

HIV Medical Case Management: Practice Standards and Administrative Guidelines

Wisconsin AIDS/HIV Program
Bureau of Communicable Diseases
Division of Public Health



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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 living with HIV in Wisconsin. The focus of their efforts was defining HIV 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 people with HIV infection. The workgroup developed administrative guidelines that identified 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 people 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 client need through the use of a newly developed acuity scale.

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 standardized forms used for assessment and service plan development.

In 2014, the Wisconsin AIDS/HIV Program established a workgroup tasked with creating the state's first set of medical case management standards. The process and tools developed in the *Practice Standards and Administrative Guidelines for HIV-Related Case Management* served as the foundation for this process.

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

Allison Kelly
Barbara Cuene
Cheryl Thiede
Crystal Collins
Dan Leamy
Dawn Socha

Emma Fashing
Ericka Sinclair
Graciela Fendt
Joanna Woodbury
Julia Blotz
Laura Johnson

Liz Alverio
Rachel Luzbetak
Roma Hanson
Veralyn Prillaman

The standards are available electronically on the Wisconsin AIDS/HIV Program website: <https://www.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 608-266-1288.

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INTRODUCTION

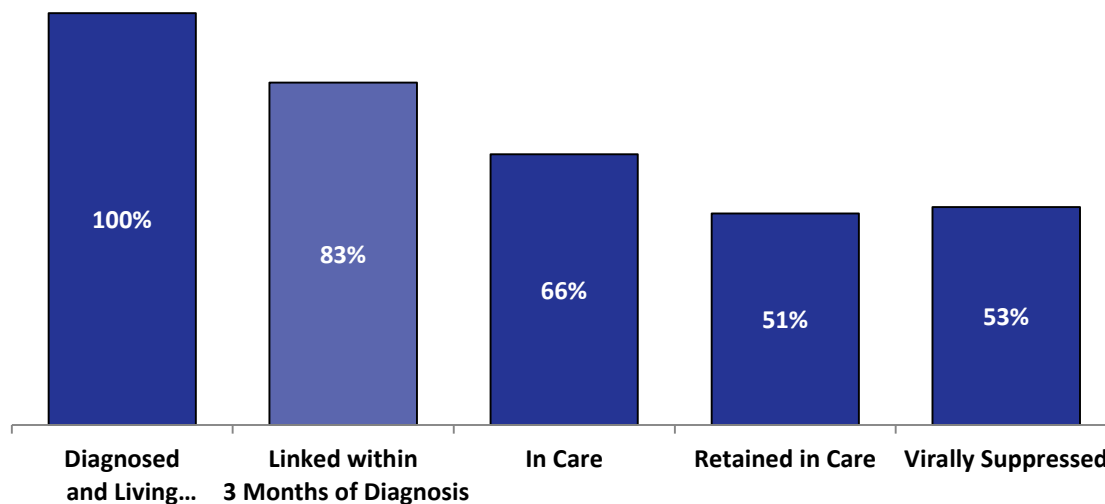
The HIV Care Continuum—sometimes referred to as the HIV treatment cascade—is a conceptual model representing the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body).

The Centers for Disease Control and Prevention (CDC) have described two different approaches for developing a care continuum:¹

- A prevalence-based continuum, depicting each step of the continuum as a percentage of the *total* number of people living with HIV, including those unaware of their infection
- A diagnosis-based continuum, depicting each step of the continuum as a percentage of those diagnosed and reported with HIV infection (i.e., those aware of their HIV infection)

The diagnosis-based continuum, which is presented in this paper, is most useful for monitoring and evaluating the HIV care delivery system.

Figure 1: 2014 Wisconsin HIV Care Continuum²



- *Diagnosed and Living with HIV [n=6,373 or 100%]:* There were an estimated 6,462 People Living with HIV/AIDS (PLWHA) of any age reported to be alive and living in Wisconsin as of December 31, 2013. Of those, 6,373 were ages 13 or older and were still alive and living in Wisconsin as of December 31, 2014.
- *Linked within Three Months of Diagnosis [n=187/225 or 83%]:* Among 225 people newly diagnosed with HIV infection during 2014, 83% had laboratory evidence of linkage to care within three months of diagnosis. An additional 8% (n=19) were linked to care more than three months after diagnosis, and the remaining 19 remain unlinked at the time of this analysis.

¹ Centers for Disease Control and Prevention. Understanding the HIV Care Continuum. December 2014. Available at http://www.cdc.gov/hiv/pdf/dhap_continuum.pdf

² Wisconsin Department of Health Services. Wisconsin AIDS/HIV Program Notes. November 2015. Available at <https://www.dhs.wisconsin.gov/publications/p00792-15-november.pdf>

- *In Care [n=4,187/6,373 or 66%]:* Of those diagnosed and living with HIV, 66% had at least one care visit during 2014.
- *Retained in Care [n=3,272/6,373 or 51%]:* Of those diagnosed and living with HIV, 51% had at least two visits, 90 days apart, during 2014.
- *Virally Suppressed [n=3,373/6,373 or 53%]:* Of those diagnosed and living with HIV, 53% had suppressed viral load as of their last viral load test in 2014.
- *Viral Suppression among Those with a Viral Load Test [n=3,373/3,849]:* While not shown in Figure 1, most (88%) PLWHA who had at least one viral load test (indicating some care) were virally suppressed as of their last viral load test during 2014.

Definition of Medical Case Management

Medical case management (MCM) services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan, which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems. MCM may also include 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 care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic reevaluation and adaptation of the care plan, at least every six months, as necessary during the enrollment of the client.³

Using this Document

Practice standards establish a definition of what it means to provide a high-quality service. This document establishes practice standards for HIV medical case management services funded by the Wisconsin AIDS/HIV Program. In addition to providing a benchmark for MCM service delivery, these standards also seek to:

- Provide a definition of HIV medical case management in Wisconsin.
- Ensure compliance with Ryan White legislation and other applicable federal regulations.
- Clarify service expectations and required documentation across agencies funded by the Wisconsin AIDS/HIV Program to provide MCM services.
- Ensure individuals living with HIV/AIDS throughout the state have access to comparable MCM services regardless of location or other demographic factors.
- Encourage more efficient use of resources and avoid duplication of services.

This document is divided into four sections:

1. **Ryan White Part B and Life Care Services Universal Standards of Care:** Standards to which all agencies funded by the Wisconsin AIDS/HIV Program to deliver *any* core or support service must adhere.

³ Health Resources and Services Administration. Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services. Policy Notice 10-02. Available at <http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html>

- 2. Medical Case Management Standards for All Medical Case Management Providers:** Standards to which all agencies funded by the Wisconsin AIDS/HIV Program to deliver MCM must adhere.
- 3. Medical Case Management Standards for Community-Based Providers:** Standards to which all community-based providers funded by the Wisconsin AIDS/HIV Program to deliver MCM must adhere.
- 4. Medical Case Management Standards for Clinic-Based Providers:** Standards to which all clinic-based providers funded by the Wisconsin AIDS/HIV Program to deliver MCM must adhere.

Each section is organized using the following format:

Standard	Measure

The “Standard” column lists the requirements subgrantees delivering medical case management services must meet. The “Measure” column lists the criteria the Wisconsin AIDS/HIV Program will use to determine whether subgrantees are adequately meeting standards.

WISCONSIN’S MEDICAL CASE MANAGEMENT MODEL

Background

The Wisconsin AIDS/HIV Program has had practice standards in place for delivery of HIV non-medical (psychosocial) case management services since the early 1990s. In 2006, HRSA established criteria for a new Ryan White core medical service known as medical case management (MCM). The Wisconsin AIDS/HIV Program has funded agencies throughout the state to provide MCM since 2009; however, many of the agencies funded to provide MCM were using the state’s non-medical case management practice standards to guide their work. Others adopted their own systems of MCM service delivery. In December 2013, the Wisconsin AIDS/HIV Program established a workgroup tasked with developing statewide MCM practice standards. The current structure of Wisconsin’s MCM services and corresponding practice standards described in this document are the result of the efforts of the Medical Case Management Practice Standards Workgroup.

Transition to Medical Case Management

Prior to 2015, the Wisconsin AIDS/HIV Program funded both non-medical and medical HIV case management. Most non-medical case managers were located in community-based agencies while medical case managers were located in clinic-based programs. All HIV case managers in Wisconsin are now categorized as medical case managers based on the following considerations:

- The HRSA definition of MCM includes not only follow-up and coordination of medical services, but also assessment of psychosocial needs and linkage to support services as key components of effective MCM services.
- The HRSA definition of non-medical case management clearly states that non-medical case management services “do not involve coordination and follow-up of medical treatments.” Case managers throughout the state previously funded as non-medical case managers were already providing these services. Removing care coordination and medical follow-up as required tasks of

certain case managers may have resulted in reductions in statewide levels of retention in HIV medical care and viral load suppression.

- HIV medical clinics throughout the state do not have capacity to employ the number of medical case managers needed to support all of the individuals requiring MCM services. As a result, community-based case managers are still needed to provide medical follow-up and coordination for individuals living with HIV in Wisconsin.

Medical Case Management Goals

The central goal of MCM is to promote and support ongoing client engagement in HIV medical care, ultimately resulting in HIV viral load suppression and a reduction in new HIV infections; consistent with goals outlined in the National HIV/AIDS Strategy.

As the client achieves positive clinical outcomes, medical case managers also work to support and encourage the client's independence, sense of empowerment, and self-sufficiency. As such, MCM requires the consent and active participation of the client in decision-making and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, compassionate trauma-informed care, a culturally competent provider, and quality case management services.

Delivery of Medical Case Management Services

In Wisconsin, MCM services are delivered in a variety of settings including AIDS service organizations, community-based organizations, federally qualified health centers, and outpatient medical clinics. This allows several points of access for clients seeking MCM services. For the purposes of defining MCM practice standards, providers of MCM services are divided into two categories:

1. **Community-Based Providers:** Medical case managers who do *not* operate directly within an HIV outpatient medical clinic. Community-based medical case managers serve clients who receive medical care from a variety of HIV clinics.
2. **Clinic-Based Providers:** Medical case managers who operate directly within an HIV outpatient medical clinic. Clinic-based medical case managers typically serve clients receiving medical care at their designated clinic. Registered nurses providing MCM are also considered clinic-based providers regardless of whether they operate within a specific HIV outpatient medical clinic or travel between clinics to work with various medical providers.

Although specific processes used to deliver MCM services may differ based on location of the provider, both clinic-based and community-based medical case managers work to achieve the same goals; promoting and supporting client retention in HIV medical care and viral suppression.

Depending on location, certain medical case managers may be better positioned to address specific needs of the client. For example, because clinic-based medical case managers work directly with clients' HIV medical providers, it may be more efficient for them to manage and track outcomes of referrals to other medical subspecialties. Similarly, community-based case managers may be able to better assist clients with issues related to housing or food insecurity since they are able to meet with clients in nontraditional settings. Because of this, clients may work with both a community-based and clinic-based medical case manager. If a client is working with a community-based medical case manager, the clinic-based case manager provides brief services in order to avoid duplication of services. This process is explained in greater detail in subsequent sections of this document.

RYAN WHITE PART B AND LIFE CARE SERVICES UNIVERSAL STANDARDS OF CARE

All agencies funded by the Wisconsin AIDS/HIV Program to deliver any core or support services, including medical case management, must adhere to the following universal standards of care and maintain proper documentation to verify ongoing compliance with the standards. All standards of care are in accordance with Ryan White HIV/AIDS Program legislation (PHS ACT 2616) and HRSA/HAB-issued monitoring standards and policy notices for Ryan White grantees.

Standard	Measure
<p>A. Payer of Last Resort</p> <ol style="list-style-type: none"> In accordance with federal regulations, all Ryan White funds are used as payer of last resort. As such, Ryan White funds are not to be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source [PHS Act 2617(b)(7)(F)]. Life Care Services funding shall also be used as payer of last resort as described above. 	<ul style="list-style-type: none"> Documentation of efforts showing “vigorous pursuit of client enrollment into health care coverage for which clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored insurance and/or private health insurance)” (HAB Policy Clarification Notice 13-05). Verification that “...clients are enrolled in health care coverage whenever possible or applicable, and are informed about the consequences of not enrolling (HAB Policy Clarification Notice 13-05). If providing a Medicaid-eligible service, verification that the agency is certified with and appropriately billing the Wisconsin Medicaid Program. Verification that the agency bills all relevant third-party payer sources.
<p>B. Access to Care</p> <ol style="list-style-type: none"> Subgrantees provide services regardless of clients’ ability to pay and/or current or past health condition (HAB Universal Monitoring Standards A1, A2). Subgrantees provide services to all eligible individuals without discrimination on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, religion, political beliefs, marital status, and familial or parental status. Subgrantees develop outreach strategies that ensure low-income individuals are aware of services provided and how to access them (HAB Universal Monitoring Standards A4). 	<ul style="list-style-type: none"> Written nondiscrimination policy in compliance with applicable state and federal laws. Verification that any agency policies related to billing, collection, co-pay, and schedule of charges do not act as a barrier to providing services (HAB Universal Monitoring Standards A2). Documentation of individuals who were refused services with reasons for refusal specified; including any complaints from clients and the result of the complaint (HAB Universal Monitoring Standards A2). Verification of compliance with the Americans with Disabilities Act (HAB Universal Monitoring Standards A4). Verification that the agency is accessible by public transportation or

<p>4. Delivery of services occurs in a setting accessible to low-income individuals living with HIV/AIDS. (HAB Universal Monitoring Standards A4, A5).</p>	<p>provides clients with transportation assistance (HAB Universal Monitoring Standards A4).</p> <ul style="list-style-type: none"> • Documentation of outreach activities implemented to ensure that low-income individuals with HIV/AIDS are aware of services offered and the process for accessing services; including copies of promotional materials used (HAB Universal Monitoring Standards A5).
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<p>C. Trauma-Informed Service Delivery</p> <ol style="list-style-type: none"> 1. Trauma-informed care (TIC) is a strengths-based framework that is grounded in the understanding of and responsiveness to the impact of trauma. It is an empowerment model that emphasizes the strengths and resiliency of clients, and seeks to minimize the power imbalance between client and provider. Cultural competence is a critical component in ensuring that delivery of services is trauma-informed. 2. Subgrantees deliver services in accordance with the values of TIC as outlined by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. Core TIC values include: <ul style="list-style-type: none"> • Safety • Trustworthiness • Choice • Collaboration • Empowerment 3. Subgrantees provide ongoing training opportunities for staff that promote knowledge of and skill building in trauma-informed service delivery. Staff may be required to attend periodic trainings on trauma-informed care hosted by the Wisconsin AIDS/HIV Program. 	<ul style="list-style-type: none"> • Evidence that written agency policies and procedures reflect a patient-centered approach that promotes TIC values. • Documentation of trainings provided by the agency that promote knowledge of and skill-building in trauma-informed service delivery. • Documentation of staff attendance at TIC trainings hosted by the agency and/or the Wisconsin AIDS/HIV Program.
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<p>D. Culturally and Linguistically Appropriate Service Delivery</p> <ol style="list-style-type: none"> 1. Cultural competence is a critical component in ensuring that delivery of services is trauma-informed. Subgrantees comply with the National Culturally and Linguistically Appropriate Services (CLAS) Standards, which require health and social service providers to “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.” 2. Subgrantees assure the availability and competence of language assistance provided to limited English proficient clients and/or clients with physical/cognitive conditions limiting their ability to communicate. 	<ul style="list-style-type: none"> • Evidence that written agency policies and procedures reflect a patient-centered approach that promotes culturally and linguistically appropriate services. • Documentation of the specific language assistance services available to clients and competence of providers. • Documentation of client choice if a client’s family members/friends are used as interpreters. • Documentation of trainings provided by the agency that promote knowledge of and skill building in cultural competency. • Documentation of staff attendance at cultural competency trainings hosted by the agency and/or the Wisconsin AIDS/HIV Program.
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<p>3. Family and friends are not used to provide interpretation services, except upon request by the client.</p> <p>4. Subgrantees provide ongoing training opportunities for staff that promote knowledge of and skill building in culturally competent service delivery. Staff may be required to attend periodic trainings on culturally competent practice hosted by the Wisconsin AIDS/HIV Program.</p>	
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<p>E. Eligibility Determination (TBD)</p> <p>1. The Ryan White Part B Grantee develops eligibility criteria for provision of services to low-income individuals living with HIV/AIDS (HAB Universal Monitoring Standards B1).</p> <p>2. Eligibility determination includes process for verification of HIV status, Wisconsin residency, insurance status, and household income as it relates to the Federal Poverty Level (FPL).</p> <p>3. Reassessment of client eligibility occurs at least every six months (HAB Universal Monitoring Standards B1).</p>	<ul style="list-style-type: none"> • Written policy outlining eligibility requirements for services provided and processes for initial eligibility determination and six-month reassessment (HAB Universal Monitoring Standards B1). • Procedures for ensuring clients are aware of eligibility requirements, including requirement for eligibility reassessment every six months (HAB Universal Monitoring Standards B1). • Client records include documentation of clients' eligibility determination, including verification of: <ul style="list-style-type: none"> ○ HIV/AIDS diagnosis ○ Wisconsin Residency ○ Low income ○ Insurance status ○ Determination of eligibility and enrollment in other third party insurance programs ○ Dates of initial determination and ongoing six month redeterminations
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<p>F. Referral Relationships</p> <p>1. Subgrantees maintain appropriate referral relationships with entities that constitute key points of entry as defined by federal Ryan White legislation (HAB National Monitoring Standards-Part B Program F2) including:</p> <ul style="list-style-type: none"> • Emergency rooms • Substance abuse and mental health treatment programs • Detoxification centers • Detention facilities • Sexually transmitted disease clinics • Homeless shelters • HIV disease counseling and testing sites • Health care points of entry specified by eligible areas • Federally Qualified Health Centers <p>2. Subgrantees maintain appropriate referral relationships with agencies that provide support services that the subgrantee itself does not directly provide.</p>	<ul style="list-style-type: none"> • Access to list of local and statewide resources available for client referrals. • Documentation in client records of referrals offered including date and type of referral. Documentation must also include outcome of the referral, including refusal by client to accept referral if applicable.
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G. Confidentiality

1. Subgrantees develop confidentiality policies and procedures in accordance with state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) when applicable.
2. Protection of client confidentiality includes development and routine use of a Client Release of Information form detailing the circumstances when client information may be released and to whom, as well as procedures for ensuring that all client files, records, and identifying information are maintained in strict confidentiality.
3. Files, records, or other documentation containing client information are maintained for a minimum of seven years. After seven years, paper files are disposed of by using a cross-cutting shredding machine specifically designed for confidential information.
4. All subgrantee staff and volunteers who have access to client information are provided with the agency confidentiality policies and procedures and trained accordingly.
5. Confidentiality policies and procedures are posted in prominent areas accessible to staff and clients.
6. Staff/volunteers sign confidentiality agreements signaling their understanding and ability to comply with confidentiality requirements.

- Written confidentiality policy in accordance with state and federal laws that includes:
 - Process for training of staff and volunteers.
 - Agency staff/volunteer confidentiality agreements.
 - Procedures for use of Client Release of Information form and instructions for completing the form correctly.
 - Procedures for release of information via mail, phone, fax, voicemail, email, and/or text message.
 - Policy for storing client information.
 - Procedures for maintaining confidentiality if information is taken out of the office.
 - Procedure for investigating breaches of confidentiality.
 - Penalties for violating agency policies..
- Client records include up-to-date Client Release of Information that corresponds to each request for information. Each release includes:
 - Client signature and date of signature.
 - Name of agency/individuals with which information will be shared.
 - Specific information that will be shared.
 - Expiration date of release (no more than 12 months from date of client signature).
- Demonstration that all paper client files, records, and identifying information are kept in a locked file or cabinet inside of a locked room.
- Demonstration that all electronic client files, records, and identifying information are password protected with access limited to appropriate staff. Screensavers are password protected and set for less than 10 minutes.
- Verification that client files are kept for a minimum of seven years and disposed of in accordance with confidentiality standards.
- Confidentiality policies and procedures posted in prominent areas accessible to staff and clients.

H. Client Input

1. Subgrantees develop and implement structured and ongoing strategies to obtain client input in the design and delivery of services (HAB Universal Monitoring Standards A1).
2. Strategies may include: Client advisory boards, focus groups, client satisfaction surveys, and/or public meetings (HAB Universal Monitoring Standards A1).

- Written policy outlining strategies for obtaining client feedback including:
 - Timeframe and frequency of activities
 - Procedures for clients to follow in order to provide input (HAB Universal Monitoring Standards A1).
- Documentation of client advisory board members and meeting minutes if applicable (HAB Universal Monitoring Standards A1).
- Documentation of content of client feedback and actions taken to address

	client suggestions/concerns (HAB Universal Monitoring Standards A1).
<p>I. Grievance Procedure</p> <ol style="list-style-type: none"> 1. Subgrantees develop fair and reasonable grievance policies and procedures to address client complaints that cannot be resolved informally. Policies include an appeal process. 2. Grievance policies and procedures prohibit the agency and its staff and volunteers from discriminating or retaliating against clients for filing a grievance or because of any conditions resulting from resolution of the grievance. 3. Grievance policies and procedures may include the agency's right to reject grievances that are frivolous in nature or that upon investigation are deemed to have no merit. The client is provided with written notification of rejection of the grievance. 4. Subgrantees make clients aware of their right to file a grievance with the AIDS/HIV Program in instances where clients feel their complaints are not being adequately addressed by the subgrantee agency. 5. All subgrantee staff and volunteers are provided with the agency grievance policies and procedures and trained accordingly. 6. Subgrantees make clients aware of the grievance policies and procedures. 7. Documentation of grievances and appeals is maintained for a minimum of five years from the date of resolution. 8. Grievance policies and procedures are posted in prominent areas accessible to staff and clients. 9. The standards listed above do not supersede applicable state or federal laws or regulations. 	<ul style="list-style-type: none"> • Written grievance policies and procedures that includes specific processes and timelines for the following: <ul style="list-style-type: none"> ○ Initiating a grievance following the event(s) that triggered the grievance. ○ Initial response from the agency acknowledging receipt of the grievance. ○ Investigation of event(s) that led to the grievance. ○ Notification of extension of time needed for the agency to investigate the grievance. ○ Written notification to the aggrieved of the decision of the grievance, including results of the investigation, any resulting changes in policies/procedures and/or any redress to the aggrieved. ○ Written notification of the right of the aggrieved to appeal the initial decision, including timeframes for submitting an appeal. ○ Written notification to the aggrieved of decision and/or appeal. ○ Process for transferring grievances to the AIDS/HIV Program. • Documentation of formal grievance that includes: <ul style="list-style-type: none"> ○ Name or client ID of the aggrieved. ○ Date the grievance or appeal was filed. ○ Summary statement of the reason(s) for the grievance. ○ Summary statement of the significant facts of the investigation. ○ Summary state of the resolution of the grievance. ○ Date of resolution. ○ If appealed, all of the above information pertaining to the appeal. • Verification that documentation of grievances and appeals is maintained for a minimum of five years from the date of resolution. • Grievance policies and procedures posted in prominent areas accessible to staff and clients.
<p>J. Client Rights and Responsibilities</p> <ol style="list-style-type: none"> 1. Subgrantees must ensure that clients receiving Ryan White and/or LCS funded services are aware of their rights and responsibilities prior to provision of the service. 	<ul style="list-style-type: none"> • Written materials informing clients of their rights and responsibilities including explanations of the following: <ul style="list-style-type: none"> ○ Agencies must provide services to eligible clients regardless of the client's ability to pay for the service and the client's current or past health condition. ○ Services must be available and reasonably accessible to all Wisconsin residents living with HIV/AIDS who request services and reside in the agency's service area.

	<ul style="list-style-type: none"> ○ Agencies must be accessible to individuals with low incomes living with HIV/AIDS. The agency must be accessible by public transportation (or through provision of transportation assistance) and comply with the Americans with Disabilities Act (ADA). ○ Services provided and eligibility requirements. ○ Services are voluntary and clients have right to decline any or all services. ○ Mutual expectations of the program and client conduct when receiving services. <ul style="list-style-type: none"> ● Procedures for ensuring client receipt of material outlining rights and responsibilities.
<p>K. Crisis Intervention</p> <ol style="list-style-type: none"> 1. Subgrantees have policies and procedures for addressing client crises during business and non-working hours as related to mental health, AODA, or other emergency issues. 2. All subgrantee staff and volunteers are provided with the agency crisis intervention policies and procedures and trained accordingly. 	<ul style="list-style-type: none"> ● Written crisis intervention policy that includes: <ul style="list-style-type: none"> ○ Specific procedures for addressing client crises during business hours and nonworking hours. ○ Process for client assessment used to determine specific actions steps and/or need for an individual crisis plan. ○ Specific training to be provided to agency staff/volunteers. ● Verification that crisis intervention policy is distributed to all agency staff/volunteers. ● Documentation of staff/volunteer attendance at training related to agency crisis intervention policies and procedures.
<p>L. Quality Management</p> <ol style="list-style-type: none"> 1. Subgrantees develop and implement a Quality Management Plan to ensure compliance with standards of care. 2. Quality Management plans include procedures for regular collection, monitoring, and reporting of performance data for purposes of monitoring quality of services and identifying quality improvement initiatives. 3. Subgrantees submit performance measure data to the AIDS/HIV Program semi-annually. 	<ul style="list-style-type: none"> ● Written Quality Management Plan that includes: <ul style="list-style-type: none"> ○ Quality expectations for providers and services. ○ Methods to report and track expected outcomes. ○ Methods for monitoring compliance with standards of care and applicable federal regulations. ○ Methods for collection and reporting of performance data. ● Timely submission of performance data to the AIDS/HIV Program.
<p>M. Data Reporting</p> <p>Subgrantees maintain unduplicated client-level data electronically and submit data to the Wisconsin AIDS/HIV Program upon request for completion of state/federal reports and ongoing monitoring of subgrantee performance and compliance with standards.</p>	<ul style="list-style-type: none"> ● Timely submission of required performance data to the Wisconsin AIDS/HIV Program in July and January of each year. ● Timely submission of service utilization data upon request from the Wisconsin AIDS/HIV Program. ● Timely submission of the Ryan White Services Report (RSR) to HRSA in

	<p>February of each year.</p> <ul style="list-style-type: none"> • Submission of other client-level data upon request from the Wisconsin AIDS/HIV Program and/or HRSA.
<p>N. Fiscal</p> <ol style="list-style-type: none"> 1. Subgrantees establish 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). 2. Subgrantees submit monthly expenditure reports to the AIDS/HIV Program. Financial reporting forms F-00642 and F-80855 need to be submitted electronically to the CARS unit at DHS600RCars@dhs.wisconsin.gov including your Ryan White contract administrator as a cc. 3. Final expenditure reports are submitted to the AIDS/HIV Program within 30 days of the contract's end date. 4. Subgrantees that sub-contract with other agencies to provide services ensure that subcontractors submit expenditures within a 30-day period. 5. Subgrantees receiving more than \$25,000 submit an annual audit, unless granted permission to waive this requirement by the Department of Health Services. <ul style="list-style-type: none"> • Audit complies with Wis. Stat. § 46.036 <i>Government Auditing Standards</i> and OMB Circular A-133 "Audits of States, Local Governments, and Non-Profit Organizations." • Audit reporting packages include all appropriate financial statements, audit schedules, management letters, and management responses. 6. Subgrantee agencies' sliding fee scales and payment policies are easily accessible to clients prior to service delivery and made available to the Wisconsin AIDS/HIV Program upon request. 7. Billing, collection, co-pay, and sliding fee policies implemented by subgrantees may not act as a barrier to providing services (HAB Universal Monitoring Standards A2). 	<ul style="list-style-type: none"> • Written protocol for documenting and tracking expenditures. • Maintenance of a general ledger system that clearly tracks: <ul style="list-style-type: none"> ○ Cost centers. ○ Transaction dates. ○ Transaction description. ○ Amount of debits and credits. • Accurate documentation and timely submission of monthly expenditure reports to the Wisconsin AIDS/HIV Program. • Accurate documentation and timely submission of annual audits to the Wisconsin AIDS/HIV Program and DHS/Division of Enterprise Services. • Accurate documentation and timely submission of final expenditure reports. • Procedures for ensuring that clients are aware of agency sliding fee scales and payment policies that are applicable. • Verification that sliding fee scales and payment policies do not act as a barrier to clients accessing services.
<p>O. Ryan White Part B and Life Care Services Site Visits</p> <ol style="list-style-type: none"> 1. The Wisconsin AIDS/HIV Program conducts site visits with all Part B/LCS funded agencies annually or more often as needed. 	<ul style="list-style-type: none"> • Maintain appropriate documentation for all Part B/LCS-funded services in accordance with federal requirements and Part B/LCS standards of care. • Ensure AIDS/HIV Program staff have access to all records pertaining to any Part B/LCS-funded services during annual site visits and/or upon

<p>2. During the site visit, AIDS/HIV Program staff review expenditures, compliance with standards of care, service performance, quality management activities, and provide technical assistance if needed. Site visits include audits of client charts/files.</p> <p>3. All records pertaining to any Part B/LCS-funded service are made available to the AIDS/HIV Program or its agents upon request for purposes of conducting program monitoring, evaluation, consultation, and/or TA.</p>	<p>request.</p>
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MEDICAL CASE MANAGEMENT STANDARDS FOR ALL MEDICAL CASE MANAGEMENT PROVIDERS

All agencies (clinic-based and community-based) funded by the Wisconsin AIDS/HIV Program to deliver medical case management (MCM) must adhere to the following MCM standards in addition to the Universal Standards of Care outlined in the previous section of this document.

Standard	Measure
<p>A. Scope of Medical Case Management Services</p> <ol style="list-style-type: none"> 1. Subgrantees provide MCM services in accordance with HRSA's definition of MCM. 2. MCM services “ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family member’s needs and personal support systems. This includes the provision of treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS treatments” (HAB National Monitoring Standards- Part B Program B13). 	<ul style="list-style-type: none"> • Charts for clients receiving MCM services include documentation of all MCM services offered and/or provided to the client including evidence of: <ul style="list-style-type: none"> ○ Client-centered services that link the client with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible. ○ Coordination and follow-up of medical treatments. ○ Treatment adherence counseling. ○ Client-specific advocacy. ○ Outcome of service referrals (HAB National Monitoring Standards- Part B Program B13).
<p>B. Required Medical Case Management Activities</p> <ol style="list-style-type: none"> 1. The delivery of MCM services includes the following activities as defined by HRSA: <ul style="list-style-type: none"> • Initial assessment of service needs. • Development of a comprehensive, individualized care plan. • Coordination of services required to implement the care plan. • Continuous client monitoring to assess the efficacy of the care plan. • Periodic re-evaluation and adaptation of the care plan, at least every six months, or as necessary during the enrollment of the client (HAB National Monitoring Standards- Part B Program B13). 2. Specific processes and guidelines used to complete the above activities will vary based on whether the agency delivering MCM services is clinic-based or community-based. <ul style="list-style-type: none"> • For specific practice standards relating to the delivery of required MCM activities in <i>clinic-based</i> settings, see the section beginning page 30 of this document. • For specific practice standards relating to the delivery of required MCM activities in <i>community-based</i> settings, see the section beginning page 22 of this document. 	<ul style="list-style-type: none"> • Charts for clients receiving MCM services include documentation verifying provision of required MCM activities including: <ul style="list-style-type: none"> ○ Initial assessment of service needs. ○ Development of a comprehensive, individualized care plan. ○ Continuous monitoring to assess the efficacy of the plan. ○ Periodic reevaluation and adaptation of the plan at least every six months (HAB National Monitoring Standards- Part B Program B13).

C. Medical Case Management Client Charts/Records

1. Client charts and electronic files are legal documents and must be maintained for the purposes of internal organization and auditing as well as external auditing. For legal and auditing purposes, if no record of an encounter or incident is found, then the encounter/incident did not occur. Accurate record keeping ensures a higher quality of care and protects the service provider and client by documenting every action taken on the client's behalf.
 2. Subgrantees maintain individual client charts/records for all clients receiving MCM services.
 3. Client charts include documentation of:
 - Client eligibility.
 - All encounters with or on behalf of the client.
 - Required MCM activities as outlined above.
 4. Subgrantees have processes in place for routine supervisory review of medical case managers' client charts to ensure that documentation is appropriate, timely, and meets required standards.
 5. All files, records, and identifying information pertaining to clients is maintained in strict confidentiality in accordance with the Part B/LCS Universal Standards of Care, and state and federal laws; including the Health Insurance Portability and Accountability Act (HIPAA) when applicable.
- Charts for clients receiving MCM services include documentation of client eligibility including:
 - Verification of HIV status.
 - Proof of Wisconsin residency.
 - Proof of income.
 - Proof of insurance status.
 - Redetermination of eligibility every six months.
 - Charts for clients receiving MCM services include timely documentation of all encounters with or on behalf of the client as well as services offered and/or provided to the client. This includes the following information:
 - Types of encounters/communication.
 - Types of services offered or provided.
 - Date and duration of the encounters (HAB National Monitoring Standards—Part B Program B 13).
 - Charts for clients receiving MCM services include documentation of all MCM services offered and/or provided to the client including evidence of:
 - Client-centered services that link the client with health care, psychosocial, and other services as well as assistance in accessing other eligible public and private programs.
 - Coordination and follow-up of medical treatments.
 - Treatment adherence counseling.
 - Client-specific advocacy.
 - Outcome of service referrals (HAB National Monitoring Standards- Part B Program B13).
 - Charts for clients receiving MCM services include documentation verifying completion of required MCM activities including:
 - Initial assessment of service needs.
 - Development of a comprehensive, individualized care plan.
 - Continuous monitoring to assess the efficacy of the plan.
 - Periodic reevaluation and adaptation of the plan at least every six months (HAB National Monitoring Standards—Part B Program B13).
 - Written procedures for routine supervisory review of all MCM client charts as well as documentation of when reviews occurred.
 - Verification of agency compliance with confidentiality guidelines as outlined in the Part B/LCS Universal Standards of Care, as well compliance with applicable state and federal laws.

<p>D. Medical Case Manager Qualifications upon Hire</p> <ol style="list-style-type: none"> 1. All medical case managers funded by the Wisconsin AIDS/HIV Program meet the following qualifications upon hire: <ol style="list-style-type: none"> a) Bachelors or Master's degree in health, human, or education services. OR b) Associate's degree in health or human services and previous professional experience working with individuals from diverse and/or historically underserved populations. 2. The above requirements may be waived in situations where the candidate does not meet the above criteria but has two or more years of professional experience providing case management or other HIV-related services. 	<p>Verification that all case managers funded by the Wisconsin AIDS/HIV Program meet required qualifications upon hire.</p>
<p>E. Medical Case Management Supervisor Qualifications upon Hire</p> <ol style="list-style-type: none"> 1. All MCM supervisors funded by the Wisconsin AIDS/HIV Program meet the following qualifications upon hire: <ol style="list-style-type: none"> a) Master's degree in health or human services and two years of case management experience. OR b) Bachelor's degree in health or human services and three years of case management experience. 	<p>Verification that all case management supervisors funded by the Wisconsin AIDS/HIV Program meet required qualifications upon hire.</p>
<p>F. New Staff Training and Orientation</p> <ol style="list-style-type: none"> 1. Subgrantees provide 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. 2. Training includes: <ul style="list-style-type: none"> • Provision of agency policies and procedures. • Job shadowing for core case management activities. • Performance monitoring during probationary period. 3. Included in the probationary period, new case managers are monitored for satisfactory completion of required case management activities and appropriate interactions with clients. These activities are monitored in person by appropriate supervisory staff at least once before case manager is approved to provide services independently. 	<ul style="list-style-type: none"> • Written policies and procedures for training of new case management staff that include specific training to be offered, job shadowing, and supervisory observation of initial completion of required case management activities. • Documentation that all newly hired case management staff completed new staff training as outlined in the agency policies and procedures within 90 days of hire.

G. Professional HIV Case Manager Certification and Continuing Education

1. All medical case managers funded by Ryan White Part B and/or Life Care Services complete the Professional HIV/AIDS Case Manager Certification Program, sponsored by the Wisconsin AIDS/HIV Program within 12 months of date of hire.
2. In order to obtain certification, medical case managers attend the following trainings offered by the University of Wisconsin HIV Training System (<http://www.wihiv.wisc.edu/trainingsystem/>) and receive a score of 75% or better on the HIV Case Manager Knowledge Assessment (RN case managers are not required to take the HIV Case Manager Knowledge Assessment):
 - HIV Basic Facts Online (not required for RN case managers).
 - HIV Counseling Skills.
 - Direct Service 101 (not required for RN case managers).
3. Specific trainings required for certification may be updated and/or revised based on the discretion of the Wisconsin AIDS/HIV Program.
4. Medical case managers complete a minimum of 12 hours of continuing education annually in order to maintain certification. Medical case managers and supervisors also attend an annual case managers meeting hosted by the Wisconsin AIDS/HIV Program.
5. Agencies and/or MCM supervisors are responsible for monitoring case manager compliance with ongoing training requirements and certification maintenance, including authorizing appropriate training opportunities to satisfy the maintenance requirements.
6. Personnel records related to training and certification are subject to review during Part B/LCS site visits.

- Procedures for tracking case manager progress towards certification, attendance at trainings, and completion of annual continuing education requirements.
- Verification of completion of Professional HIV/AIDS Case Manager Certification Program within 12 months of hire including documentation of the following:
 - Case manager attendance at required trainings.
 - Successful completion of HIV Case Manager Knowledge Assessment.
- Documentation of case managers' completion of 12 hours of continuing education each year.

H. Performance Evaluation

1. Following completion of a probationary period (length determined by individual agency), all medical case managers and MCM supervisors have written and documented performance evaluations at minimum of every 12 months.
2. Performance evaluations are conducted by an immediate supervisor who can attest to the performance of the individual.

- Written procedures in place for routine performance evaluation of all case management staff and supervisors, including process to be followed if evaluation indicates performance does not meet standards.
- Documentation showing completion of annual performance evaluations for all case management staff and supervisors.

<ol style="list-style-type: none"> 3. Any individual who displays deficiencies in an area is put on a corrective action plan and monitored for progress. 4. For the purposes of auditing, AIDS/HIV Program staff may request a record of performance evaluations for current employees. 	
<p>I. Delivery of other Ryan White/LCS Funded Services</p> <ol style="list-style-type: none"> 1. Case management agencies that are funded by the Wisconsin AIDS/HIV Program to provide other HIV core and/or support services adhere to Ryan White Part B/LCS Standards of Care, in addition to federal requirements. 2. Standards of care for other HIV core and support services are available in a separate document entitled, "Standards of Care: Ryan White Part B and Life Care Services." 	<p>Verification of compliance with Ryan White Part B/LCS Standards of Care and federal requirements in the delivery of all services funded by the Wisconsin AIDS/HIV Program.</p>

MEDICAL CASE MANAGEMENT STANDARDS FOR COMMUNITY-BASED PROVIDERS

Community-based medical case managers must deliver MCM services in accordance with the standards outlined in the following section of this document. The Wisconsin AIDS/HIV Program has developed standardized forms to ensure delivery of case management activities complies with state standards. These forms can be modified to include additional information that an agency deems necessary; however, the information included on the standardized forms developed by the AIDS/HIV Program is a required minimum for collection. Utilizing the specific paper form is not necessary. Agencies may convert the information from the standardized forms into fields in electronic databases; however, none of the information from the standardized paper form should be omitted from the electronic record.

Standard	Measure
<p>A. Intake</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Time Requirement: Due within 10 working days of referral or initial client contact.</p> </div> <ol style="list-style-type: none"> 1. During intake, key information concerning the client and their presenting concern(s) is collected including: <ul style="list-style-type: none"> • Contact and identifying information. • Presenting concern(s). • Emergency contact. • Insurance status. • Contact information for other service providers and corresponding ROIs. • Proof of income and Wisconsin residency. • Demographics. • Proof of HIV positive status. (<i>Verification must be received within 30 days of intake in order for client to continue to receive Ryan White or Life Care Services funded services</i>). 2. Immediate referrals are made under the following circumstances: <ul style="list-style-type: none"> • Client not engaged in medical care. • Client on medication but will run out in less than 10 days. • Client is a danger to themselves or others. 3. Intake may be performed by agency staff who are not case managers provided they meet all of the following criteria: <ul style="list-style-type: none"> • Are an employee of the service provider/agency. • Received proper onsite training and signed the agency confidentiality agreement. • Completed the HIV Basics Online Course offered through the UW HIV Training System. 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Verification intake was completed within 10 days of initial referral or contact. • Documentation of all elements outlined on the intake form (Appendix A). • Documentation of referral(s) made and outcome of referral(s). <p>Verification that staff completing intake have required qualifications.</p>

B. Wisconsin Acuity Index

Time Requirement: Initial Wisconsin Acuity Index due within 30 days of Intake.

Acuity Levels 1-2: Due every 365 days or sooner as life circumstances change.

Acuity Level 3: Due every 180 days or sooner as life circumstances change.

1. The Wisconsin Acuity Index (WAI) is used to determine clients' needs and eligibility for case management.
2. The WAI evaluates client level of need in the following areas:

• Linkage and Retention in HIV Medical Care	• Nutrition
• Adherence to Antiretroviral Therapy (ART)	• Income and Entitlements
• Health Literacy	• Transportation
• Mental Health	• Legal
• Substance Abuse	• Culture and Language
• Health Insurance	• Children and Dependents
• Housing	• Social Support
• Oral Health	

3. The WAI is completed before or in conjunction with the Comprehensive Assessment (if Acuity Level 1-3).
4. Clients who score Acuity Level 1-3 on the WAI are eligible for MCM.
5. Clients who score Acuity Level 0 on the WAI are not eligible for MCM and are offered brief services.
6. Case managers may make adjustments to clients' Acuity Level if they feel that it does not accurately represent the client's level of need. Scoring adjustments must be approved by the agency's case management supervisor. Justification for the adjustment must be documented.

Client file includes the following:

- Completed Wisconsin Acuity Index form (Appendix B) including initial WAI and all subsequent WAIs completed with the client.
- Verification that initial WAI was completed within 30 days of Intake.
- Verification that the WAI was completed at least annually for all clients with Acuity Levels 1-2.
- Verification that the WAI was completed at least semi-annually for all clients with Acuity Level 3.
- Verification that WAI is completed more frequently for clients with significant changes in life circumstances.
- Documentation of supervisory approval for any acuity level scoring adjustments.
- Documentation of justification for any acuity level scoring adjustments.

C. Initial Comprehensive Assessment

Time Requirement: Due within 30 days of Intake.

Client file includes the following:

- Verification that initial comprehensive assessment was completed within 30 days of intake.

1. The Comprehensive Assessment describes the client’s medical and psychosocial needs in detail. 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 client’s resources and strengths, including family and other supports, which may be utilized during service planning.
2. The Comprehensive Assessment is completed with all clients who are eligible for MCM (Acuity Level 1-3).
3. The case manager has primary responsibility for completion of the Comprehensive Assessment and meets face-to-face with the client at least once during the assessment process.
4. At minimum, Initial Comprehensive Assessment includes gathering the following information:
 - Client Contact Information
 - Client Demographics
 - Collateral Contact Information
 - HIV Status and Risk Information

And information related to clients’ needs in the following areas:

 - Education
 - Finances
 - Physical Health and Medical Care
 - Adherence to HIV Medications
 - Substance Use
 - Housing
 - Social Support and Relationships
 - Employment
 - Health Insurance
 - Retention in HIV Medical Care
 - Behavioral Health
 - Risk Reduction
 - Transportation
 - Legal
5. Community-based case managers are encouraged to use the Comprehensive Assessment form developed by the AIDS/HIV Program to ensure they are gathering all of the required information listed above. Agencies may revise the state form or develop their own assessment tool as long as all of the elements on the Comprehensive Assessment form are covered. Any assessment tools developed must be strengths-based.
6. If all relevant information necessary to complete the assessment is not received from the client 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 client within an additional 30 days, the client is discharged from services.

- Documentation of all elements outlined on Comprehensive Assessment form (Appendix C).
- Brief narrative of assessment findings in progress notes.
- Documentation of referral(s) made and outcome of referral(s).

D. Initial Service Plan Development

Time Requirement: Due within 10 working days of the completion of the Initial Comprehensive Assessment

Client file includes the following:

- Verification that initial service plan development was completed within 10 working days of completion of initial comprehensive assessment.
- Documentation of all elements outlined on Service Plan form

<ol style="list-style-type: none"> 1. Development of a service plan is a central component of MCM and provides the client and case management team with a proactive, concrete, step-by-step approach to addressing client needs. 2. Client needs identified during Comprehensive Assessment are prioritized and translated into a Service Plan, which defines specific goals and action steps needed to meet goals. 3. The case manager has primary responsibility for the development of the service plan. 4. 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 client and, if appropriate, family, close support persons, and other providers. 5. At minimum, the initial Service Plan includes: <ul style="list-style-type: none"> • Problem statement • Goal(s) • Action steps [action to be taken to work towards goal(s)] • Individual responsible for the action step • Anticipated timeframe for each action step • Client signature and date, or documentation of verbal approval • Supervisor's signature and date indicating review and approval 6. The service plan is updated with outcomes and revised or amended in response to changes in the client's life circumstances or goals. Schedule for service plan review is detailed in Section G. Service Plan review. 	<p>(Appendix D).</p>
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<p>E. Service Plan Implementation</p> <ol style="list-style-type: none"> 1. Implementation of action steps begins immediately after development of the Service Plan. 2. The specific activities performed during service plan implementation will vary based on the unique needs of each client. However, all activities must promote and support client engagement in HIV medical care and viral load suppression. 3. Oversight of service plan implementation is the responsibility of the case manager. 4. Communication and coordination with the client's HIV care team is essential for effective implementation to occur. 5. The type and frequency of contact with the client is based on client needs. However, minimum required contacts have been established for case managed clients based on Acuity Level established by the Wisconsin Acuity Index: <ul style="list-style-type: none"> • Acuity Level 1: Quarterly direct client contact 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Verification that Acuity Level 1 clients are contacted at least quarterly by the case manager. • Verification that Acuity Level 2 clients are contacted at least monthly by the case manager. • Verification that Acuity Level 3 clients are contacted at least twice monthly by the case manager. • Evidence of regular and ongoing contact with key members of the client's HIV care team. • Documentation of all implementation efforts in accordance with Medical Case Management Practice Standards for all MCM providers.
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- Acuity Level 2: Monthly direct client contact
 - Acuity Level 3: Twice monthly direct client contact
6. All implementation efforts are documented in the client's file in the accordance with documentation standards outlined in Section C: Medical Case Management Client Charts/Records under Medical Case Management Practice Standards for All Medical Case Management Providers.
 7. The client's right to privacy and confidentiality in contacts with other providers and individuals is ensured and in accordance with applicable state and federal laws and Part B/LCS Universal Standards of Care.

- Verification of compliance with applicable state and federal confidentiality and privacy laws and Part B/LCS confidentiality standards outlined in Section G of the Universal Standards of Care.

F. Reassessment

Time Requirement:

Acuity Levels 1-2: Due every 365 days or sooner as life circumstances change.

Service Level 3: Due every 180 days or sooner as life circumstances change.

1. A reassessment reevaluates client functioning, health, and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or ongoing needs.
2. The case manager has primary responsibility for the reassessment and meets face-to-face with the client at least once during the reassessment process.
3. At minimum, reassessment includes gathering information on the following:
 - Client Contact Information
 - Collateral Contact Information
 - Client Demographics
 - HIV Status and Risk Information

And information related to clients' needs in the following areas:

 - Education
 - Employment
 - Finances
 - Health Insurance
 - Physical Health and Medical Care
 - Retention in HIV Medical Care
 - Adherence to HIV Medications
 - Behavioral Health
 - Substance Use
 - Risk Reduction
 - Housing
 - Transportation
 - Social Support and Relationships
 - Legal

- Client file includes the following:
- Verification reassessment is completed every 365 days for clients with Acuity Levels 1-2.
 - Verification reassessment is completed every 180 days for clients with Acuity Level 3.
 - Verification that reassessment is completed sooner for clients who have significant changes in life circumstances.
 - Documentation of all elements outlined on Comprehensive Assessment form (Appendix C).
 - Brief narrative of reassessment findings in progress notes.
 - Documentation of referral(s) made and outcome of referral.

G. Service Plan Review

Time Requirement:

Acuity Level 1: Review by primary case manager and client occurs every six months. Supervisory review occurs annually.

Acuity Level 2: Review by primary case manager and client occurs every six months. Supervisory review occurs every six months.

Acuity Level 3: Review by the primary case manager and client occurs quarterly. Supervisory review occurs every six months.

1. Service plan review includes updating the status of existing action steps and identifying new goals and action steps to work towards meeting goals.
2. The case manager has primary responsibility for the updated service plan. Client input and approval of the plan occurs each time the case manager reviews the plan.
3. Supervisory review of the service plan occurs at intervals stated above. The supervisor's signature indicates review and approval of the plan.

Client file includes the following:

- Verification of service plan review by case manager and client every six months and by supervisor annually for clients with Acuity Level 1.
- Verification of service plan review by case manager, client, and supervisor every six months for clients with Acuity Level 2.
- Verification of service plan review by case manager and client quarterly and by supervisor every six months for clients with Acuity Level 3.
- Documentation of all elements outlined on Service Plan form (Appendix D).

H. Discharge/Graduation

1. Upon termination of active MCM services, the client is discharged from case management.
2. Common reasons for discharge include:
 - Client completed case management goals.
 - Client is no longer in need of service.
 - Client is referred to another case management program.
 - Client relocates outside of service area.
 - Client chooses to terminate service.
 - Client is no longer eligible for services.
 - Client lost to follow-up or does not engage in service.
 - Client incarceration greater than six months.
 - Agency initiated termination due to behavioral violations.
 - Client death.
3. Client is considered lost to follow-up if three attempts to contact client (via phone, email, or written correspondence) are unsuccessful. Discharge proceedings are initiated by the agency 30 days following the third attempt if there is no response from the client.
4. The case manager notifies the client (through face-to-face meeting, telephone, or letter) of plans to discharge the client from MCM.

Client file includes the following:

- Documentation of three attempted contacts to reach client and 30-day waiting period after third attempt before proceeding with discharge due to lost to follow-up.
- Verification that client was informed of plans to be discharged.
- Verification that client was provided with written documentation explaining reason for discharge, process for appeal, and information about readmission (if applicable).
- Brief narrative in progress notes explaining reason for discharge.
- Supervisor signature indicating approval for discharge.
- Documentation of referral to grief counseling or other support services for affected individuals in event of client death.

<ol style="list-style-type: none"> 5. The client receives written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the discharge from service. Information about readmission is shared also with the client if applicable. 6. Reason for discharge is documented in the client record. 7. Discharges are approved by case management supervisor. 8. In the event of client death: <ul style="list-style-type: none"> • Referral information about grief counseling or other support services is shared with family and/or significant others. • Case management agency determines the timeline for bereavement support services for affected family and/or significant other. 	
<p>I. Readmission</p> <ol style="list-style-type: none"> 1. A new Wisconsin Acuity Index must be completed for all clients seeking readmission after discharge from MCM services. 2. No additional paperwork is required at time of readmission if: <ul style="list-style-type: none"> • Client scores at Acuity Level 1-2 • Readmission occurs within six months of discharge from MCM services. 3. A reassessment and new service plan must be completed for clients who score Acuity Level 3 or clients who score Acuity Level 1-2 who were discharged from MCM services greater than six months ago. 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Newly completed Wisconsin Acuity Index form (Appendix B) • Documentation of all elements outlined on Comprehensive Assessment form (Appendix C) for clients who score Acuity Level 3 or who score Acuity Level 1-2 and were discharged from MCM services more than six months ago. • Documentation of all elements outlined on Service Plan form (Appendix D) for clients who score Acuity Level 3 or who score Acuity Level 1-2 and were discharged from MCM services more than six months ago.
<p>J. Brief Services</p> <ol style="list-style-type: none"> 1. Clients who choose not to enroll in MCM or who are not eligible for MCM (Acuity Level 0) are offered Brief Services. 2. Clients are provided with contact information for an agency representative(s) that they may contact when a service is needed. 3. In Brief Services: <ul style="list-style-type: none"> • Case managers are not required to complete a comprehensive assessment or service plan with the client. • Clients are not contacted proactively by case management staff but rather contact the 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Documentation of client request for services including staff response and outcome of request. • Documentation of client eligibility. • Documentation of offer for risk-reduction counseling and referral to Partner Services.

<p>designated agency representative to request specific assistance.</p> <ol style="list-style-type: none">4. Client eligibility for Ryan White services must be verified at time of service request.5. Brief Services clients are offered risk-reduction counseling and referral to Partner Services (PS).	
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MEDICAL CASE MANAGEMENT STANDARDS FOR CLINIC-BASED PROVIDERS

Clinic-based medical case managers must deliver MCM services in accordance with the standards outlined in the following section of this document. The Wisconsin AIDS/HIV Program has developed standardized forms to ensure delivery of case management activities complies with state standards. Any of the forms can be modified to include additional information that an agency deems necessary, however the information included on each of the standardized forms is a required minimum for collection. Utilizing the specific paper form is not necessary. Agencies may convert the information from the standardized forms into fields in electronic databases; however, none of the information from the standardized paper form should be omitted from the electronic record.

Standard	Measure
<p>A. Brief Services</p> <ol style="list-style-type: none"> 1. Clinic-based case managers provide Brief Services to clients who are already working with or plan to work with a community-based case manager. The clinic-based case manager does not need to complete the Acuity Scale with these clients. 2. In Brief Services: <ul style="list-style-type: none"> • Clinic-based case managers are not required to complete a comprehensive assessment or service plan with the client. • Clinic-based case managers may meet with clients when they attend medical appointments or at the request of the medical provider or client. 3. Clients are provided with contact information for an agency representative(s) that they may contact when a service is needed. 4. Client eligibility for Ryan White services must be verified at time of service request. 5. Brief Services clients are offered risk-reduction counseling and referral to Partner Services (PS). 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Documentation of client request for services including staff response and outcome of request. • Documentation of client eligibility. • Documentation of offer for risk reduction counseling and referral to Partner Services.
<p>B. Wisconsin Acuity Index</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Acuity Levels 1-2: Due every 365 days or sooner as life circumstances change.</p> <p>Acuity Level 3: Due every 180 days or sooner as life circumstances change.</p> </div> <ol style="list-style-type: none"> 1. The Wisconsin Acuity Index (WAI) is used to determine clients' needs and eligibility for case management. 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Completed Wisconsin Acuity Index form (Appendix B) including initial WAI and all subsequent WAIs completed with the client. • Verification that the WAI was completed at least annually for all clients with Acuity Levels 1-2. • Verification that the WAI was completed at least semi-

<p>2. The WAI evaluates client level of need in the following areas:</p> <ul style="list-style-type: none"> • Linkage and Retention in HIV Medical Care • Adherence to Antiretroviral Therapy (ART) • Health Literacy • Mental Health • Substance Abuse • Health Insurance • Housing • Oral Health • Nutrition • Income and Entitlements • Transportation • Legal • Culture and Language • Children and Dependents • Social Support <p>3. Clinic-based case managers complete the WAI with clients who are not currently or do not plan to work with a community-based case manager.</p> <p>4. Because clinic-based case managers provide Brief Services to a large number of clients, caseloads of medically case-managed clients should be no greater than 35.</p> <p>5. Clients who score Acuity Level 1-3 on the WAI are eligible for MCM.</p> <p>6. If the clinic-based case manager does not have availability on their caseload and/or the client's needs would be more appropriately addressed by a community-based case manager, the client is offered referral to a community-based case manager and provided Brief Services by the clinic-based case manager.</p> <p>7. Clients who score Acuity Level 0 on the WAI are not eligible for MCM and are offered Brief Services.</p> <p>8. Case managers may make adjustments to clients' Acuity Level if they feel that it does not accurately represent the client's level of need. Scoring adjustments must be approved by the agency's case management supervisor. Justification for the adjustment must be documented.</p>	<p>annually for all clients with Acuity Level 3.</p> <ul style="list-style-type: none"> • Verification that WAI is completed more frequently for clients with significant changes in life circumstances. • Documentation of supervisory approval for any Acuity Level scoring adjustments. • Documentation of justification for any Acuity level scoring adjustments. • Documentation of referrals made to community-based case managers and reason for referral.
<p>C. Initial Comprehensive Assessment</p> <p>1. The Comprehensive Assessment describes the client's medical and psychosocial needs in detail. 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 client's resources and strengths, including family and other supports that may be utilized during service planning.</p> <p>2. The Comprehensive Assessment is completed with all clients who are eligible for MCM (Acuity Level 1-3).</p>	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Documentation of all elements outlined on Comprehensive Assessment form (Appendix C). • Brief narrative of assessment findings in progress notes. • Documentation of referral(s) made and outcome of referral(s).

<p>3. Completion of the assessment may be the primary responsibility of the case manager or shared among members of the HIV care team.</p> <p>4. The case manager and/or members of the HIV care team meet face-to-face with the client at least once during the assessment process.</p> <p>5. At minimum, Initial Comprehensive Assessment includes gathering the following information:</p> <ul style="list-style-type: none"> • Client Contact Information • Client Demographics • Collateral Contact Information • HIV Status and Risk Information <p>And information related to the client's needs in the following areas:</p> <ul style="list-style-type: none"> • Education • Finances • Physical Health and Medical Care • Adherence to HIV Medications • Substance Use • Housing • Legal • Employment • Health Insurance • Retention in HIV Medical Care • Behavioral Health • Risk Reduction • Transportation <p>6. Clinic-based case managers are encouraged to use the Comprehensive Assessment form developed by the AIDS/HIV Program to ensure they are gathering all of the required information listed above. Agencies may revise the state form or develop their own assessment tool as long as all of the elements on the Comprehensive Assessment form are covered. Any assessment tools developed must be strengths-based.</p>	
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<p>D. Initial Service Plan Development</p> <p>1. Development of a service plan is a central component of MCM and provides the client and case management team with a proactive, concrete, step-by-step approach to addressing client needs.</p> <p>2. Client needs identified during assessment are prioritized and translated into a Service Plan, which defines specific goals and action steps needed to meet goals.</p> <p>3. Oversight for development of the service plan may be the primary responsibility of the case manager or shared among members of the HIV care team.</p> <p>4. 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 client and, if appropriate, family, close support persons, and other providers.</p> <p>5. At minimum, initial Service Plan includes:</p>	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Documentation of all elements outlined on Service Plan form (Appendix D).
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<ul style="list-style-type: none"> • Problem statement • Goal(s) • Action steps [action to be taken to work towards goal(s)] • Individual responsible for the action step <ul style="list-style-type: none"> • Anticipated timeframe for each action step • Client signature and date, or documentation of verbal approval • Supervisor's signature and date indicating review and approval <p>6. The service plan is updated with outcomes and revised or amended in response to changes in the client's life circumstances or goals. Schedule for service plan review is detailed in Section G. Service Plan Review.</p>	
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<p>E. Service Plan Implementation</p> <ol style="list-style-type: none"> 1. Implementation of action steps begins immediately after development of the Service Plan. 2. The specific activities performed during service plan implementation will vary based on the unique needs of each client. However, all activities must promote and support client engagement in HIV medical care and viral load suppression. 3. Oversight of service plan implementation is the responsibility of the case manager. 4. Communication and coordination with the client's HIV care team is essential for effective implementation to occur. 5. The type and frequency of contact with the client is based on client needs. However, minimum required contacts have been established for case managed clients based on Acuity Level established by the Wisconsin Acuity Index: <ul style="list-style-type: none"> • Acuity Level 1: Quarterly direct client contact • Acuity Level 2: Monthly direct client contact • Acuity Level 3: Twice monthly direct client contact 6. All implementation efforts are documented in the client's file in accordance with documentation standards outlined in Section C: Medical Case Management Client Charts/Records under Medical Case Management Practice Standards for All Medical Case Management Providers. 7. The client's right to privacy and confidentiality in contacts with other providers and individuals is ensured and in accordance with applicable state and federal laws and Part B/LCS Universal Standards of Care. 	<ul style="list-style-type: none"> • Client file includes the following: <ul style="list-style-type: none"> ○ Verification that Acuity Level 1 clients are contacted at least quarterly by the case manager. ○ Verification that Acuity Level 2 clients are contacted at least monthly by the case manager. ○ Verification that Acuity Level 3 clients are contacted at least twice monthly by the case manager. ○ Evidence of regular and ongoing contact with key members of the client's HIV care team. ○ Documentation of all implementation efforts in accordance with Medical Case Management Practice Standards for all Medical Case Management Providers. • Verification of compliance with applicable state and federal confidentiality and privacy laws and Part B/LCS confidentiality standards outlined in Section G of the Universal Standards of Care.
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<p>F. Reassessment</p> <div style="border: 2px solid black; padding: 5px; margin-top: 10px;"> <p>Time Requirement: Acuity Levels 1-2: Due every 365 days or sooner as life circumstances change. Service Level 3: Due every 180 days or sooner as life circumstances change.</p> </div>	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Verification reassessment is completed every 365 days for clients with Acuity Levels 1-2.
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<ol style="list-style-type: none"> 1. A reassessment reevaluates client functioning, health, and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or ongoing needs. 2. The case manager has primary responsibility for the reassessment and meets face-to-face with the client at least once during the reassessment process. 3. At minimum, reassessment includes gathering information on the following: <ul style="list-style-type: none"> • Client Contact Information • Client Demographics • Collateral Contact Information • HIV Status and Risk Information <p>And information related to the client's needs in the following areas:</p> <ul style="list-style-type: none"> • Education • Finances • Physical Health and Medical Care • Adherence to HIV Medications • Substance Use • Housing • Social Support and Relationships • Employment • Health Insurance • Retention in HIV Medical Care • Behavioral Health • Risk Reduction • Transportation • Legal 	<ul style="list-style-type: none"> • Verification reassessment is completed every 180 days for clients with Acuity Level 3. • Verification that reassessment is completed sooner for clients who have significant changes in life circumstances. • Documentation of all elements outlined on Comprehensive Assessment form (Appendix C). • Brief narrative of reassessment findings in progress notes. • Documentation of referral(s) made and outcome of referral.
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G. Service Plan Review VII. Service Plan Review

Time Requirement:

Acuity Level 1: Review by primary case manager and client occurs every six months. Supervisory/care team review occurs annually.

Acuity Level 2: Review by primary case manager and client occurs every six months. Supervisory/care team review occurs every six months.

Acuity Level 3: Review by the primary case manager and client occurs quarterly. Supervisory/care team review occurs every six months.

<ol style="list-style-type: none"> 1. Service plan review includes updating the status of existing action steps and identifying new goals and action steps to work towards meeting goals. 2. The case manager has primary responsibility for the updated service plan. Client input and approval of the plan occurs each time the case manager reviews the plan. 3. Supervisory review of the service plan occurs at intervals stated above. The supervisor's signature indicates review and approval of the plan. 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Verification of service plan review by case manager and client every six months and by supervisor annually for clients with Acuity Level 1. • Verification of service plan review by case manager, client, and supervisor every six months for clients with Acuity Level 2. • Verification of service plan review by case manager and client quarterly and by supervisor every six months for clients with Acuity Level 3. • Documentation of all elements outlined on Service Plan form (Appendix D).
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H. Discharge/Graduation

<ol style="list-style-type: none"> 1. Upon termination of active MCM services, the client is discharged from case 	<p>Client file includes the following:</p> <ul style="list-style-type: none"> • Verification that client was informed of plans to be
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<p>management.</p> <p>2. Common reasons for discharge include:</p> <ul style="list-style-type: none"> • Client completed case management goals. • Client is no longer in need of service. • Client is referred to another case management program. • Client relocates outside of service area. • Client chooses to terminate service. • Client is no longer eligible for services. • Client lost to follow-up or does not engage in service. • Client incarceration more than six months. • Agency initiated termination due to behavioral violations. • Client death. <p>3. Clinics may set definition of “lost to follow-up” and set parameters regarding discharge of these clients from MCM services.</p> <p>4. The case manager notifies the client (through face-to-face meeting, telephone, or letter) of plans to discharge the client from MCM.</p> <p>5. The client receives written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the discharge from service. Information about readmission is shared also with the client if applicable.</p> <p>6. Reason for discharge is documented in the client record.</p> <p>7. Discharges are approved by case management supervisor.</p> <p>8. In the event of client death:</p> <ul style="list-style-type: none"> • Referral information about grief counseling or other support services is shared with family and/or significant others • Case management agency determines the timeline for bereavement support services for affected family and/or significant other 	<p>discharged.</p> <ul style="list-style-type: none"> • Verification that client was provided with written documentation explaining reason for discharge, process for appeal, and information about readmission (if applicable). • Brief narrative in progress notes explaining reason for discharge. • Supervisor signature indicating approval for discharge. • Documentation of referral to grief counseling or other support services for affected individuals in event of client death.
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I. Readmission

1. A new Wisconsin Acuity Index is completed for all clients seeking readmission after discharge from MCM services if they are not currently or do not plan to work with a community-based case manager.
2. No additional paperwork is required at time of readmission if both of the following apply:
 - Clients score at Acuity Level 1-2
 - Readmission occurs within six months of discharge from MCM services
3. A reassessment and new service plan must be completed for clients who score Acuity Level 3 or clients who score Acuity Level 1-2 who were discharged from MCM services more than six months ago.

Client file includes the following:

- Newly completed Wisconsin Acuity Index form (Appendix B).
- Documentation of all elements outlined on Comprehensive Assessment Form (Appendix C) for clients who score Acuity Level 3 or who score Acuity Level 1-2 and were discharged from MCM services more than six months ago.
- Documentation of all elements outlined on Service Plan form (Appendix D) for clients who score Acuity Level 3 or who score Acuity Level 1-2 and were discharged from MCM services more than six months ago.