Registered Nurse Case Management

Service Definition

Registered Nurse Case Management (RNCM) is the delivery of a range of client-centered activities focused on improving health outcomes in clients needing more medical, social, and community-based support. RNCM services are based in a clinical setting; however, RNCMs often conduct services outside of a clinic. RNCM includes all types of case management encounters (for example, face-to-face, phone contact, and any other forms of communication). RNCM is considered a Medical Case Management service as defined by HRSA PCN 16-02.

Key service components and activities for RNCM include:

- Program enrollment and eligibility determination.
- Initial assessment of service needs.
- Annual assessment of service needs.
- Ongoing assessment of the client's and other key family members' needs and support systems.
- Development of a comprehensive, individualized service plan.
- Continuous client monitoring to assess the efficacy of the service plan.
- Re-evaluation of any service plan at least every six months.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments.
- Resource referral and system navigation.
- Appointment reminders.
- Coordination of transportation assistance.
- Client-specific advocacy and review of utilization of services.
- Medication adherence support and tools.
- Triage new and ongoing medical issues.
- Patient and family education.
- Interdisciplinary education.
- Clinical expertise in the coordination of medical care.
- Coordination of care with other Ryan White Part B providers.
- Coordination of care with providers on medical team.

Clients will be referred by other Ryan White Part B HIV Care Services Providers to RNCM if they are: Pregnant

- Under the age of 18

RNCM may also include referrals to benefits counseling to assist eligible clients in obtaining access to other public and private programs for which they may be eligible (for example, Medicaid, Medicare Part D, ADAP, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance marketplaces and/or exchanges).

Subrecipients providing RNCM services are expected to comply with the Universal Standards of Care, as well as these additional standards:

Standard 1: Providers of RNCM case services in Wisconsin must ensure services are delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

RNCM is funded under the Ryan White Medical Case Management service category as defined in Policy Clarification Notice (PCN) 16-02.As such, providers are responsible for determining eligibility at enrollment and for confirming eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500% FPL at initial enrollment in accordance with the Wisconsin Ryan White Part B Eligibility Policy.

Standard 2: During initial contact, key information about the client can be collected or verified in the Electronic Medical Record (EMR).

Providers must attempt to collect and/or confirm the following client information:

- Contact and identifying information
- Emergency contact, if available
- Insurance status
- Documentation of income and status of residing in Wisconsin
- Demographic information
- Contact information for other service providers and corresponding release of information (ROI)
- Proof of HIV diagnosis

Documentation

Documentation of all elements outlined above must be completed within 30 days of first medical visit, initial referral, or contact. Documentation must show any corresponding ROIs as needed and applicable.

Standard 3: Immediate referrals to additional services must be made for clients with most needs.

Immediate referrals to the appropriate services and resources are required for clients that:

- Are not currently engaged in medical care.
- Are in need of and not engaged in mental health services.
- Are on medication but will run out before their next medical appointment.
- Are a danger to themselves or others.

Documentation

Documentation of immediate referrals must be included in the client record.

Standard 4: Intake may be performed by providers, non-service provider staff or interns.

Intake may be performed by subrecipient staff or interns who are not RNCMs provided they meet all the following criteria:

- Are an employee or intern of the subrecipient
- Received proper onsite training and signed the agency confidentiality agreement.
- Completed the HIV Basics Online Course offered through the UW HIV Training System

Documentation

The client record must indicate who performed the intake.

If the client record shows that intake is performed by someone who is not an RNCM, the personnel file for the person doing the intake must document the required criteria.

Standard 5: The appropriate Wisconsin Acuity Index tools (WAI) for the client's age must be used to determine clients' needs and level of self-sufficiency.

The WAI should be completed within 30 days of intake and evaluates client level of needs. If client is in under 18 and in pediatric care, the Pediatric Wisconsin Acuity Index Tool (PWAI) is used, when it is available. If a client is in adult care, the standard WAI is used.

Documentation

Completed WAI or PWAI form is available for review by the Wisconsin CDHR upon request.

The client record must document that the initial WAI or PWAI was completed within 30 days of intake.

If initial WAI or PWAI was completed past 30 days of intake, the client record must document circumstances leading to delay in completion.

Standard 6: Based on WAI or PWAI score, the RNCM determines if the client should be referred to another type and/or and additional Ryan White Part B service.

If a client scores a 0, they will be referred to brief services, unless the score is adjusted up for life circumstances.

If a client scores a 3, they can be referred to also participate in Linkage to Care (LTC) services, as appropriate. A client may accept or decline any service they are referred to. If a client accepts the referral, RNCM must either perform a warm hand-off or work in collaboration with the other service provider.

Documentation

Documentation of WAI or PWAI score and actions taken that are consistent with the WAI or PWAI score are in the client record.

Standard 7: Within 30 days of the WAI or PWAI completion, clients with a score above 0 must be further assessed.

A comprehensive assessment is completed by reviewing EMR as well as communicating directly with the client and/or family members. The client's medical and psychosocial needs must be documented in detail. Service needs are gathered and added to the service plan. The service plan will outline what needs are being addressed and by whom; service gaps; barriers to service access; and service coordination gaps. This assessment also evaluates the client's resources and strengths, including family and other supports.

An assessment should include all the client information gathered at intake, and address client needs in the following areas:

- Education
- Financial information
- Medical care team
- Adherence to HIV medications
- Substance use
- Housing
- Social support and relationships
- Overall health
- Employment
- Health insurance
- Retention in HIV medical care
- Mental health
- Harm reduction methods
- Transportation
- Oral health
- Nutrition
- Vision care
- Activities of daily living
- Domestic violence screening
- Dependents
- Alternative therapies or medicines
- Legal
- General health literacy
- Comorbidities
- Knowledge of HIV

Documentation

The client record must document that all required information in each relevant area was collected through a formal and informal assessment.

RNCMs are encouraged to use the comprehensive assessment form developed by the Wisconsin CDHR Section to ensure they are gathering all the required information listed above.

Subrecipients may revise the state form or develop their own form of assessment as long as all of the elements on the Comprehensive Assessment form are covered. Any assessment tools developed must be strengths-based and easily accessible.

Standard 8: The provider has primary responsibility for completion of a comprehensive assessment.

Providers must meet face-to-face with the client at least once during the assessment process, either virtually or in-person.

If the provider is unable to acquire all relevant information necessary to complete the assessment within 90 days of the assessment date due to no response from the client, the provider must continue efforts to outreach to client until they are aware client is declining services or engaged in services elsewhere. See the Ryan White Part B Universal Standards for further guidance.

Documentation

The client record must document actions taken by the case manager to complete the comprehensive assessment.

Standard 9: Based on the findings of the initial assessment, the RNCM and client and/or guardian collaboratively develop an initial service plan.

Development of a service plan is a central component of RNCM and provides the client and/or guardian and case management team with a proactive, concrete, step-by-step approach to addressing client needs.

Client needs identified during a comprehensive assessment are prioritized and translated into a service plan, which defines specific goals, action steps needed to meet goals, and who will be the responsible party for each action step.

The RNCM has primary responsibility for the development of the service plan. Active client and/or guardian involvement, defined by participation, input, and agreement 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.

At minimum, the initial service plan includes:

- Goal(s).
- Action steps [to be taken towards goal(s)].
- Individual responsible for the action step.
- Anticipated timeframe for each action step, when applicable.
- Client and/or guardian signature and date, or documentation of verbal approval.
- Supervisor's signature and date indicating review and approval, when determined by WAI score.

Documentation

A service plan, with all required elements, must be available for review by the Wisconsin CDHR Section upon request.

Standard 10: Action steps begin immediately after development of the service plan.

Specific activities performed to reach service plan goals during the service plan use will vary based on the unique needs of each client. However, at least one activity must directly relate to promoting and supporting client engagement in HIV medical care and overall health.

Documentation

The client record must document specific activities and promotion/support of client engagement in HIV medical care and overall health.

Standard 11:Communication and coordination with the client's care team is essential for effective case management to occur.

Frequent care consultation must happen with other members of the client'sl care team. When a client is receiving additional case management services at the RNCM agency or a different social services agency, the RNCM must work with other service providers to ensure coordination of care and reduce barriers to care.

Documentation

The client record must contain evidence of regular and ongoing contact with key members of the client's care team.

Standard 12: The type and frequency of contact with the client is based on client needs.

All RNCM clients must be contacted at least quarterly. Expectations for higher frequency of contact based on acuity score is listed on the acuity documents.

Documentation

The client record must document a frequency of contact based on acuity score.

Standard 13: Client acuity must be reassessed periodically, based on acuity level.

The WAI or PWAI must be re-administered at least annually for all RNCM clients. Expectations for re-administering WAI or PWAI are listed on the acuity documents.

Documentation

The client record must document that the client's acuity was reassessed at the frequency appropriate based on the most recent WAI or PWAI score.

Standard 14: The client must receive ongoing assessment, based on the acuity level, that is clearly documented in the client record.

The assessment record must be re-documented at least annually for all RNCM clients.

Frequency of assessment may be altered based on acuity score. Frequency for each category is listed on the WAI and PWAI forms.

Re-assessment does not need to be completed for clients who have significant life changes. Rather, a new WAI or PWAI is to be administered and the timing of other required documents will be determined by that score. A new WAI must also be completed when a client transitions out of pediatric and into adult care.

Documentation

The client record must document assessment is completed at the intervals required by the client's WAI or PWAI score.

The client record must document that the client's acuity was re-assessed at the frequency appropriate based on the most recent WAI or PWAI score or sooner if dictated by changes in the life circumstances of the client.

The client record should also include a brief narrative of reassessment findings in progress notes, documentation of referral(s) made, and outcome of referral.

Standard 15: The client's service plan must be reviewed, based on acuity level.

Service plan review includes updating the status of existing action steps and identifying new goals and action steps to work towards meeting goals.

The provider has primary responsibility for the updated service plan.

Client and/or guardian input and approval of the plan is required each time the RNCM reviews the plan.

The frequency of service plan review is based on the client's WAI or PWAI score. Expectations for reviewing a service plan are listed on the WAI or PWAI document.

Supervisory review of the service plan occurs at intervals stated on WAI or PWAI form.

Standard 16: Upon completion of RNCM services, the client must transition to self-management, a less intensive care service, or is discharged.

Reasons for client completion include:

- Client completed RNCM goals.
- Client WAI score reaches 0.
- Client is no longer eligible for services.
- Client is no longer in need of service.
- Client is considered "lost to follow-up" or does not engage in service. *
- Client is referred to another case management or RNCM program.
- Client relocates outside of service area.

Reasons for client discharge include:

- Agency initiated discharge due to behavioral violations (this should be a last resort).
- Client chooses to discharge service.
- Client reaches maximum age for services.
- Client death.

*See Universal Standards for guidance.

Documentation

The client record must document which reason(s) for completion or discharge were met.

A brief transition or discharge narrative must be included in the client record.

If transitioning to other care services, documentation should include, at minimum, the client's service plan and evidence of communication between RNCM and the care services provider taking over client's care.

The RNCM should inform the care services provider taking over client's care of plans to discharge no later than three weeks prior to discharge. A warm hand off should take place whenever possible.