specific terms especially abbreviations or maintain an agency-wide standard definition for consistency
4. Notes should be objective or "judgment neutral"
5. Note should be non-diagnostic, noting only the author's observation (e.g. "Consumer was stumbling and slurring his words" rather than "Consumer was drunk")
6. Write in third person (e.g. case manager met with consumer this afternoon)
7. Always make a note of the date when incident occurred or note was made
8. Notes should be made each time an encounter occurs with or related to the consumer, including but not limited to:
   - Each incident of consumer contact (in-person meeting, phone, e-mail, etc.)
   - Each collateral contact
   - Service distribution to the consumer
   - Receipt of any paper work or information from consumer or third party

MEDICAL CASE MANAGEMENT

The Ryan White Treatment Modernization Act of 2006 included the definition for a new form of HIV case management entitled Medical Case Management (MCM). MCM is defined by HRSA as follows:

> ***"Medical Case management services (including treatment adherence)*** are a range of consumer-centered services that link consumers with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component 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 consumer'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. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination services required to implement the plan; (4) consumer monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the consumer. It includes consumer-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication."

The Wisconsin AIDS/HIV Program is currently in the process of designing and implementing, with stakeholder input, a new model that incorporates the concepts of medical case management in accordance with HRSA's definition while also taking into consideration the unique challenges of Wisconsin's geographic diversity. With stakeholder and community input, the current implementation plan begins in early 2010 with full implementation expected by 2011. On going status updates to the implementation plan and the medical case management model will be posted to the AIDS/HIV Program website at http://dhs.wisconsin.gov/aids-hiv/ beginning in early 2010.

HIV CASE MANAGEMENT STANDARDS

The following section includes each of the standards of care established for HIV case management services in Wisconsin. The standards are outlined below:

I. Intake ………………………………………………………………. 19

II. Wisconsin Acuity Index ……………………………………………… 21

III. Initial Comprehensive Assessment …………………………… 22

IV. Service Plan Development ……………………………………. 24

V. Service Plan Implementation ……………………………………. 26

VI. Comprehensive Reassessment…………………………………..... 28

VII. Brief Reassessment …………………………………………….. 30

VIII. Service Plan Update …………………………………………………. 31

IX. Case Coordination and Case Conferencing …………………… 32

X. Crisis Intervention ……………………………………………… 33

XI. Case Closure/Graduation ……………………………………... 34

XII. Non Case Managed Consumers …….…………………….…... 36

I. INTAKE (Required for non-case managed consumers)

The brief intake occurs during the initial meeting with the consumer. The case manager or case management program staff gathers information to address the consumer's immediate needs and to encourage his/her engagement in services. This tool, along with the *Wisconsin Acuity Index* (WAI) may also be used to screen consumers for their eligibility for case management services and to assess the consumer's willingness and readiness to engage in case management services. This may be performed by non-case managers provided they have had the following:

- be an employee of the service provider/agency,
- received proper onsite training and signed the agency confidentiality agreement, and
- registered for and attended the Foundations in HIV Services in Wisconsin training offered through the HIV Training System

Standard	***Criteria***
Key information concerning the consumer, family, caregivers and informal supports is collected and documented to determine consumer eligibility, need for ongoing case management services, and appropriate level of case management services. **Time Requirement:** Due within 10 working days of referral or initial consumer contact.	1. Emergent needs are identified during the Brief Intake/Assessment process. 2. Emergent needs are addressed promptly. 3. Brief Intake documentation includes, at minimum: **a. Basic Information** • Presenting problem • Contact and identifying information (name, address, phone, birth date, etc.) • Primary language spoken • Demographics • Emergency contact • Confidentiality concerns • Household members • Insurance status • Proof of income and residency • Proof of HIV positive status (*Verification must be received within 30 days of intake in order for consumer to continue to receive Ryan White or Life Care Services funded services*) • Other current health care and social service providers, including other case management providers **b. Brief overview of status and needs regarding** • Food/clothing • Finances/benefits (*Proof of Income must be received within 30 days of intake in order for consumer to continue to receive Ryan White or Life Care Services funded services*)

	• Housing • Transportation • Legal services • Substance abuse • Mental health • Domestic violence • Support system • HIV disease, other medical concerns, access to and engagement in health care services • Prevention of HIV/AIDS transmission • Prevention of HIV disease progression 4. Documentation includes appropriate releases, including authorization for the release of HIV Confidential Information and other releases for information as required by applicable law. 5. Immediate referrals should be made under the following circumstances: • Consumer not engaged in medical care • Consumer on medication but will run out in less than 10 days • Consumer is a danger to themselves or others 6. Wisconsin AIDS/HIV Program Guidelines for Developing Agency Policies and Procedures contains instructions on developing policies for all services including the intake and assessment process.

II. WISCONSIN ACUITY INDEX (Required)

The *Wisconsin Acuity Index* (WAI) should be used to screen consumers to determine their needs and eligibility for case management services and to assess consumer readiness to engage in case management services. The WAI should be completed prior to or in conjunction with the Comprehensive Assessment in order to establish eligibility for case management services

<table>
<tr><th>Standard</th><th>Criteria</th></tr>
<tr><td>Eligibility for case management services is established utilizing the WAI and the level of need for services and care coordination is determined.

Time Requirement:
The Wisconsin Acuity Index (WAI) should be completed within 30 calendar days of intake and every 365 days thereafter or as life circumstances change for acuity levels 1 & 2. For acuity level 3, index should be re-evaluated every 180 days.

If no intake occurs, the WAI should be completed within 40 days of consumer referral.</td><td>1. Needs are categorized and weighted according to severity.

2. Core services are given more weight than supportive services.

3. The WAI evaluates consumer level of need based on the following areas:

a. CORE SERVICE AREAS

• HIV disease progression
• Current medical health status
• Adherence and knowledge base of HIV
• Oral Health
• Mental Health
• Substance Abuse
• Medical Benefits and Insurance
• Housing

b. SUPPORTIVE SERVICE AREAS

• Nutrition
• Income and Entitlements
• Transportation
• Legal
• Culture/Language/Access to Care
• Children and Dependents

4. Documentation includes completion of the WAI document including case manager and supervisory signatures and comments.

5. Consumer is assessed for case management eligibility and eligibility is documented on WAI.</td></tr>
</table>

III. INITIAL COMPREHENSIVE ASSESSMENT (Required)

The Comprehensive Assessment is required for consumers who are enrolled in case management services (Acuity Level 1-3). It expands upon the information gathered in the Brief Intake/Assessment to provide the broader base of knowledge needed to address complex, longer-standing social and/or medical needs.

At this time the importance of client engagement in the development, implementation, and evaluation of their service plan is *crucial*.

Due to the extent of the Comprehensive Assessment, supervisory oversight is required. Supervisory sign off signifies review of the content and approval of the quality of the assessment conducted by the case manager.

Standard	***Criteria***
A Comprehensive Assessment describes in detail the consumer's medical, physical and psychosocial condition and needs. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated. The assessment also evaluates the consumer's resources and strengths, including family and other supports, which can be utilized during service planning. **Time Requirement:** Due within 30 calendar days of Brief Intake. If no intake occurs, the comprehensive assessment should be completed within 40 days of consumer referral.	1. Initial Comprehensive Assessment includes at a minimum: **a. Consumer health history, health status, and health-related needs, including but not limited to:** **CORE SERVICES** • HIV disease progression • Tuberculosis • Hepatitis • Sexually transmitted diseases • Other medical conditions • OB/GYN, including current pregnancy status • Medications and adherence • Allergies to medications • Dental care • Alcohol/drug use/smoking history and current status • Mental health • Vision care • Home care • Current health care providers; engagement in and barriers to care • Clinical trials • Complementary therapy **b. Consumer's status and needs related to:** **SUPPORT SERVICES** • Nutrition • Financial resources and entitlements • Housing (including results of home visits to assess living situation)

	• Transportation • Support systems • Identification of children and separate assessment of children's needs • Parenting needs • Partner notification needs (PS) • HIV disclosure status/issues • Domestic violence • Legal needs (e.g. health care proxy, living will, guardianship arrangements, landlord/tenant disputes) • Activities of daily living • Knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission • Employment/education **c. Additional information:** • Copy of photo identification (driver's license, passport, etc.) if consumer has one • Copy of Insurance card • Proof of Income and residency • Consumer strengths and resources • Other agencies serving consumer • Brief narrative summary • Name of person completing the assessment and date of completion • Supervisor signature and date, signifying review and approval 2. The case manager has primary responsibility for the Comprehensive Assessment and meets face-to-face with the consumer at least once during the assessment process. 3. If all relevant information necessary to complete the assessment is not received from the consumer within 30 days of the assessment date, two verbal and one written request must be filed by the case manager within 30 days of non-receipt. If no response is received from the consumer within additional 30 days, consumer must be discharged from services. 4. The Comprehensive Assessment is documented in the case record on forms developed by the Wisconsin AIDS/HIV Program or in the consumer's electronic record.

IV. SERVICE PLAN DEVELOPMENT (Required)

Service planning is a critical component of case management services and provides the consumer and case management team with a proactive, concrete, step-by-step approach to addressing consumer needs.

The Service Plan can serve additional functions, including: focusing a consumer and case manager on priorities and broader goals, especially after crisis periods; teaching consumers how to negotiate the service delivery system and break objectives into attainable steps; and serving as a review tool at reassessment to evaluate accomplishments, barriers, and re-direct future work. Active client involvement, defined by client presence and input, in each aspect of the service plan development is required.

Goals, objectives, and activities of the service plan are determined with the participation of the consumer and, if appropriate, family, close support persons and other providers.

Standard	***Criteria***
Consumer needs identified at Comprehensive Assessment are prioritized and translated into a Service Plan, which defines specific goals, objectives, and activities to meet those needs. This is required for all case managed consumers (Service Levels 1-3). **Time Requirement:** Due within 10 working days of the completion of the Initial Comprehensive Assessment	i. Initial Service Plan includes at the minimum: • Problem statement (general) • Goal(s) • Action Steps (work plan, action to be taken, follow up tasks) • Individual responsible for the activity (case manager or team member, consumer, family member, agency representative) • Anticipated time frame for each activity • Either a consumer signature and date, signifying agreement or verbal approval documented • Supervisor's signature and date, indicating review and approval ii. The case manager has primary responsibility for the development of the service plan. iii. The service plan is included in the case record on forms developed by the Wisconsin AIDS/HIV Program or in an electronic database. iv. The service plan is updated with outcomes and revised or amended in response to changes in consumer life circumstances or goals. Based on Service Level determined by the WAI, review schedule is as follows OR more frequently as life circumstances change: **a. Service Level 1:** Case Manager review required every 6 months; supervisory review required annually; consumer review required annually.

	b. Service Level 2: Case Manager review required quarterly; supervisory review required every 6 months; consumer review required annually. **c. Service Level 3:** Case Manager review required quarterly; supervisory review required quarterly; consumer review required every 6 months.

V. SERVICE PLAN IMPLEMENTATION (Required):
Consumer contact, Monitoring and Follow up

The bulk of case management work occurs in the implementation of the service plan. Implementation involves carrying out of tasks, listed in the plan, including but not limited to the following activities:

- Provider contact in person, by phone, or in writing (including e-mail correspondence)
- Assistance to consumer in applying for services or entitlements
- Assistance in arranging services, making appointments, confirming service delivery dates
- Follow up and tracking for referrals and core medical appointments
- Monitoring of treatment and medication adherence
- Encouragement to consumer to carry out tasks they agreed to in service plan
- Direct education to the consumer as needed
- Support to enable consumer to overcome barriers and access services
- Negotiation and advocacy as needed
- Building confidence in self-management
- Other case management activities as needed by consumer

In general, the type and frequency of contact should be based on consumer needs. However, there are minimum required contacts for case managed consumers based on service level established by the Wisconsin Acuity Index:

Level 1: Quarterly direct consumer contact

Level 2: Monthly direct consumer contact

Level 3: Twice monthly direct consumer contact

Standard	***Criteria***
Provision of case management services outlined in the Service Plan proceeds immediately after its completion. Consumers are contacted based on their level of need. Consumer status is monitored. Case management staff follows up to determine receipt of service.	1. Oversight of service plan implementation is the responsibility of the case manager. 2. Progress notes in the case management record detail the advancement of the case management effort for consumer and record the outcomes of activities. 3. Evidence is documented in the consumer's chart that the case manager contacts the consumer by a means and frequency appropriate to the consumer's need, or according to the minimum requirements issued by the Wisconsin AIDS/HIV Program. 4. Documentation indicates contact with consumer and/or providers (occurring after service date) to determine if services are:

	• Delivered as expected • Utilized by the consumer • Satisfactory to the consumer • Continue to be appropriate to the consumer's need • Result in positive outcomes 5. Case management provider follows up on problems with service delivery. 6. Status of the consumer is monitored on a regular basis. 7. The consumer's right to privacy and confidentiality in contacts with other providers and individuals is assured: • The consumer's consent to consult with other service providers is obtained. The provider complies with Wisconsin statues and HIPAA regulations (if applicable) regarding the confidentiality of HIV-related information 8. Confidential HIV and consumer level documentation is secured against unauthorized access.

VI. COMPREHENSIVE REASSESSMENT (Required)

Reassessment provides an opportunity to review a consumer's progress, consider successes and barriers, and evaluate the previous period of case management activities. In conjunction with updating the Service Plan, Reassessment is a useful time to determine whether the current level of service and model of case management is appropriate, or if the consumer should be offered alternatives.

Standard	***Criteria***
A reassessment reevaluates consumer functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or on-going needs. **Time Requirement:** ***Service Levels 2 & 3*:*** **Comprehensive** reassessment is required 365 days after completion of initial assessment. Thereafter, every 365 days at minimum, or sooner if consumer circumstances change significantly. **Consumers with a Level 3 designation must be reassessed every 6 months alternating the brief and comprehensive assessments as detailed in the following section.*	Each *comprehensive* reassessment includes: **a. Updated personal information** • Current contact and identifying information • Emergency contact • Confidentiality concerns • Household members • Insurance status (and updated copy of cards) • Other health and social service providers • Current proof of Income and residency **b. Updated consumer health history, health status, and health-related needs including but not limited to:** **CORES SERVICES** • HIV disease progression • Tuberculosis • Hepatitis • Sexually transmitted diseases • Other medical conditions • OB/GYN, including current pregnancy status • Medications and adherence • Allergies to medications • Dental care • Alcohol/drug use/smoking history and current status • Mental health • Vision care • Home care • Current health care providers; engagement in and barriers to care • Clinical trials • Complementary therapy

	c. Updated consumer status and needs related to: **SUPPORTIVE SERVICES** • Nutrition • Financial resources and entitlements • Housing (including results of home visits to assess living situation) • Transportation • Support systems • Identification of children and separate assessment of children's needs • Parenting needs • Partner notification needs (PS) • HIV disclosure status/issues • Domestic violence • Legal needs (e.g. health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes) • Activities of daily living • Knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission • Employment/education 1. The case manager has primary responsibility for the comprehensive reassessment and meets face-to-face with the consumer at least once during the reassessment process. 2. The comprehensive reassessment is documented in the case record utilizing forms developed by the Wisconsin AIDS/HIV Program or directly input into an electronic database. 3. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information and other releases for information as required by applicable law. 4. Wisconsin AIDS/HIV Program Guidelines for Developing Agency Policies and Procedures contains instructions on developing policies for all services including the intake and assessment processes.

VII. BRIEF REASSESSMENT (Required)

For Service Level 1 consumers, the brief reassessment serves to update the consumer file in the same manner as the comprehensive assessment with less detail required due to the lower level of need and case complexity. For Service Level 3 consumers, the brief assessment is completed 6 months following the comprehensive assessment to ensure closer monitoring of consumer status.

Standard	***Criteria***
A reassessment reevaluates consumer functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or on-going needs. **Time Requirement:** ***Service Level 1:*** **Brief** reassessment is required 365 days after completion of initial assessment. Thereafter, every 365 days at a minimum, or sooner if consumer circumstances change significantly. **Time Requirement:** ***Service Level 3:*** **Brief** reassessment is required 180 days after completion of initial assessment. Thereafter, every 180 days following a comprehensive reassessment at a minimum, or sooner if consumer circumstances change significantly.	Each *Brief* Reassessment includes: **a. Updated consumer information in the following areas:** • Contact and identifying information • Emergency contact • Confidentiality concerns • Household members • Insurance status (and updated copy of cards) • Other health and social service providers, including other case managers • Current proof of income and residency **b. A reevaluation of the consumer's status and needs regarding:** • Medical health status • Oral health status • Mental health status • Substance Abuse • Food/clothing • Finances/benefits • Housing • Transportation • Legal • Domestic violence • HIV disease and other medical concerns • Prevention of transmission and secondary support (Partner Services) • Social support system 1. The case manager has primary responsibility for the brief reassessment. The brief reassessment is performed in person or by phone. *(In person reassessment is preferred but not required)* 2. The brief reassessment is documented in the consumer chart utilizing the form developed by the Wisconsin AIDS/HIV Program. 3. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information and other releases for information as required *(may be mailed to consumer)*

VIII. SERVICE PLAN UPDATE (Required)

A reassessment (brief or comprehensive) is always accompanied by a revision of the Service Plan. However a service plan must also be updated between reassessments (according to case management service level) or as life circumstances change.

<table>
<tr><th>Standard</th><th>Criteria</th></tr>
<tr><td>
A new or updated service plan is required at regular intervals outlined below or sooner if consumer circumstances necessitate a chance in goals, objectives, or case management activities.

Time Requirement:

Service Level 1:
Review by primary case manager should occur every 6 months. Supervisory review should occur annually. Consumer input and approval must be obtained annually.

Service Levels 2:
Review by primary case manager should occur quarterly. Supervisory review should occur every 6 months. Consumer input and approval must be obtained annually.

Service Levels 3:
Review by the primary case manager should occur quarterly. Supervisory review should occur quarterly. Consumer input must be obtained twice annually.
</td><td>
1. An updated service plan must include:
• information regarding the status of open problem logs
• closing of problem logs that have reached completion
• identification of new problems or actions required.

2. The case manager has primary responsibility for the updated service plan. The update is conducted in person once annually for Acuity Index Level 2 or every 6 months for Acuity Index Level 3 consumers (during the reassessment) or can be done over the phone during the brief reassessment for Acuity Index Level 1 consumers.

3. The case management supervisor must sign off on each Service Plan update, indicating review and approval of the plan.

4. The service plan update is documented in the case record on forms developed by the Wisconsin AIDS/HIV Program or in an electronic database.
</td></tr>
</table>

IX. CASE COORDINATION AND CASE CONFERENCING
(Optional for Acuity Levels 1-2; Required for Acuity Level 3)

Case coordination includes communication, information sharing, and collaboration that occurs regularly with case management and other staff serving the consumer within and between agencies in the community. Coordination activities may include directly arranging access to services; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes.

Case conferencing differs from routine coordination. Case conferencing is a more formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the consumer.

Case conferences can be used to identify or clarify issues regarding a consumer's status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

Case conferences may be face-to-face or by phone/video conference, held at routine intervals or during significant change. During conferences and contacts with providers, the client's service plan should be shared and reviewed to ensure transparency in treatment plan and effective collaboration. Case conferences are documented in the consumer's case record.

Standard	***Criteria***
Case conferencing is utilized as a specific mechanism to enhance case coordination. **Time Requirement:** **Service Levels 1 & 2:** Recommended as needed and appropriate for care coordination **Service Level 3:** Quarterly communication with each of the core medical providers either individually or via multidisciplinary case conferencing. As needed communication with non-core providers	1. Coordination activities include frequent contacts with other service providers and case managers and are documented in the progress notes. 2. Evidence of timely case conferencing/care coordination with key providers should be found in the Consumer's electronic record. 3. The Consumer's right to privacy and confidentiality in contacts with other providers is maintained. • The Consumer's written consent to consult with other providers is obtained. The provider complies with Wisconsin HIV confidentiality laws and HIPAA regulations (if applicable) for the release of HIV-related information as well as the Wisconsin AIDS/HIV Program's policy on Release of Information.

X. CRISIS INTERVENTION (Required)

A clear crisis intervention policy and staff training on crisis intervention help ensure quick resolution of emergencies to minimize any damaging consequences (i.e. acute medical, social, physical or emotional distress).

Standard	*Criteria*
Agency has a policy for consumer crisis intervention that ensures all onsite emergencies are addressed immediately and effectively. This policy is reviewed and updated annually or more frequently as necessary. Consumers are provided resources to address a crisis after hours.	1. All consumers are provided with emergency contact information that includes resources and guidance to secure assistance outside of agency business hours upon intake. 2. Program staff is trained on agency crisis policy and how to respond to crisis situations. This training and the policy is conducted internally at each agency on an annual basis. 3. Wisconsin AIDS/HIV Program Guidelines for Developing Agency Policies and Procedures contains general instructions on developing policies and procedures for crisis situations.

XI. CASE CLOSURE/GRADUATION and READMISSION

Consumers who are no longer engaged in active case management service should have their cases closed based on the criteria and protocol outlined below. A closure summary usually outlines the progress toward meeting identified goals and services received to date.

Common reasons for case closure include:

- Consumer completed case management goals
- Consumer is no longer in need of service (e.g. consumer is capable of resolving needs independent of case manager assistance)
- Consumer is referred to another case management program
- Consumer relocates outside of service area
- Consumer chooses to terminate service
- Consumer is no longer eligible for services
- Consumer lost to care or does not engage in service
- Consumer incarceration greater than 6 months in a state or federal penitentiary
- Agency initiated termination due to behavioral violations
- Consumer death

Standard	***Criteria***
Upon termination of active case management services, a consumer case is closed and contains a closure summary documenting the case disposition.	**a. Discharge/graduation** 1. Closed cases include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary). 2. In the event of consumer death: • Referral information about grief counseling or other support services is shared with family and/or significant others • Case management agency will determine the timeline for bereavement support services for affected family and/or significant other 3. Supervisor signs off on closure summary indicating approval (electronic review is acceptable). 4. In the event that a consumer becomes ineligible for case management services: • Case manager notifies supervisor of intent to discharge consumer • Case manager reports to supervisor on the consumer’s circumstances that make them ineligible for continued services (decrease in Acuity Index Level, behavior, etc.)

	5. Client is considered non compliant with care if 3 attempts to contact client (via phone, e-mail or written correspondence) are unsuccessful. 30 days following the 3rd attempt discharge proceedings should be initiated by agency. 6. In accord with written policies and procedures established by each agency, the case manager notifies the consumer (through face-to-face meeting, telephone conversation or letter) of plans to discharge the consumer from case management services. 7. The consumer receives written documentation explaining the reason(s) for discharge and the process to be followed if consumer elects to appeal the discharge from service. 8. Information about reestablishments is shared with the consumer. • Consumer is provided with contact information and process for reestablishment 9. Wisconsin AIDS/HIV Program Guidelines for Developing Agency Policies and Procedures contains instructions on developing policies for all services including the discharge process. **b. Readmission** 1. In the event that a consumer seeks readmission following a case closure the following applies: 2) All consumers must receive a new Acuity Index Score: • For Acuity Index Level 1-2, no additional paper work or file review is required if readmission occurs within 6 months and pending no significant change in life circumstances • For Acuity Index Level 3, a reassessment and new service plan must be created to ensure that current issues are prioritized (if within 6 months, brief reassessment may be performed)

XII. NON CASE MANAGED/BRIEF SERVICES CONSUMERS

For HIV positive consumers who either choose not to enroll in case management services or who are not eligible for enrollment (zero acuity), "brief services" allow for case management staff to assist these consumers with service navigation and benefits procurement outside of formal case management.

The distinction between case management services and brief services is 1) consumers are not required to complete a comprehensive assessment; 2) consumers are not contacted proactively by case management staff but rather contact the designated staff member to request specific assistance; and 3) consumers need not comply with case management rights and responsibilities.

Consumer Eligibility	***Requirements for Brief Services Consumers***
In order to be eligible for Brief Services, consumer must be: • HIV Positive • A resident of Wisconsin Consumers should be provided with contact information for an agency representative(s) that they may contact when a service is needed.	**a. Completion of Intake form** *i)* ***A completed intake form must be on file for any brief services consumer within the 12 month period prior to the date of service provision*** *(i.e. a consumer receiving a funded service on 01/01/2010 must have a valid intake form and current supporting documentation on file dated no earlier than 01/01/2009)* • Demographic information • HIV status information • Presenting problems • Immediate needs and action steps (mini service plan) • Insurance status **b. Collection of supporting documentation** • Proof of HIV Status • Proof of income and residency • Copy of insurance card(s) • Copy of Photo ID (if consumer has it) **c. Other requirements** • Provision of prevention counseling including transmission and harm reduction information • Referral to Partner Services (PS) program if accepted

GLOSSARY OF TERMS

The definitions listed in the glossary should be considered in the context of case management as defined and described in the *Practice Standards and Administrative Guidelines for HIV Related Non-medical Case Management*.

Acuity

A measure of the severity of identified consumer needs. In Wisconsin, the Acuity Index tool is used to determine this measure.

Agency

The entity ultimately accountable for case management services, or one to which a consumer has been referred. The agency is usually the organization sponsoring a case management program, which in turn provides direct case management services.

AIDS Service Organization (ASO)

Not-for-profit agency governed by a Board of Directors and staffed by individuals who often reflect the community served by the organization. These organizations are funded to provide specific health and social services to assist individuals living with HIV/AIDS. In Wisconsin, services must include both HIV prevention and care services in addition to other services.

Best Practice

A technique, methodology or action that, through experience and/or research, has proven to lead to a desired result. Best practices may include performance recommendations that assist agencies in meeting or exceeding the set standard.

Case Conference

A formal, planned, structured activity, separate from routine contact that brings together individuals providing specific services to a consumer for the purpose of assuring unduplicated, integrated and well-coordinated services. A case conference is usually interdisciplinary and includes, preferably, a consumer and members of his/her support network, core services care providers and the case manager(s). A case conference may be used to clarify a consumer's current status, review progress and barriers towards goals, map roles and responsibilities of the participants, create an integrated service plan, or adjust current plans to respond to a consumer's situation. Case conferences may be required at routine intervals, depending on consumer Acuity Index Level and are also recommended during times of significant change, crisis, or lack of progress. A case conference is documented in the progress notes of the consumer record. If the consumer is absent from the case conference, appropriate releases of information must be in place.

Case Manager

An individual responsible for carrying out case management activities, including assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention and case closure.

Consumer/Consumer

Any individual, family or group receiving case management or other funded services. In some instances, the consumer may consist of an individual and his/her caregiver or an individual and his/her substitute decision maker (power of attorney).

Consent to Enroll in Case Management

A designated form presented to a consumer and discussed during the Comprehensive Assessment process outlining case management services, the voluntary nature of the program, and the right to decline all or part of services. The consumer's signature confirms agreement to participate in the case management program and care coordination.

Community Based Organization (CBO)

Not-for-profit agency governed by a Board of Directors and staffed by individuals who often reflect the community served by the organization. These organizations may be funded to provide specific health and social services to assist individuals living with HIV/AIDS. Service may include case management, crisis intervention, housing, meals, HIV prevention services, and others.

Coordination of Care

Contact and communication between a case manager and other service providers including medical, mental health, substance use, social service, and staff of other agencies to assure that each entity is informed of consumer's status related to service acquisition and meeting set goals or objectives. Coordination is a routine activity of case management, which updates providers on consumer progress and barriers as well as helps define provider roles and responsibilities, and avoid service duplication.

Crisis Intervention

An immediate response by a service provider to address a consumer's emergency need (e.g. emergency medical situation, domestic violence, mental health crisis, etc.). An active crisis should be reflected in the progress notes of a consumer file and case management supervisor should be notified.

Documentation

Recorded information in the consumer file or other source documents required to accurately track service provision and consumer monitoring. Specific guidance relating to documentation protocols can be found on page 26 of this document.

Cultural Competency

Staff ability to make services respectful of a consumer's cultural beliefs and behaviors, whether influenced by gender, ethnicity, poverty, language, disability, sexuality, age or other cultural influences, so that services are sensitive, comfortable, and acceptable to consumers. Cultural competency implies that service delivery is designed and implemented with the understanding that culture and language have considerable impact on how consumers access and respond to health and human services.

Goals (service plan)

A statement of broad outcomes that a consumer and case manager have agreed upon. These should be simple and achievable and are the basis for the tasks and activities that consumer and case manager will undertake.

Harm Reduction

An approach to behavior change that incorporates immediate and practical strategies for reducing harm associated with drug-related and sexual risk behaviors. An individualized, consumer-centered approach requiring a non-judgmental assessment of the consumer's current behavioral practices, and work toward small gradations in risk reduction to achieve behavioral changes in a manner consistent with the consumer's abilities and desires.

Immediate Needs

Consumer-identified issues that must be addressed at once to stabilize the consumer's situation and facilitate further engagement in services.

Indicator

A performance measure used as a guide to monitor, evaluate or improve the quality of case management or care. Indicators can relate to case management processes (core functions) and results (outcomes).

Medical Care Coordination/ Medical Case Management

Refer to HRSA definition outlined on page 38 of this document.

Non-Case Managed/Brief Services

Reactive provision of information and referral or other limited services for consumers who score below a Level 1 on the Wisconsin Acuity Index (WAI) or those who receive certain services but decline to enroll in case management despite meeting eligibility criteria.

Objective (service plan)

A short term desired outcome, agreed upon between a case manager and a consumer, that contributes to the achievement of a broader goal in a consumer's service plan. Objectives are concrete and may require one or more activities to reach the desired result.

Partner Notification Assistance

Service to determine if a consumer has informed past and present sexual and needle-sharing partners of their exposure to HIV and offer assistance with disclosure. Partner notification activities may include individual interventions such as role-playing with a consumer who wishes to self-inform partners, referral to self-help group discussions on partner notification, or referral to Partner Services (PS) Program administered by the Wisconsin AIDS/HIV Program. Consumer needs regarding partner notification should be reviewed regularly and included in assessments/reassessments.

Performance Measure

A performance measure is a quantitative tool that provides an indication of an organization’s performance in relation to a specified process or outcome.

Proof of HIV Status

Documentation that provides verification of sero-positive HIV test, such as a letter from physician, copies of laboratory results of HIV tests, T-cell and viral load results or medical chart documentation. Acquiring this documentation directly from a provider requires a release of information signed by the consumer. Proof of HIV Status is required for a consumer to receive any Ryan White or Life Care Services funded service.

Referral

A joint decision between the consumer and case manager in which the consumer agrees to accept a service referral from the case manager. This referral should be to a service that the consumer is not currently accessing and can be internal or external to the agency. Case Managers are required to follow up on referrals to Core Medical services as described in Appendix D.

Referral Arrangements/Agreements

Pre-established agreements with other agencies to send or accept consumers for specified program services. An ongoing active partnership with agencies offering needed services is essential in providing quality case management. Often Memorandums of Understanding (MOU) or Linkage Agreements help to establish regular and smooth referrals and agencies are encouraged to create these.

Service

A term used to describe a more formal well-defined group of activities intended to accomplish a specific task.

Activities (service plan)

A set of tasks or steps that a consumer and case manager have agreed upon that will result in the implementation and/or completion of goals and objectives of a Comprehensive Service Plan. These tasks may be completed by the case manager/team, the consumer, another assigned person or, in some cases, jointly.

Service Provider

An individual or organization that provides a service to a consumer.

Standards

A set of requirements that the agency/program must follow when providing AIDS Institute-supported Comprehensive or Supportive Case Management Services.

Supportive Services

Non-medical or supportive services as defined by the Health Resource and Services Administration (HRSA) for the purposes of the Ryan White Treatment Modernization Act. Supportive services include: Case Management (non-medical); Child care services; Pediatric development assessment and early intervention services (*Note: This is not allowed under Part B*); Emergency financial assistance; Food bank/home-delivered meals; Health education/risk education; Housing services; Legal services; Linguistics services; Medical transportation services; Outreach services; Permanency planning (*Note: This is not allowed under Part B*); Psychosocial support services; Referral for health care/supportive services; Rehabilitation services; Respite care; Treatment adherence counseling (by non-medical personnel outside of the medical case management and clinical setting).

APPENDIX A:
Acronyms in HIV/AIDS Prevention and Care

Wisconsin HIV Community Planning Network
Acronyms

ADAP	AIDS Drug Assistance Program
AHP	Advancing HIV Prevention OR also used as abbreviation for AIDS/HIV Program
AHPI	Advancing HIV Prevention Initiative
AIDS	Acquired Immune Deficiency Syndrome
AN	AIDS Network
AODA	Alcohol and Other Drug Abuse
ARCW	AIDS Resource Center of Wisconsin
ARV	Antiretroviral
ASL	American Sign Language
ASO	AIDS Service Organization
ATEC	AIDS Training and Education Center – See MATEC
AZT	Azidothymidine (chemical name for zidovudine, brand name is Retrovir)
BHC	Black Health Coalition
BRFSS	Behavioral Risk Factor Surveillance Survey
CADR	CARE Act Data Report renamed in 2007 – see RDR
CAIR	Center for AIDS Intervention Research
CAPS	Center for AIDS Prevention Studies (University of California, San Francisco)
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act, now known as the Ryan White HIV/AIDS Treatment Modernization Act of 2006
CAS	Client Assessment Sheet
CBA	Capacity Building Assistance
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CHC	Community Health Centers
CLD	Client Level Data
CLI	Community Level Intervention
CMS	Centers for Medicare and Medicaid Services (Federal)
COBRA	Consolidate Omnibus Reconciliation Act
CPG	Community Planning Group
CQI	Continuous Quality Improvement
CTR	Counseling, Testing, and Referral
D&HH	Deaf and Hard of Hearing
DD	Developmental Disabilities
DEBIs	Diffusion of Effective Behavioral Interventions
DHS	Department of Health Services (Wisconsin)
DNA	Deoxyribonucleic acid
DOC	Department of Corrections
DPH	Division of Public Health
DPI	Department of Public Instruction
DWD	Department of Workforce Development
EBIs	Effective Behavioral Interventions
EC	Emerging Communities

EFA	Emergency Financial Assistance
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
EPSC	Evaluation and Program Support Center
FDA	Food and Drug Administration
FOA	Funding Opportunity Announcement
FTE	Full Time Equivalent
FTM	Female to Male (Transgender)
GAMP	General Assistance Medical Program
GLBT	Gay, Lesbian, Bisexual, Transgender
GLBTQ	Gay, Lesbian, Bisexual, Transgender, Questioning
GLI	Group Level Intervention
GPR	General Purpose Revenue
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau (Office within the federal Health Resources and Services Administration)
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HC/PI	Health Communication / Public Information
HCV	Hepatitis C Virus
HIRSP	Health Insurance Risk Sharing Plan
HIV	Human Immunodeficiency Virus
HIV-positive:	HIV-infected, person has tested positive on standard HIV-antibody test
HOH	Hard of Hearing
HOPWA	Housing Opportunities for People With AIDS
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development (Federal)
IDU	Injection Drug Use/Injection Drug User
ILI	Individual Level Intervention
IQ	Intelligence Quotient
IRC	(Wisconsin HIV/STD/HCV) Information Referral Center
LCS	Life Care Services (state funded case management services)
LGBT	Lesbian, Gay, Bisexual, Transgender
LHD	Local Health Department
LLEGO	National Latina/o Lesbian, Gay, Bisexual & Transgender Organization
MA	Medicaid
MAI	Minority AIDS Initiative
MATEC	Midwest AIDS Training and Education Center
MCSM	Men of Color who have Sex with Men
MMWR	Morbidity and Mortality Weekly Report
MSA	Metropolitan Statistical Area
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men and are also Injection Drug Users
MTF	Male to Female (Transgender)
NAHOF	National Association on HIV Over Fifty

NASTAD	National Alliance of State and Territorial AIDS Directors
NCHSTP	National Center for HIV, STD, and TB Prevention
NEP	Needle Exchange Programs
NGLTF	National Gay and Lesbian Task Force
NGO	Non-Governmental Organizations
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor – "Non-Nukes"
NRTI	Nucleoside Analog Reverse Transcriptase Inhibitor – "Nukes"
OMB	Office of Management and Budget (Federal)
OSHA	Occupational Safety and Health Administration
PCM	Prevention Case Management
PCR	Polymerase Chain Reaction (test or assay)
PCRS	Partner Counseling & Referral Services now known as Partner Services or PS
PEMS	Prevention Evaluation Monitoring System
PHIP	Prevention for HIV Infected Persons
PHS	Public Health Service (Federal)
PI	Protease Inhibitor
PIR	Parity, Inclusion, and Representation (Older language within CDC for prevention)
PLWA	Person Living with AIDS
PLWH	People Living with HIV
POL	Popular Opinion Leader
PTLT	Prevent, Test, Link, and Treat
PS	Partner Services, formerly Partner Counseling & Referral Services or PCRS
PSE	Public Sex Environment
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RDR	Ryan White Program Data Report (Replaces the CADR in 2007)
RFP	Request For Proposals
RNA	Ribonucleic Acid
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAPG	Statewide Action Planning Group
SCSN	Statewide Coordinated Statement of Needs
SEP	Syringe Exchange Programs
SI	Structural Interventions
SIECUS	Sexuality Information and Education Council of the United States
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TGA	Transitional Grant Area
TTY	Text Telephone
UMOS	United Migrant Opportunities Services

WAPC	Wisconsin Association for Prenatal Care
WSW	Women who have Sex with Women
YAC	Youth Advisory Council
YMSM	Young Men who have Sex with Men
YRBS	Youth Risk Behavior Survey
ZDV	Zidovudine (generic name for Azidothymidine, brand name is Retrovir)

APPENDIX B:
Wisconsin AIDS/HIV Program Grievance Standards

Standards for Grievance Policies and Procedures for HIV Care and Prevention Provider Agencies

The AIDS/HIV Program, HIV care and prevention providers and consumers of services share a common goal of having high quality HIV-related services available to persons living with HIV disease in Wisconsin. However, consumers may have legitimate complaints about services or service providers. Often these complaints can be resolved informally by the parties involved. The AIDS/HIV Program encourages consumers and providers to attempt informal solutions before engaging formal processes, but sometimes attempts to resolve complaints informally fail. Providers must have formal grievance policies and procedures in place to address complaints that can not be resolved informally or when the complainant does not want to pursue an informal resolution. HIV care and prevention provider agencies that receive funding from the Division of Public Health, AIDS/HIV Program will be required by contract to have written grievance policies and procedures. The AIDS/HIV Program acknowledges that funded agencies range from small community-based organizations to large public institutions, and that grievance processes may differ between agencies. However, the Program believes that certain fundamental elements should be included in any grievance policy and procedure. Therefore, funded agencies may develop their own grievance policies and procedures, but they must comply with the following standards:

I. Fair and reasonable grievance policies and procedures must be written and must acknowledge and assure that clients have certain rights and responsibilities, including the right to file formal grievances.

II. Agency grievance policies and procedures must prohibit the agency and its staff (paid and unpaid) from discriminating or retaliating against the complainant for filing a grievance or because of any conditions of the resolution of the grievance.

III. Agency staff must be trained and understand the rights of the clients they serve.

IV. Agency staff and clients must be made aware of grievance policies and procedures. The policy and procedures must be posted in prominent areas where staff and clients will see them. Also, clients must be informed of the policy and procedures for filing a grievance upon entrance to care or prevention services. Ongoing clients must be reminded of the policy and procedure periodically. Notices of the grievance policy and procedures must be available in writing, and must also reasonably be made available in alternate formats as needed to accommodate the special needs of clients. Examples of alternate formats include:

    A. Written notices in other languages to meet the needs of clients with limited English proficiency.

B. Oral notices such as audio tapes or video tapes for clients with limited reading skills or for clients with visual impairments.

C. Written notices in large print format for clients with limited vision or in Braille for clients who are blind.

V. Grievance procedures must clearly identify the title of a specific staff position or positions that a client may contact for assistance to initiate a grievance. Method(s) of contact such as phone numbers or e-mail addresses must also be clearly provided.

VI. Grievances must be documented and submitted in writing. If the aggrieved individual is unable to submit the grievance in writing, the grievance may be presented orally and transcribed by the recipient of the grievance or at the request of the aggrieved by a third party.

VII. Grievance procedures must include reasonable and specific time frames for:

A. Initiating a grievance following the event or events that trigger the grievance.

B. Initial response from the agency acknowledging receipt of the grievance.

C. Investigation of the events that lead to the grievance.

D. Notification of extension of the time needed for the agency to investigate the grievance.

E. Notification in writing to the aggrieved of the decision of the grievance including, results of the investigation, any resulting changes in policy or procedures relative to the grievance or any redress to the aggrieved.

F. Notification in writing of the right of the aggrieved to appeal the results of the grievance, including timeframes for submitting the appeal.

G. Notification in writing to the aggrieved of the decision of the appeal.

VIII. Agencies may include in their policy the right to reject grievances that are frivolous in nature or that upon investigation are determined to have no merit. The aggrieved individual must be notified in writing of the rejection of the grievance.

IX. Agencies must include in their policy the right of the aggrieved to appeal the initial decision of the agency, and may include additional levels of appeal (the right to appeal the decision of the initial appeal).

X. Agencies must maintain a confidential written log of formal grievances that at a minimum includes the:

A. Name or unique identifier of the aggrieved

B. Date the grievance or appeal was filed

C. Summary statement of the reason(s) the grievance was filed

D. Summary statement of the significant facts of the investigation

E. Summary statement of the resolution of the grievance

F. Date of resolution

G. If appealed, a separate entry on the log containing the information in A through F relative to the appeal.

XI. For monitoring purposes, agencies must make the grievance log with personal identifiers removed available upon request for inspection by the AIDS/HIV Program or its agent.

XII. Agencies must maintain written documentation of a grievance its investigation and resolution, and if appealed its appeal, for a period of five years from the date of final resolution.

XIII. These standards do not supersede applicable state or federal laws or regulations.

XIV. Agencies that are not able to meet all of the requirements of these standards for grievance policies and procedures may submit a written request to the Director of the AIDS/HIV Program to waive certain requirements.

APPENDIX C:
Confidentiality Standards for Wisconsin HIV Case Management Providers and Agencies

Confidentiality Standards for Wisconsin HIV Case Management Providers and Agencies

The Wisconsin AIDS/HIV Program emphasizes the importance of consumer confidentiality in service delivery. Confidentiality ensures that information regarding a consumer's HIV status, behavioral risk factors, or use of services cannot be released without his or her documented consent.

The AIDS/HIV Program has established written guidance in conformance with HIPAA and State of Wisconsin confidentiality laws surrounding health related information[i]. HIV care providers and agencies must take steps to ensure that their practice conforms to these policies and procedures.

PROCEDURES

A. For collateral communication and care coordination on behalf of the consumer

Upon entry into case management services, each consumer must complete the following documentation:

1. A Consent to Enroll in Case Management Services
2. A Client Rights and Responsibilities Form (including consumer's responsibility to maintain the confidentiality of other agency consumers)
3. Written Release of Information for all exchange of health related information and documented verbal authorization for all verbal communication related to the consumer

B. For electronic record maintenance

When a consumer file is generated, the following guidelines must be adhered to:

1. Access to electronic records must be password protected and access should be limited to staff members with demonstrated need for the information
2. Screensavers on computers should be password protected as well and set for less than 10 minutes
3. Staff members should not share passwords for consumer protected information with anyone

C. For paper record maintenance

When a consumer file is generated, the following guidelines must be adhered to:

1. All materials should be maintained in a locking file cabinet or drawer within a locked office or room
2. Files must be locked at all times other than when immediately in use
3. Any superfluous or outdated documentation should be maintained for a minimum of 7 years and then disposed of with a cross-cutting shredding machine specifically designed for confidential information

D. Transport of records from secure office or location

When files, either electronic or paper need to be transported to an alternate location, the following guidelines must be adhered to:

1. Electronic files may be transported via a password protected device (USB external drive, etc.) TEMPORARILY
2. Once the electronic files have been reviewed or edited, the updates should be made to the central database and then deleted (formatted) from the temporary drive
3. The external drive or data storage devise may not leave the possession of the case management staff at any time and the case manager assumes full responsibility for the protection of the data

4. Paper files may also be transported to an alternate location for the purposes of case review or auditing in a locking file folder or other secure device.
5. Once the files have been reviewed the documents should either be returned to a location with a double lock system or disposed of according to the above guidelines if superfluous.

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[i] Wisconsin AIDS/HIV-related statues that apply to confidentiality are as follows: 146.82(1)-146.84(4); 252.15(2)-252.15(9).

APPENDIX D: Guidance for Referral Follow Up

Referral Follow Up

What is a referral: a joint decision between the client and case manager in which the client agrees to accept a service referral from the case manager. This referral should be to a service that the client is not currently accessing.

What a referral is NOT:

- A casual suggestion to a client during conversation;
- A written comment about a potentially necessary service that appears in a client's file;
- Activities that are considered part of care coordination. For example, if a client is already receiving regular medical care, but the client has not received an annual pap smear, the case manager may suggest to the client that this would be a good idea and may even contact the physician to schedule an appointment for the client. This is not a referral to medical care since the client is already in medical care, this would be considered care coordination.

Which referrals should be included in the report:

- Referral follow-up should be reported to the state only for the following 4 core medical services: medical, dental, mental health and AODA. However, as the coordinator of your client's care and for maximal client well-being, referral follow-up should occur, and be documented, for all services.
- Referrals to both internally provided and externally provided services should be included in the report.

Referral status categories: 1) Pending; 2) Refused; 3) Completed; 4) Closed; 5) Lost to follow up

Referral status category	Applicable referral outcome
Pending	Referral issued, client has not yet acted upon referral (e.g. **no** appointment has been made with the referred provider).
	Appointment is made for a future date.
	Appointment is made; client does not show due to life circumstances but agrees to reschedule, or has rescheduled, the appointment.
	Client switches to another case manager within the same agency while the referral is still pending.
Refused	Referral issued and upon next contact with client, client states he/she no longer interested in the referred service.
	Appointment is made; client does not show up for the appointment because he/she no longer wants the service.
Completed**	Appointment is made and client keeps appointment.
Closed	Client dies while referral is pending.
	Client is discharged while referral is pending.
	Client chooses to discontinue case management services while referral is pending.
Lost to Follow Up	Referral issued; case manager attempts to follow up with client several times (# of required contact attempts per agency policy) and unable to contact client (e.g. phone disconnected, client does not answer calls, client does not return calls). At this point the referral should be changed to "lost to follow-up" and re-issued, if applicable, once the client can be contacted.

***A referral should be marked "completed" only if the kept appointment has been verified with the provider; client self-report of a kept appointment is not sufficient (unless a current information release does not exist). However, for optimal client care, attempts should be made to obtain information releases for all core medical services. In the case of non-reported referral follow-up (e.g. for support services), client self-report of referral outcome is sufficient.*

Performance Measure:

Of referrals made during the reporting period, give the number of referrals *at the end* of the reporting period that are:

- Pending
- Refused
- Completed
- Closed
- Lost to follow up

APPENDIX E:
Transportation Policy for Ryan White Part B and Life Care Services

Transportation Policy for Ryan White Part B and Life Care Services

Effective Date: April 1, 2009

Payer of Last Resort: The Ryan White and Life Care Services programs are always to be payers of last resort for all services covered by your agency. Case managers must ensure that client files are up to date and contain accurate insurance coverage information.

Coordination with private insurance: Clients who have private coverage for transportation must utilize the mode of transportation covered by their insurance network. Ryan White and Life Care Services funds may not be used to pay for services that are a covered benefit of the insurance plan. When clients have a copay that must be paid, Ryan White and Life Care Services funds may be used to cover the cost of the copay.

Coordination with Medicaid, BadgerCare Plus, and other State administered plans: Clients who have coverage under a state administered plan like Medicaid or BadgerCare Plus must obtain care from a Medicaid certified provider. The provider must bill the appropriate state program for reimbursement. Ryan White and Life Care Services may not be used to cover the cost of services rendered. Medicaid transportation is coordinated at the county level, so agencies should contact their local county human services department to verify appropriate policy and procedures.

Coordination of services for uninsured clients: For clients that have no other transportation coverage, Ryan White and Life Care Services funds may be used to provide assistance according to the following guidelines:

Overall Transportation Policy

1. Transportation funds, including bus tickets and gas cards, may only be used to assist a client in accessing a core AIDS/HIV medical service or to meet with the client's psychosocial case manager. **The allowed services are:**
    - Outpatient/ambulatory medical care
    - Oral health care
    - Mental health treatment
    - Medical case management (including treatment adherence provided in a hospital/clinical setting)
    - Medical nutrition therapy
    - Substance abuse treatment
    - Psychosocial case management.

    Funds may not be used to cover transportation costs related to the other Ryan White support services, any other services, or for other activities including personal errands, grocery shopping, other shopping, banking, social/recreational events, restaurants, or family gatherings.
2. Documentation that the appointment was kept must be maintained in the client file. If the case manager is unable to verify an appointment because the client has not signed a medical release form the appointment may be verified using the following:
    - Visit summary or invoice printout from the provider
    - Signed letter by the provider, on the provider's letterhead, stating the client had seen on specific date.
    - Appointment card from the provider's office that has been signed by the provider.

3. If client fails to keep appointments, additional transportation assistance is not to be provided. Each agency should establish policy to determine how a client can re-access transportation services after losing the privilege because of missed appointments.
4. If an agency decides to provide transportation assistance it must be recorded separately in the contract budget. It cannot be included as part of another service area.
5. As Ryan White and Life Care Services funds are a limited resource agencies must:
    - Establish strict eligibility guidelines for receiving transportation assistance.
    - Conduct cost analysis to determine the most cost efficient mode of transportation.

Gas Card Policy

1. When using gas cards documentation detailing starting and end point addresses is required. This must include mileage calculated by an official mapping site such as Mapquest.
    - For example a round trip between 1 W. Wilson Street in Madison to 400 Water Ave in Hillsboro is 93.54 miles going and 92.72 miles returning.
2. Reimbursement should be calculated at $.10/mile.
    - For the trip described above the reimbursement rate is 186.26 miles * $.10 = $18.63.
3. Gas cards must be distributed in $10.00 increments and should be rounded to the nearest $10.00 total.
    - For the above example $20.00 in gas cards should be distributed.
4. The agency must establish a detailed tracking system to ensure the client is not receiving additional gas cards when there is still a balance on the previously issued card(s).
    - In the above example, the client would still have a balance of $1.37. If the client now needs to get from 1 W. Wilson Street in Madison to 600 Highland Avenue in Madison the mileage is 3.04 miles going and 2.94 miles returning for a total of 5.98 miles. The reimbursement rate is 5.98 miles * $.10 = $.60. The additional $.60 would be covered under the original $20.00 issued in gas cards leaving a new balance of $.77.
5. The tracking system must include the following elements, which must be made available for AIDS/HIV Program staff to review upon request and during site visits:
    1) Client ID
    2) Date(s) of service
    3) Starting and end destination addresses
    4) Name of core medical service provider
    5) Mileage calculations
    6) Reimbursement calculations
    7) Card values provided, and
    8) Remaining card balance
6. Gas cards must be redeemable only for gas, and may not be used towards the purchase of other items or redeemed for cash.

Bus Tickets

1. Monthly bus passes should not be utilized.
2. The agency must establish a detailed tracking system including:
    1) Client ID
    2) Date(s) of service
    3) Starting and end destination addresses
    4) Name of core medical service provider
    5) Cost of bus ticket

6) Ticket balance (if using multiple ride ticket)

This tracking system must be available to AIDS/HIV Program staff on request and at site visits.

3. When issuing a multiple ride ticket the agency must ensure the client had kept core medical service appointments equal to the number of rides on the ticket before issuing another bus ticket.

Cab Rides

As agencies are expected to use the most cost efficient mode of transportation available, the AIDS/HIV Program would not expect to see cab rides used on a routine basis. There may be instances where due to geographic location or client's physical or mental condition where a cab ride is the best transportation option available. Provision of cab rides should also be consistent with the agency's established eligibility criteria. When cab rides are provided, the need should be detailed in the client's file and available for AIDS/HIV Program staff to review on request and at site visits.

APPENDIX F:
Wisconsin Quality Management Plan and Performance Measures

Quality Management Plan for Ryan White Part B and Life Care Services Funded Programs

AIDS/HIV Program
Wisconsin Division of Public Health

November 2008

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QUALITY STATEMENT

Quality Goal

The goal of the Wisconsin AIDS/HIV Program's Quality Management (QM) program is to ensure that persons living with HIV and AIDS (PLWH/A) in Wisconsin receive the highest quality medical and supportive services. To accomplish this goal, the Wisconsin QM program will ensure:

1. **Adherence to standards and expectations:**
   Ensure that direct service medical providers adhere to established practice standards, Public Health Service (PHS) Guidelines and user expectations to the extent possible;
2. **Supportive services focus on access and adherence:**
   Ensure that critical HIV-related supportive services focus on achieving appropriate access and adherence with HIV care; and
3. **Available data are used effectively:**
   Ensure that available demographic, clinical and health care utilization information, as well as available health outcomes data, are used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

Scope of Quality Management Program

The Wisconsin AIDS/HIV Program's QM program covers all services funded through Part B of the Ryan White Treatment Modernization Act and/or the state-funded Mike Johnson Early Intervention and Life Care Services grant. The funding sources are described in Appendix A. Because many of Wisconsin's Part B and Life Care Services (LCS) grantees also receive funding from other Ryan White Parts (Parts C, D and F), some of the Program's quality monitoring and assurance activities may also apply to these other Ryan White Parts.

Quality Definitions

- **Quality** is defined as the degree of excellence of a product or service. In terms of Ryan White and LCS, the quality of a service is the degree to which a service meets or exceeds professional standards, guidelines and users expectations.

- A **Performance Measure** is a quantitative tool that provides an indication of the quality of a service or process.

- An **Outcome** is the benefit or other result (positive or negative) for clients that may occur during or after receiving a service.

- **Quality Assurance** is a program for the systematic monitoring and evaluation (e.g. through performance measurement) of the various aspects of a service to ensure that standards of quality are being met.

- **Quality Improvement** refers to conducting activities aimed at improving processes to enhance the quality of care and services.

- The term **Quality Management Program** encompasses all grantee-specific quality activities, including the formal organizational quality infrastructure (stakeholders and resources), quality assurance and quality improvement activities.

- In this document, the word **client** is used to describe an individual who is infected with HIV and who receives health and/or support services that are funded through the State of Wisconsin with Ryan White or LCS funds.

QUALITY INFRASTRUCTURE

Leadership

Leadership for the AIDS/HIV QM program resides within the Wisconsin Division of Public Health's AIDS/HIV Program. Quality management efforts are led by the Quality Assurance Coordinator with oversight from the Care and Surveillance Supervisor and additional input from the AIDS/HIV Program Director.

Quality Program Participant Groups

The QM program consists of staff within the AIDS/HIV Program, the Statewide Action Planning Group QM committee, the Ryan White Part B and LCS funded agencies, the Wisconsin Division of Enterprise Services' Bureau of Fiscal Services (BFS), and the Health Resources and Services Administration (HRSA). Clients also play an important role in identifying service needs and areas for service improvement. The role of each of these stakeholders is described below.

I. AIDS/HIV Program Staff

The care and treatment staff is primarily responsible for QM activities, which are described below. Contact information for Program staff can be found in Appendix B.

- Quality Assurance Coordinator: develop the Part B quality management plan, review agency QM programs, including QM plans and quality improvement activities, monitor utilization of grant-funded services by coordinating data collection and compiling reports (e.g. quarterly utilization reports, biannual performance measures), support ongoing QM projects for ADAP, develop and implement outcomes for ADAP, and provide QM training and technical assistance to sub-contracted agencies and the Wisconsin HIV Community Planning Network.
- Life Care Services Coordinator: conduct contract monitoring activities for LCS funded-agencies including reviewing program expenses, work with Quality Assurance Coordinator to develop and monitor performance measures related to case management, ensure adherence to state HIV case management service standards through annual chart reviews and monitoring of performance measures, and develop and implement policies and procedures to improve the overall delivery of statewide case management services.
- Ryan White Grant Coordinator: conduct fiscal monitoring through annual budget and monthly expenditure reviews, conduct annual site visits to review fiscal records and program progress, ensure grantee compliance with Federal and State regulations, and

implement policies and procedures to improve the overall delivery of statewide HIV services in Wisconsin.
- AIDS Drug Assistance Program (ADAP) Coordinator: conduct ongoing fiscal monitoring to ensure sustainability of the ADAP program, review client eligibility for both ADAP and insurance programs, and implement policies and procedures to improve administration of the ADAP program.
- Insurance Program Coordinator: conduct ongoing fiscal monitoring to ensure sustainability of the Wisconsin Health Insurance Premium Subsidy program, conduct annual reviews of health insurance client charts to verify client information and program eligibility, and implement policies and procedures to improve administration of the insurance program.
- AIDS/HIV Program Director and Care and Surveillance Supervisor provide oversight and guidance to staff regarding daily responsibilities and those related to quality management.

In addition, the AIDS/HIV Program's Epidemiologist and Surveillance Coordinator may occasionally be involved in data collection or analyses.

II. Statewide Action Planning Group QM Committee

The Statewide Action Planning Group makes up a portion of the Wisconsin HIV Community Planning Network, Wisconsin's joint prevention and care planning body (http://www.wihiv.wisc.edu/communityplanning/). The Network assists communities and the Wisconsin Division of Public Health in the development, implementation and prioritization of HIV prevention and care services in Wisconsin. The Statewide Action Planning Group (SAPG), which is made up of twenty-five ambassadors who facilitate communication in all five regions of the state, participates in developing a joint HIV prevention and care services plan and advises the Wisconsin AIDS/HIV Program on the development, implementation and prioritization of HIV prevention and care services in Wisconsin.

The SAPG QM Committee was formed in February 2008 and is chaired by, and made up of, SAPG members who work directly with the Quality Assurance Coordinator. The role of this committee is to provide input, advice and expertise on the development and implementation of quality assurance and quality improvement activities related to Ryan White Part B and LCS funded HIV care and treatment services. In addition, these members serve as conduits of quality information to the agencies and communities in which they work. Activities may include:
- Participating in the quality management planning process;
- Assisting with performance measure development and implementation;
- Reviewing and providing input on annual revisions of the quality management plan; and
- Serving as a forum for identifying emerging issues related to the HIV continuum of care and quality improvement activities.

III. Ryan White Part B and LCS Funded Agencies

The quality management role of the funded agencies is to have a plan for monitoring, and to actively monitor, the quality of services they provide. Agencies are contractually obligated to "…develop and implement a quality assurance program to insure that their services meet client needs. This should include strategies to obtain client input regarding services on a regular basis. Strategies should be inclusive and reflective of the diversity of the agency's client population." In addition progress toward workplan objectives are reported twice per year and demographic and utilization data are reported quarterly to the State, and on an annual basis to HRSA via the Ryan White HIV/AIDS Program Annual Data Report (RDR). The agencies receiving Ryan White and LCS funding in 2008 are listed in Appendix C.

IV. Wisconsin Division of Enterprise Services/Bureau of Fiscal Services

The Division of Enterprise Services (DES) provides management support for fiscal services, information technology, personnel, affirmative action, and employment relations. Located within DES, the Bureau of Fiscal Services (BFS) is responsible for all internal fiscal monitoring of federal grants. The Program and Federal Accounting section located within BFS is responsible for the preparation and submission of the Ryan White Financial Status Reports. The Community Aids Reporting System unit, also located in BFS, is responsible for monitoring and processing payments for all contracted agencies. Also housed within DES, the Office of Audit provides coordination of DHFS contract monitoring, audits, and program review processes. Evaluation and Audit staff review A-133 fiscal audits submitted by Ryan White Part B grantees on an annual basis.

V. Health Resources and Services Administration

HRSA's HIV/AIDS Bureau (HAB) is committed to improving the quality of care and services and ultimately the quality of life for PLWH/A. To support grantee quality assurance and QM activities, HRSA provides:

- Technical assistance
- On-line training and resources
- HAB Performance Measures for Adult/Adolescent Clients (Core medical measures released; draft measures for systems, oral health, medical case management and ADAP recently released for comment)
- Site visits
- Program and fiscal monitoring through various reporting requirements

VI. Clients

Client input is a critical piece to delivering high quality services. Client input is obtained through the grievance process, which each funded agency is required to have; client satisfaction surveys and needs assessments; participation on Client Advisory Boards; participation in the Wisconsin AIDS/HIV Community Planning Network and Statewide Action Planning Group; and attendance at conferences for PLWH/A held across the state. In addition, information feedback should be obtained by clients through ongoing communication with providers.

Resources

In fiscal year 2008, 3 % of the total Ryan White budget was allocated for Planning & Evaluation and Quality Management activities. These funds cover, in part, the activities of the Quality Assurance Coordinator, Life Care Services Coordinator, Ryan White Coordinator, and Program Epidemiologist. Because both agencies that receive LCS funding also receive Ryan White Part B funding, all grantee quality activities are covered by the Ryan White funding.

Quality Management resources provided by the following organizations are consulted frequently:

- Health Resources Services Administration HIV/AIDS Bureau (http://hab.hrsa.gov/special/qualitycare.htm)
- National Quality Academy (http://nationalqualitycenter.org/QualityAcademy/)
- Institute for Healthcare Improvement (http://www.ihi.org/IHI/Topics/HIVAIDS/)
- New York State Department of Health AIDS Institute (http://www.hivguidelines.org/Content.aspx)
- Target Center: Technical Assistance for the Ryan White Community (http://careacttarget.org/)

QUALITY GOALS & ACTIVITIES

The primary QM goals are to ensure that:

- Funded services adhere to PHS guidelines, established clinical practice, and user expectations;
- Program improvement includes supportive services linked to access and adherence to medical care; and
- Demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic.

Annual Quality Activities

Ongoing quality assurance and quality management activities are summarized in the tables below. Table 1 describes the quality assurance activities related to monitoring Ryan White Part B and LCS subcontracted agencies, and Table 2 describes quality management activities related to the ADAP, Insurance and Laboratory Reimbursement programs, as well as more broad care and treatment outcomes.

Table 1: Quality Assurance Activities for Ryan White Part B and Life Care Services Funded Agencies in Wisconsin

Quality Activities	State AIDS/HIV Program	Funded Agencies	SAPG QM Committee
Fiscal Monitoring	▪ Review annual Ryan White/LCS budgets ▪ Review monthly expenditure reports to ensure agency spending is on track ▪ Review annual A-133 grantee audits ▪ Review Financial Status Reports and send to HRSA	▪ Ensure that expenditures are allowable by federal and state guidelines ▪ Submit monthly expenditures to CARS program and Ryan White Coordinator for review ▪ Submit annual A-133 audit	
Site Visits	Conduct annual on-site visits with funded agencies to: review expenditures, service performance and quality improvement initiatives, and to provide technical assistance if needed	Prepare necessary documentation for site visit	
Agency Workplans (Service Objectives and Performance Measures)	▪ Develop uniform performance measures for core medical services ▪ Work with agencies to develop performance measures for support services ▪ Review progress against performance measures biannually ▪ Identify areas for improvement and assist agencies in developing quality improvement projects	▪ Develop performance measures for support services ▪ Report progress against performance measures biannually ▪ Monitor performance data internally to identify areas for improvement ▪ Develop quality improvement projects as necessary and monitor success	▪ Participate in group discussions to develop uniform performance measures ▪ Provide feedback on uniform performance measures
Quarterly Utilization Data	▪ Review quarterly utilization data submitted by funded agencies ▪ Enter data in Care & Treatment analysis database ▪ Work with agencies to identify areas for improvement and infrequently utilized programs and assist in implementing quality improvement projects as necessary	▪ Report demographic and utilization data to State for each funded services on a quarterly basis ▪ Review data internally to identify service gaps or areas for improvement ▪ Develop quality improvement projects based on data, as necessary ▪ Work with State to develop programs to address identified service gaps	
Annual Utilization/Quality Data (Ryan White Data Report- RDR)	▪ Review end-of-year agency reports ▪ Communicate questions or errors to agencies for revision ▪ Approve final report prior to uploading to HRSA	▪ Report end-of-year data to HRSA, via the State ▪ Make corrections, as identified by Ryan White Coordinator	

Table 1, continued

Quality Activities	State AIDS/HIV Program	Funded Agencies	SAPG QM Committee
Agency Quality Management Programs	▪ Review agency Quality Management program annually ▪ Review agency Quality Management plans annually ▪ Review quality improvement initiatives and results ▪ Provide technical assistance related to quality, as needed ▪ Carry out activities as described in the state Ryan White Part B/LCS Quality Management Plan; post plan on AIDS/HIV Program website	▪ Funded agencies are contractually obligated to develop and implement a quality assurance program ▪ Conduct internal quality assurance and quality improvement activities ▪ Adhere to state Ryan White Part B/LCS Quality Management Plan	
Case Management Audit	▪ Perform annual audit of client charts to ensure standards of care are being met ▪ Perform chart audits as needed for quality improvement purposes	▪ Practices should adhere to current case management practice standards ▪ Client charts and associated paperwork should reflect services provided	
Case Management Certification	▪ Conduct trainings related to case management certification ▪ Develop case manager trainings based on identified needs or service gaps ▪ Monitor case manager training attendance	▪ Ensure that case managers obtain the training necessary to maintain the certification (note that the case management certification is optional) ▪ Work with case managers to develop weaker skill areas	
Utilize Client Input to Improve Services	▪ Modify agency contracts to require and recommend means of obtaining client input ▪ Provide guidance and resources for effectively obtaining and utilizing client input ▪ Assure mechanisms in place to obtain representative & accurate reflection of client input on services	▪ Contractually obligated to obtain client input ▪ Client input should be used to improve services ▪ Clients should be educated on expectations for agency uses of client input and realistic timeframes for improvement ▪ Client input, and results of input, should be displayed or fed back to service consumers	▪ Participate in the development of guidance for agencies regarding client input ▪ Review aggregate summations of agency's efforts and results related to client input
Technical Assistance	▪ Provide technical assistance to agencies related to quality management programs, written quality management plans, developing and monitoring performance measures and developing quality improvement projects ▪ Facilitate technical assistance directly from HRSA, if necessary	Request technical assistance, as needed	

Table 2: Quality Assurance Activities for Ryan White Funded Programs Administered by the AIDS/HIV Program

Quality Activities	State AIDS/HIV Program	Funded Agencies	SAPG QM Committee
Programs Administered by the AIDS/HIV Program			
Insurance Program	▪ Monitor the process and cost utilization of the insurance premium subsidy program ▪ Provide biennial budget projections for the program		
ADAP Program	▪ Monitor the process and cost utilization of the AIDS Drug Assistance Program ▪ Provide biennial budget projections for the program ▪ Implement cost-saving measures (e.g. HIRSP Pilot Program) ▪ Implement HRSA ADAP Performance Measures, once available		
Laboratory Reimbursement Program	Monitor the process and cost utilization of the Laboratory Reimbursement Program		
Evaluation of QM Plan	▪ Obtain stakeholder input throughout the year on revisions to the quality management program and plan ▪ Develop a draft revision for stakeholder input by January 1 of each year ▪ Finalize revised plan by April 1 of each year ▪ Communicate revised plan to stakeholders	Provide ongoing input on revising the QM plan	▪ Provide ongoing input on revising the QM plan ▪ Review and approve the draft revision of the QM plan
Monitoring Health Outcomes			
Perinatal Transmission Rates	Monitor trends in perinatal transmission rates annually		
HIV-related Hospitalizations/ER	Monitor trends in HIV-related hospitalizations and emergency department visits annually		
Mortality Rate	Monitor trends in HIV-related deaths		
Annual Quality Report	Provide feedback to agencies on results of quality activities	Review report	Review report, aid in dissemination

2008 Quality Priorities

1. Develop the Wisconsin AIDS/HIV Program Ryan White Part B and LCS Quality Management Plan
   Implementation Timeline: draft plan to be finalized by October 2008

2. Develop and implement uniform performance measures for selected service areas
   Implementation Timeline: progress against new performance measures for primary care medical services/medical case management, oral health services and psychosocial case management to be reported starting in October 2008

3. Develop guidance on maximizing client input.
   Implementation Timeline: Contract language modification to be completed by 4/1/2009; guidance and resources on obtaining consumer input to be completed by January 1, 2009.

PERFORMANCE MEASUREMENT

Uniform Performance Measures

The following performance measures will be used to assess the quality of services provided by the Ryan White Part B and LCS sub-contracted agencies starting in 2008. All providers funded for these services will report data on these performance measures twice per year to the Wisconsin AIDS/HIV Program for review. The AIDS/HIV Program recognizes, however, that even when high quality services are provided, client outcomes may not always improve due to external circumstances beyond the provider's control. However, providing high quality services offers the best chance for improved client outcomes.

Detailed descriptions of each measure, including how to calculate each measure and benchmarks, can be found in Appendices D-F.

Primary Medical Care & Medical Case Management

1. Percentage of clients who had two or more CD4 T-cell counts performed during the previous 12 months.
2. Percentage of clients with AIDS who are on HAART.
3. Percentage of clients who had two or more medical visits in an HIV care setting during the previous 12 months.
4. Percentage of clients with a CD4 T-cell count below 200 cells/mm^3 who were taking PCP prophylaxis.
5. Percentage of pregnant women with HIV who were prescribed antiretroviral therapy.

Oral Health Care (DRAFT Measures)

1. Percentage of clients with an updated health history assessment.
2. Percentage of clients with an annual periodontal exam.

3. Percentage of clients with an annual intra-oral exam.
4. Percentage of clients with an annual extra-oral exam.

Psychosocial Case Management

1. Percentage of active clients with a current assessment on file.
2. Percentage of active acuity level 1, 2 and 3 clients with a current service plan on file.
3. Percentage of new/re-admitted clients with service plan completed within 7 days of assessment.
4. Percentage of clients with a recent medical appointment in an HIV care setting.
5. Referral follow-up (Measure to be developed)

Agency-Developed Performance Measures

For all other funded services (mental health, substance abuse and support services), agencies will develop their own performance measures and submit progress against the measures twice per year. The Quality Assurance Coordinator will work with agencies to ensure that agency-developed performance measures are acceptable quality indicators. Progress against performance measures is monitored and assessed by the AIDS/HIV Program's care and treatment staff.

In addition, the overall quality of care and treatment services for persons living with HIV will be assessed by monitoring the health outcomes described in Table 2.

Use of Performance Data

Currently performance data are used to assess agency compliance with written standards and/or user expectations and to identify any areas for improvement. Progress against performance measures is reviewed by the Quality Assurance, Ryan White, and Life Care Services Coordinators. Questions or concerns regarding the submitted data are discussed with agencies during the annual site visit and/or via direct communication with the agency. In some cases, sub-standard compliance with performance measures may result in a corrective action plan and/or co-development of quality improvement activities.

In addition, performance data are used to support:

- Development of the Statewide Coordinated Statement of Need ,
- Development of the Wisconsin AIDS/HIV Program's Comprehensive Plan,
- Statewide Action Planning Group planning and decision-making activities,
- Contract monitoring activities,
- Agency-led quality monitoring and quality improvement initiatives,
- Client concerns regarding service quality, and
- Funding decisions

CAPACITY BUILDING

Activities that build capacity to understand and conduct quality management, quality assurance, and quality improvement initiatives are available for AIDS/HIV Program staff as well as the Ryan White Part B and LCS grantees. Capacity building for Program staff include:

- Technical assistance via the HRSA Target Center and the National Quality Center
- Self-study QM tutorials through the National Quality Center's Quality Academy
- Data management technical assistance through John Snow, Inc. (http://www.datachatt.jsi.com/)
- Staff attendance at HRSA sponsored grantee meetings

Capacity building activities for grantees include:

- Written standards and policies (e.g. Psychosocial Case Management Standards, Client Advisory Board Guidance)
- CAREWare training and technical assistance
- Wisconsin HIV/AIDS Training System (http://www.wihiv.wisc.edu/trainingsystem/)
- Psychosocial Case Management Certification Program
- Site visits
- Local and HRSA All Parts Meeting
- Technical assistance
- Access to National Quality Center and similar on-line quality resources
- AIDS/HIV Program Notes

EVALUATION

Evaluation of the current quality management program will consist of the following:

- Annual revision of the quality management plan and priorities,
- Ongoing review of performance measures, especially as HRSA's HIV/AIDS Bureau releases recommended performance measures, and
- Ongoing incorporation of agency and other stakeholder feedback (e.g. SAPG QM Committee, clients, other interested stakeholders)

QUALITY MANAGEMENT PLAN UPDATES

Based upon ongoing communication with each of the key quality stakeholders mentioned in the Quality Infrastructure section, the Quality Assurance Coordinator will create a draft revision of the Quality Management plan, if necessary, by February 1 of each year. This draft will be circulated to AIDS/HIV Program staff, to the SAPG QM Committee, and to the Ryan White Part B and LCS funded agencies for input. The final revision will be completed by April 1st to correspond with the start of the new Ryan White and LCS grant years.

COMMUNICATION

The updated quality management plan will be sent to sub-contracted agencies each year. Data gathered from quarterly reporting, performance measure reporting, and health outcomes monitoring may be aggregated and sent to agencies annually via an end-of-grant-year quality report. In addition, quality information will be reported in the AIDS/HIV Program Notes and to

the Statewide Action Planning Group, it will be mentioned in the grantee contracts, and posted on the AIDS/HIV Program Website (http://dhs.wisconsin.gov/aids-hiv/index.htm)

APPENDIX A: Description of Ryan White and Life Care Services Funding

Ryan White Funding

The federal Health Resources and Services Administration (HRSA) is the major source of federal funding, other than Medicaid, which supports HIV care and treatment services in Wisconsin. The HIV/AIDS Bureau administers the Ryan White HIV/AIDS Program under the following Parts:

- Part A provides grants to Eligible Metropolitan Areas and Transitional Grants Areas that are most severely affected by the HIV/AIDS epidemic. To be an eligible EMA, an area must have reported at least 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000. In order to be eligible for a TGA, an area must have reported at least 1,000 - 1,999 new AIDS cases in the most recent five years. Part A funds may be used to provide a continuum of care for persons living with HIV disease with a requirement to provide 75 percent of the award for core medical services and 25 percent for support services. (Wisconsin is not eligible for Part A funding).
- Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP Supplemental grants and grants to States for Emerging Communities-those reporting between 500 and 999 cumulative reported AIDS cases over the most recent 5 years. All funding is distributed via formula and other criteria. Part B funds may be used to provide a continuum of care for persons living with HIV disease with a requirement to provide 75 percent of the award for core medical services and 25 percent for support services.
- Part C provides grants directly to organizations that provide comprehensive primary health care in an outpatient setting for people living with HIV disease. Part C also funds planning grants, which support organizations in more effectively delivering HIV/AIDS care and services and capacity development grants to enhance a grantees capacity to develop, strengthen, or expand access to high quality HIV primary health care services for people living with HIV or who are at risk of infection in underserved or rural communities and communities of color.
- Part D provides family centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, and youth with HIV/AIDS. Grantees are expected to provide care, treatment, and support services or create a network of medical and social service providers, who collaborate to supply services. Funded services include family-centered primary and specialty medical care, support services and logistical support and coordination. In addition grantees are to educate clients about research and research opportunities and inform all clients about the benefits of participation, and how to enroll in research.
- Part F funds special demonstration projects, AIDS Education and Training Centers which support education and training of health care providers, dental programs, and Minority AIDS Initiative grants which provide funding to evaluate and address the disproportionate impact of HIV/AIDS on women and minorities.

Life Care Services Funding

The Mike Johnson Life Care Services and Early Intervention Services (LCS) grant funds programs for persons living with HIV disease. These programs are funded by the Division of Public Health with state general purpose revenue (GPR) dollars and have historically been allocated to state-designated AIDS Service Organizations (ASOs). The Division contracts with ASOs to provide these programs directly or through subcontracts with other community service providers in their respective regions. Currently, there are two ASOs in Wisconsin: AIDS Network which provides services for the southern region; and the AIDS Resource Center of Wisconsin (ARCW) which is responsible for service provision in the other four regions of the state. The funding guidelines for the LCS grant are similar to the Ryan White Part B guidance, without the requirement to provide 75 percent of the award for core medical services. Traditionally, the majority of the funds have been used for psychosocial case management and other support services.

APPENDIX B: AIDS/HIV Care and Treatment Staff Contact Information

Title	Name	Contact Information
ADAP Coordinator	Kathleen Rogers	608-267-6875 kathleen.rogers@wisconsin.gov
Care and Treatment Supervisor	Michael McFadden	608-266-0682 michael.mcfadden@wisconsin.gov
Director, AIDS/HIV Program	Dr. James Vergeront	608-266-9853 james.vergeront@wisconsin.gov
Epidemiologist	Neil Hoxie	608-266-0998 neil.hoxie@wisconsin.gov
Insurance Program Coordinator	Vacant	(Contact Care and Surveillance Supervisor)
Life Care Services Coordinator	Leslie Anderson	608-261-8372 leslie.anderson@wisconsin.gov
Program Assistant	Terrie McCarthy	608-267-5287 terrie.mccarthy@wisconsin.gov
Quality Assurance Coordinator	Casey Schumann	608-266-3495 casey.schumann@wisconsin.gov
Ryan White Coordinator	Mari Ruetten	608-261-6397 mari.ruetten@wisconsin.gov
Surveillance Coordinator	Wendy Schell	608-266-2664 wendy.schell@wisconsin.gov

APPENDIX C: 2008 Ryan White Part B and LCS Funded Agencies

Funding for each agency by Ryan White (RW) part and/or the Mike Johnson Early Intervention and Life Care Services (LCS) grant is indicated below.

Agency	LCS	RW Part B	RW Part C	RW Part D	RW Part F
AIDS Network	X	X			
AIDS Resource Center of WI (ARCW)	X	X	X		X
Comprehensive Health Education		X			
Healthcare for the Homeless		X			
Legal Aid Society		X			
Medical College of Wisconsin, Department of Infectious Disease		X			
Medical College of Wisconsin, Department of Pediatrics, Infectious Diseases Section, WI HIV Primary Care Support Network		X		X	
Milwaukee Health Services		X	X		
New Concept Self Development Center		X			
Sixteenth Street Community Health Center		X	X		
United Migrant Opportunity Services (UMOS)		X			
University of Wisconsin HIV Clinic		X	X		

APPENDIX D: Primary Care and Nurse Case Management Performance Measures

INDICATOR #1: CD4 T-CELL COUNT

Performance Measure: Percentage of clients who had two or more CD4 T-cell counts performed during the previous 12 months

Calculation of Performance Measure:

$$\frac{\text{\# of clients with 2 or more documented CD4 T-cell counts in previous 12 months}}{\text{\# of clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients who had 2 or more CD4 T-cell counts documented during the previous 12 months

- At least one CD4 count should have a date during the first 6 months of the reporting period, and one CD4 count should have a date during the second 6 months of the reporting period, per HIVQUAL guidelines.

Denominator: Number of clients who had at least one medical visit with a provider who is certified to prescribe ARV therapy (e.g. MD, PA, NP) during the previous 12 months.

- May exclude clients newly enrolled in care during the last six months of the reporting period

Proposed Benchmark: 90%

Reference: HAV HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1 @ http://hab.hrsa.gov/special/habmeasures.htm

Reporting Timeframe:

- October 15th 2008 report covers client visits dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers client visits dated April 1, 2008 – March 31, 2009

INDICATOR #2: HAART THERAPY

Performance Measure: Percentage of clients with AIDS who are on HAART

Calculation of Performance Measure:

$$\frac{\text{\# of AIDS clients who are on HAART}}{\text{\# of AIDS clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients with AIDS who were newly prescribed, or are continuing, HAART during the previous 12 months

Denominator: Number of clients who have a diagnosis of AIDS and had at least one medical visit with a provider who is certified to prescribe ARV therapy (e.g. MD, PA, NP) during the previous 12 months.

- Diagnosis of AIDS is a history of a CD4 T-cell count below 200 cells/mm^3 or other AIDS-defining conditions
- May exclude clients newly enrolled in care during the last 3 months of the reporting period

Proposed Benchmark: 90%

Reference: HAV HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1 @ http://hab.hrsa.gov/special/habmeasures.htm

Reporting Timeframe:

- October 15th 2008 report covers client visits dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers client visits dated April 1, 2008 – March 31, 2009

INDICATOR #3: MEDICAL VISITS

Performance Measure: Percentage of clients who had two or more medical visits in an HIV care setting in the previous 12 months.

Calculation of Performance Measure:

$$\frac{\text{\# of clients with at least 2 visits during the previous 12 months}}{\text{\# of clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients with a medical visit with a provider who is certified to prescribe ARV therapy (e.g. MD, PA, NP) two or more times during the previous 12 months.

- At least one visit should have a date of service during the first 6 months of the reporting period, and one visit should have a date of service during the second 6 months of the reporting period, per HIVQUAL guidelines.

Denominator: Number of clients who had at least one medical visit with a provider who is certified to prescribe ARV therapy (e.g. MD, PA, NP) during the previous 12 months.

- May exclude clients newly enrolled in care during the last six months of the reporting period

Proposed Benchmark: TBD

Reference: HAV HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1 @ http://hab.hrsa.gov/special/habmeasures.htm

Reporting Timeframe:

- October 15th 2008 report covers client visits dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers client visits dated April 1, 2008 – March 31, 2009

INDICATOR #4: PCP PROPHYLAXIS

Performance Measure: Percentage of clients with a CD4 T-cell count below 200 cells/mm^3 who were taking PCP prophylaxis

Calculation of Performance Measure:

$$\frac{\text{\# of clients who were taking PCP Prophylaxis with CD4 T-cell count} < 200\ \text{cells/mm}^3}{\text{\# of clients with at least 1 visit in previous 12 months and a CD4 T-cell count} < 200\ \text{cells/mm}^3}$$

Numerator: Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed, or are continuing, PCP prophylaxis during the previous 12 months

Denominator: Number of clients who had at least one medical visit with a provider who is certified to prescribe ARV therapy (e.g. MD, PA, NP) during the previous 12 months AND who had a CD4 T-cell count below 200 cells/mm^3

- May exclude clients with CD4 T-cells counts below 200 cells/mm^3 repeated within 3 months rose above 200 cells/mm^3
- May exclude clients newly enrolled in care during the last 3 months of the reporting period

Proposed Benchmark: 95%

Reference: HAV HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1 @ http://hab.hrsa.gov/special/habmeasures.htm

Reporting Timeframe:

- October 15th 2008 report covers client visits dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers client visits dated April 1, 2008 – March 31, 2009

INDICATOR #5: ARV THERAPY FOR PREGNANT WOMEN

Performance Measure: Percentage of pregnant women with HIV who are prescribed antiretroviral therapy

Calculation of Performance Measure:

$$\frac{\text{\# of pregnant clients who were prescribed HAART during } 2^{nd} \text{ and } 3^{rd} \text{ trimester}}{\text{\# of pregnant clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of pregnant women who were prescribed (or continuing) antiretroviral therapy during the 2nd and 3rd trimester

Denominator: Number of pregnant women who had at least one medical visit with a provider with prescribing privileges (e.g. MD, PA, NP) during the previous 12 months

- May exclude clients who are in the 1st trimester and newly enrolled in care during the last 3 months of the measurement year
- May exclude clients whose pregnancy is terminated

Proposed Benchmark: TBD

Reference: HAV HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1 @ http://hab.hrsa.gov/special/habmeasures.htm

Reporting Timeframe:

- October 15th 2008 report covers client visits dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers client visits dated April 1, 2008 – March 31, 2009

APPENDIX E: Draft Oral Health Performance Measures

INDICATOR #1: ANNUAL HEALTH HISTORY ASSESSMENT

Performance Measure: Percentage of clients with an updated health history assessment

Calculation of Performance Measure:

$$\frac{\text{\# of clients with an updated health history assessment}}{\text{\# of clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients with a documented health history assessment taken within the previous 12 months

- Health history assessment includes contact information for a primary care provider and whether the client is receiving care; current medications and changes in regimen; allergies (baseline); laboratory data including CBD, hepatitis B & C status (baseline) and CD4 and viral load results

Denominator: Number of clients with at least 1 oral health visit within the previous 12 months

Proposed Benchmark: TBD

Practice Standard Reference: From New York Part A Quality Performance Indicators for Oral Health (http://www.hivguidelines.org/Content.aspx?pageID=45)

Reporting Timeframe:

- October 15th 2008 report covers health history assessments and visits dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers health history assessments and visits dated April 1, 2008 – March 31, 2009

INDICATOR #2: ANNUAL PERIODONTAL EXAM

Performance Measure: Percentage of clients with an annual periodontal exam

Calculation of Performance Measure:

$$\frac{\text{\# of clients with an annual periodontal exam}}{\text{\# of clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients with a documented periodontal exam with a date of service during the previous 12 months

- Periodontal exam requires documentation of any one of the following: examination of pocket depths, gingival inflammation, plaque index, fremitus, recession, bleeding assessment, or tooth mobility

Denominator: Number of clients with at least 1 oral health visit within the previous 12 months

Proposed Benchmark: TBD

Practice Standard Reference: From New York Part A Quality Performance Indicators for Oral Health (http://www.hivguidelines.org/Content.aspx?pageID=45)

Reporting Timeframe:

- October 15th 2008 report covers exams dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers exams dated April 1, 2008 – March 31, 2009

INDICATOR #3: ANNUAL INTRA-ORAL EXAM

Performance Measure: Percentage of clients with an annual intra-oral exam

Calculation of Performance Measure:

$$\frac{\text{\# of clients with an annual intra-oral exam}}{\text{\# of clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients with a documented intra-oral exam with a date of service during the previous 12 months

- Intra-oral exam requires documentation of dental caries screening and soft tissue examination (soft tissue examination requires documentation of any one of the following: pathology of cheeks, tongue, palate, gingiva, mucosa, pharynx, frenum or floor of mouth)

Denominator: Number of clients with at least 1 oral health visit within the previous 12 months

Proposed Benchmark: TBD

Practice Standard Reference: From New York Part A Quality Performance Indicators for Oral Health (http://www.hivguidelines.org/Content.aspx?pageID=45)

Reporting Timeframe:

- October 15th 2008 report covers exams dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers exams dated April 1, 2008 – March 31, 2009

INDICATOR #4: ANNUAL EXTRA-ORAL EXAM

Performance Measure: Percentage of clients with an annual extra-oral exam

Calculation of Performance Measure:

$$\frac{\text{\# of clients with an annual extra-oral exam}}{\text{\# of clients with at least 1 visit in previous 12 months}}$$

Numerator: Number of clients with a documented extra-oral exam with a date of service during the previous 12 months.

- Extra-oral exam requires documentation of any one of the following: examination of facial symmetry, lymph nodes, thyroid glands, or lips

Denominator: Number of clients with at least 1 oral health visit within the previous 12 months

Proposed Benchmark: TBD

Practice Standard Reference: From New York Part A Quality Performance Indicators for Oral Health (http://www.hivguidelines.org/Content.aspx?pageID=45)

Reporting Timeframe:

- October 15th 2008 report covers exams dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers exams dated April 1, 2008 – March 31, 2009

APPENDIX F: Psychosocial Case Management Performance Measures

INDICATOR #1: CURRENT ASSESSMENT

Performance Measure: Percentage of active clients with a current assessment on file.

Calculation of Performance Measure:

$$\frac{\text{\# of active clients with a current assessment}}{\text{\# of active clients in the database}}$$

Numerator Description: Number of active clients with a current assessment of file

- "Current" is defined as having an assessment dated within the 12 months prior to the report.
- The date of the most recent assessment should be evaluated for **all** clients in the database regardless of whether they have been seen during the reporting period. This allows you to identify clients who are due for re-assessment or who are lost to care.

Denominator Description: Number of active clients in the database.

- Include all active clients in the database regardless of whether they have been seen during the reporting period.

Benchmark: 90%

Practice Standard Reference: **Standard 3.2.5 Reassessment**
The client is reassessed and reevaluated through a formal reassessment process. Reassessment is conducted on a regularly scheduled basis, either annually or when unanticipated events or changes take place in the client's life (e.g., event-precipitated, recent hospitalization or loss of psychosocial support system). (2003 WI Psychosocial Case Management Practice Standards)

*Note that this measure only captures whether a client was recently assessed and does not capture the duration of time between assessments. The span of time between assessments will be reviewed by the state during the annual chart review process.

Reporting Timeframe:

- October 15th 2008 report covers assessments dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers assessments dated April 1, 2008 – March 31, 2009

INDICATOR #2: CURRENT SERVICE PLAN

Performance Measure: Percentage of active clients with a current service plan on file.

Calculation of Performance Measure:

$$\frac{\text{\# of active acuity 1-3 clients with a current service plan}}{\text{\# of active acuity 1-3 clients in the database}}$$

Numerator Description: Number of active acuity-level 1, 2 and 3 clients with a current service plan on file.

- "Current" is defined as having a service plan dated within the 12 months prior to the report.
- The date of the most recent service plan should be evaluated for **all** clients in the database regardless of whether they have been seen during the reporting period. This allows you to identify clients who are due for an updated service plan or who are lost to care.

Denominator Description: Number of active acuity level 1, 2 and 3 clients in the database.

- Include all active acuity level 1, 2 and 3 clients in the database regardless of whether they have been seen during the reporting period.

Benchmark: 90%

Practice Standard Reference: **Standard 3.2.5 Reassessment**
Clients are reevaluated or readmitted through a formal reassessment process that determines the client's case management status and the need for revisions in the service plan. (2003 WI Psychosocial Case Management Practice Standards)

* Note that this measure only captures whether a client has a recently developed service plan and does not capture the duration of time between service plans. The span of time between service plans will be reviewed by the state during the annual chart review process.

Reporting Timeframe:

- October 15th 2008 report covers service plans dated October 1, 2007 – September 31, 2008
- April 15th 2009 report covers service plans dated April 1, 2008 – March 31, 2009

INDICATOR #3: TIMELY SERVICE PLAN DEVELOPMENT

Performance Measure: Percentage of new/re-admitted clients with a service plan completed within 7 days of assessment.

Calculation of Performance Measure:

$$\frac{\text{\# of new/re-admitted clients seen during the reporting period with a timely service plan}}{\text{\# of new and re-admitted clients seen during the reporting period}}$$

Numerator Description: Number of new/re-admitted clients **served** during the reporting period with a service plan completed within 7 days of the initial assessment.

- Both new and re-admitted clients should be assessed.

Denominator Description: All new clients seen during the reporting period.

- Both new and re-admitted clients should be assessed.

Benchmark: 90%

Practice Standard Reference: **Standard 3.2.3 Service Plan Development**
Within 7 working days following assessment, a client service plan is established by the designated case manager and recorded in the client record. (2003 WI Psychosocial Case Management Practice Standards)

Reporting Timeframe:

- October 15th 2008 report covers new service plans dated April 1, 2008 – September 31, 2008 (1st 6 months of Ryan White Part B grant year)
- April 15th 2009 report covers new service plans dated April 1, 2008 – March 31, 2009 (Entire Ryan White Part B grant year)

INDICATOR #4: ENGAGING CLIENTS IN MEDICAL CARE

Performance Measure: Percentage of clients with a recent medical appointment in an HIV care setting

This measure will **not be reported as part of your workplan because it is already included in the psychosocial case management attachment that is part of your quarterly report.

The medical standard is that clients have at least 2 visits per year with their primary HIV provider, and therefore most clients in your quarterly report should be listed in row 1 of the table below.

5. Last Medical Care Visit	Male	**Female**	Transgender	**Unknown/ Unreported**	Total
In last 6 months					
6 months - 1 year					
No visit in the last 12 months					
Unknown/ Unreported					

Benchmark: 85%

Reporting Timeframe:

Quarterly Report Schedule:

- **October 15th 2008 report covers July 1, 2008 – September 31, 2008**
- **January 15th 2009 report covers October 1, 2008 – December 31, 2008**
- **April 15th 2009 report covers January 1, 2009 – March 31, 2009**
- **July 15th 2009 report covers April 1, 2009 – June 31, 2009**

INDICATOR #5: REFERRAL FOLLOW-UP

To be added once the measure has been fully developed. In the meantime, referral follow-up practices and documentation should be changed as necessary to ensure that **reporting** can occur starting with the **April 15, 2009** report.

APPENDIX G: Wisconsin Acuity Index

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
DPH 42014 (01/10)

STATE OF WISCONSIN
AIDS/HIV PROGRAM

WISCONSIN ACUITY INDEX

This form is issued under 252.12 (2) (a) 8 WI. Stats. Personally identifiable information is collected to assist HIV case managers in planning and coordinating services for persons with HIV infection (and will be used only for that purpose). Completion of this assessment is voluntary however to determine case management eligibility and service level an acuity score is necessary. This assessment must be completed on an annual basis for Acuity Level 1 and 2 clients, every 180 days for Acuity Index Level 3 clients, and/or as life circumstances change.

GENERAL INFORMATION

Client Name	Client ID Number	Date of Completion
Case Manager Name	Agency Name	
Expiration Date *(maximum 12 months from Date of Completion)*		

HIV RELATED MEDICAL (*weighted*)

Category	**Level 0** (0 pts.)	**Level 1** (3 pts.)	**Level 2** (6 pts.)	**Level 3** (9 pts.)
HIV Disease Progression ☐	Asymptomatic and non-AIDS defined; "Non-progressor"	Non-AIDS defined but progressing; On medications with undetectable status for 6 mo. AIDS diagnosis received > 2 years ago, medically stable (non-symptomatic)	Newly diagnosed but medically stable; AIDS diagnosis received within past 2 years; Currently symptomatic	Newly diagnosed and symptomatic ("late tester"); Newly accessing services; Rapid disease progression; Numerous or rapidly changing HIV related medical needs
Current Medical Health Status ☐	Medically stable; No co-infections requiring on-going treatment	Chronic conditions other than HIV that are under control with medication and treatment; Presence of acute co-infections that are being treated	Multiple medical co-morbidities requiring treatment; Client non-compliant or sporadically compliant with treatment; Presence of acute untreated co-infections; Needs 10 hrs/week or less of in home ADL assistance	In hospice care; Pregnant or recently delivered (1 year); Recent HIV related hospitalization (90 days); Needs greater than 10 hrs/week of in home ADL assistance; Requires assisted living; Crisis involving non-HIV-related health problem

CORE SERVICES *(weighted)*

Category	**Level 0** (0 pts.)	**Level 1** (2 pts.)	**Level 2** (4 pts.)	**Level 3** (6 pts.)
Adherence and Knowledge ☐	Verbalizes clear understanding about HIV disease; Aware of treatment complexities and service availability; Strong self-advocacy skills (w/ providers); Keeps medical appointments as scheduled;	Requires minimal follow-up for information and referral; Keeps majority of medical appointments; Adherent to medications for more than 3 months but less than 6 months; Moderate self-advocacy skills (w/ providers);	Little understanding about HIV disease and treatment; Poor self-advocacy skills (w/ providers); Regularly misses 50% of medical appointments; Adherent to medications only with regular, on-going	Ignorant about HIV disease, treatments and services; Non-adherent to medications and/or appointments despite assistance; Refuses/declines medications against medical advice; Demonstrated denial about diagnosis

	Treatment adherent for more than 6 months; Not currently being prescribed medication	Demonstrates some understanding of HIV disease	assistance; Misses several doses of scheduled weekly meds; Needs counseling or referral to make informed decisions about health	
Oral Health ☐	All client dental needs are being met (routine cleanings every 6 months and restorative care)	Client is engaged in dental care at least 1 time per year and 75% of dental needs are being met	Client has not been engaged in dental care for more than 1 year; Client currently engaged in complex restorative dental plan; Client refuses dental intervention despite lack of recent engagement in care; Sporadic compliance with care plan	Emergency dental services required; Client refuses dental intervention against medical advice
Mental Health ☐	Client has sufficient support services outside of case management; No history of mental illness or use of psychotropic medications	Requires minimal emotional support; Non-symptomatic or successfully treated condition; Engaged in treatment and compliant; Actively seeks structured support systems; Past history of mental illness of use of psychotropic medications	History of on-going mental illness and/or use of psychotropic medications; Requires significant emotional support; Has trouble getting along with others; Sporadic engagement in treatment or treatment unsuccessful	Active crisis occurring; Therapy required/recommended but not accessed; Suspected need for treatment but client denies referral despite significant interference in daily activities; Significant trouble with socialization
Substance Abuse ☐	No current or history of substance abuse issues	Current use with minimal functioning impairment; Greater than 1 year sobriety and actively involved in relapse prevention	Current use that affects activities of daily living; Less than 1 year sobriety; Inconsistent or unsuccessful treatment; Immediate family member with substance abuse issues	Active substance abuse causing significant functioning impairment; Indifference regarding consequences of substance abuse; Disconnected from or no motivation to seek treatment against medical advice
Medical Benefits and Insurance ☐	Adequate health insurance; Does not require assistance in securing or maintaining benefits Requires only sporadic assistance with benefits procurement	Requires minimal assistance to achieve and maintain adequate benefits; Limited gaps in service coverage	Requires significant assistance to secure and maintain benefits; Health insurance inadequate resulting in significant gaps in service (e.g. Ryan White Part C client with no comprehensive insurance coverage)	No insurance coverage resulting in limited service access and/or infrequent medical care; Insurance with high co-payments and deductibles preventing client from engaging in regular care; Ineligible for insurance and/or benefits

Housing ☐	Stable and affordable independent housing	Has section 8 voucher or HOPWA assistance; Stable subsidized housing for greater than 1 year; Currently institutionalized; Not independent but *not* seeking alternative	Transitional housing; Not independent but actively seeking alternative; Not stably housed for at least 1 year; Imminent eviction or uninhabitable home	Homeless, evicted, no place to stay; Temporary shelter; Recently released from institution

SUPPORTIVE SERVICES *(un-weighted)*

Category	**Level 0** (0 pts.)	**Level 1** (1 pts.)	**Level 2** (2 pts.)	**Level 3** (3 pts.)
Nutrition ☐	No need for nutritional intervention	Client has nutritional needs that are being met and client is stable; Nutritional status has minimal affect on heath	Client has nutritional needs that are not being addressed and health is significantly affected by nutritional status; Diabetic engaged in treatment	Patient or doctor report of wasting; Significant observed or reported weight loss or gain in past 3 months; Nutritional status is profoundly affecting health; Untreated diabetes
Income and Entitlements ☐	Income stable and sufficient; Able to complete assistance applications and manage benefits independently; Able to meet monthly financial obligations	Needs minimal assistance to access and apply for benefits; Successfully accessing food and other benefits programs	Source of income is in jeopardy; Frequently needs financial assistance or awaiting outcome of benefits application; Has only short term benefits	No income and no application for benefits; Cannot cover monthly financial obligations; Ineligible for benefits; Unfamiliar with application process and/or unable to apply without assistance; Immediate need for financial assistance
Transportation ☐	Has own means of transportation consistently available; Can afford and is comfortable with using public or private transportation	Inconsistent transportation; Unreliable transportation; Has access to transportation with occasional assistance	Frequently accessing transportation assistance in order to receive services (more than 3 times per month)	No public or private transportation available (rural area) or client is uncomfortable using it; Lack of transportation prevents access to services
Legal ☐	No legal issues	No legal problems but has not completed standard legal documents (POA, Living Will, Permanency Planning, etc.)	Pending legal issues; Probation; Bankruptcy; Child-support issues	Crisis involving legal system; Undocumented immigrant

Culture/Language/ Access to Care ☐	Regular and reliable communication between service provider; English-speaking; Literate	Requires minimal assistance in navigating system; English-speaking or reliable interpreter services available; Low to medium level of literacy; Client is blind/visually impaired and/or deaf/ hard of hearing but can access services independently or with minimal assistance	Requires more intensive assistance to navigate system; Low literacy level; Client/Family in need of culturally specific HIV education and/or interpretation; Inconsistent interpretation services available; Client is blind/visually impaired and/or deaf/ hard of hearing and requires regular assistance to access care	Non-English speaker with no access to interpreter services; Multiple language/cultural barriers that inhibit access to care and require intensive intervention; Illiterate; Inconsistent and limited communication between service provider and client; Client is blind/visually impaired and/or deaf/ hard of hearing and has great difficulty accessing services
Children and Dependents ☐	Stable; No dependents	Limited assistance with dependents/children required; Occasional child care/respite needs	On-going child care/day care needs; Grief, transition care, therapeutic intervention needed; Client is a minor and aware of HIV status; Child abuse suspected but no evidence	Involvement of Child Protective Services; Active crisis involving dependent(s); Client is a minor child and unaware of status; Single parent without support system
Social Support ☐	Supportive significant other, friends and family are aware of client's HIV status	Regular/periodic access to support network (church, support groups, AA, etc.); Occasionally requires emotional support from case manager	Inconsistent or no dependable support system; Few individuals aware of client's HIV status; Suspected abuse by support person; Regularly requires emotional support from case manager	Recent loss of primary emotional support; Absent, overburdened or poor support system; Have not disclosed status outside of care providers; Support person is abusive

ACUITY INDEX SCORING

1. ☐ HIV Disease Progression
2. ☐ Current Medical Health Status
3. ☐ Adherence and Knowledge
4. ☐ Oral Health
5. ☐ Mental Health
6. ☐ Substance Abuse
7. ☐ Medical Benefits/Insurance
8. ☐ Housing
9. ☐ Nutrition
10. ☐ Income and Entitlements
11. ☐ Transportation
12. ☐ Legal
13. ☐ Culture/Language/Access to Care
14. ☐ Children and Dependents
15. ☐ Social Support

☐ **Total Acuity Index**

TOTAL ACUITY	FREQUENCY OF CONTACTS AND SERVICE REQUIREMENTS
0-12	**SERVICE LEVEL 0** ***Brief Services/Non-Case Managed;*** Only r*eactive* contact required; eligibility for services should be re-evaluated at a minimum annually if client is accessing services
13-31	**SERVICE LEVEL 1** Minimal *proactive* contact required; Quarterly direct client contact; Annual in-person assessment required; minimum annual Acuity Index review; biannual review of service plan by case manager; annual supervisory review of service plan; limited care coordination required.
32-49	**SERVICE LEVEL 2** Moderate *proactive* contact required; Monthly direct client contact; Annual in-person assessment required; minimum annual Acuity Index review; quarterly review of service plan by case manager; bi-annual supervisory review of service plan; significant care coordination required.
50-75	**SERVICE LEVEL 3** Intensive proactive contact required; Twice monthly direct client contact; Twice annual in-person assessment required; minimum annual Acuity Index Review; quarterly review of service plan by case manager; bi-annual supervisory review of service plan; Intensive care coordination required.

SCORE JUSTIFICATION AND SUPERVISORY REVIEW

Scoring Exceptions

An automatic adjustment to service Level 3 will occur under the following circumstances:

a. HIV-related hospitalization within the past 90 days or currently in hospice care

b. Currently homeless *(without shelter, living in a shelter and/or chronically homeless)*

c. Mental Health and/or AODA crisis occurring

d. Persistently low CD4 and high Viral Load counts due to non-adherence *(per case manager discretion)*

Justify any adjustments to the Acuity Index based on client input and/or case manager observation below:

____

____

____

____

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☐ **Client Service Level (0-3)**   ☐ **Eligible for Case Management (Y/N)**

Case Manager Signature:	Date
Case Management Supervisor Signature:	Date

Case Management Supervisor Comments:

APPENDIX H:
Release of Information Guidance
(*in development*)

APPENDIX I:
Sample Policy & Procedure Document

Policy Title: Eligibility Criteria and Enrollment Procedures for HIV Case Management

Statement of Purpose: The purpose of this policy is to ensure that consumers have equal access to case management services based on the established eligibility criteria. It also ensures that each consumer will encounter the same steps in order to enroll for the service and that case management staff will appropriately document all stages of this process and supervisor will ensure that each staff member is knowledgeable about the policy and its implementation.

Date of Implementation: January 1, 2008

Reviewed: January 1, 2009

Staff Responsible for Implementing Policy: Case Management staff

Staff Responsible for Enforcement: Case Manager Supervisor

<u>Policy</u>

It is the policy of Agency A that in order for a consumer to receive case management services they must meet the following criteria:

- HIV Positive Diagnosis
  Appropriate documentation includes: reactive HIV antibody test lab form with consumer's name on it; CD4 and Viral Load lab test results with consumer name on it; HIV Verification Form with certifying physician signature present.

- Resident of Wisconsin
  Appropriate documentation includes: Current Driver's License or other picture ID with Wisconsin address; Utility bill issued within past 30 days with current address listed; Current lease agreement.

- Income below 300% of Federal Poverty Limit based on current guidelines issued according to family size
  Appropriate documentation includes: 2 pay check stubs from past 6 months; most recent tax return; Written and signed statement attesting to no income and how consumer is meeting daily living requirements; Letter from employer stating the amount of current wages.

- Acuity Score Level of 1 or higher
  If consumer acuity is less than Level 1, the consumer does not qualify for case management services.

<u>Procedures</u>

Step 1: Case Management staff conducts an intake and assessment that includes Acuity Scale Index measurement in accordance with established policies and time frames.

Step 2: Eligibility is verified by the collection of appropriate documentation which is placed in permanent consumer record.

Step 3: Consumer is offered case management services and informed about requirements for continued service including provision of all necessary forms (Rights and Responsibilities, Confidentiality, Consent to Enroll and Release of Information).

Step 4: If consumer accepts services, case manager should be assigned within 3 working days. If consumer denied service, they should be informed of their option to enroll at any point in the future pending continued eligibility.

Step 5: Consumer should be documented as actively enrolled in case management services.

APPENDIX J: Standardized Forms & Instructions

(*to be issued 04/01/2010*)