



# **N-S EMA MEDICAL CASE MANAGEMENT STANDARDS OF CARE**

Service standards<sup>1</sup> outline the elements and expectations a RWHAP Service provider follows when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction.

**N-S HIV Health Services  
Planning Council**  
[www.longislandpc.org](http://www.longislandpc.org)

**Medical Case Management** services (including treatment adherence) are a range of client-centered services that link PLWHA with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for adherence to complex HIV/AIDS treatments. Key activities include: 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) client monitoring to assess the efficacy of the plan; and 5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of medical and psychosocial support services and counseling to help clients with HIV improve their health status.

### **Objectives:**

1. Connect clients to HIV primary care services within 60 days of intake/assessment or reassessment.
2. Maintain client access to medical care for a minimum of two visits per year.
3. Maintain client adherence to antiretroviral (ARV) treatments, as prescribed, at no less than 80% rate of compliance.
4. Maintain client viral load and CD4 lab testing minimum twice per year.
5. Connect clients with necessary supportive services within 60 days of intake/assessment or reassessment, or within 15 days of a crisis intervention.

As medical and social service agencies bring different strengths to keeping PLWHA adherent to treatment and care, it is anticipated that providers will develop relationships and work together to ensure access and continuity of care. In keeping with their mission – primary care providers will necessarily concentrate their case coordination and treatment adherence activities on the medical aspects of care, for example, ensuring that clients are receiving the most appropriate antiretroviral regimen to avoid HIV resistance. CBOs and ASOs may use their expertise in addressing social support issues, such as housing instability, inadequate food and nutrition, lack of transportation, and HIV discrimination in addressing barriers to primary care and barriers that interfere with adherence to treatment.

**Medical Case Management (MCM)** services provides an opportunity for the service provider and MCM staff, to combine their expertise and resources to provide the most efficient, high quality care required to meet the client's needs and produce quality medical outcomes. The Medical Case Management components are designed to ensure timely services and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of client needs. The purpose of medical case management is to maintain the client in ongoing medical care and treatment; to assist the client with accessing needed services; to increase the client's adherence to their medical plan (i.e., medication regimen); to improve service delivery and client health outcomes.

### **MCM Service components:**

#### **1) Intake and Eligibility:**

The Intake and Eligibility involves the initial meetings with the patient during which the medical case manager gathers information to address the patient's immediate needs and to encourage his/her engagement and retention in services. The intake should also include the client's eligibility for Ryan White services and collection of required documentation (EMA RW Part A Client Eligibility requirements and HRSA/HAB Policy Notice #13-02). Medical Case Managers will assure the patient's privacy and confidentiality in all phases and activities of

medical case management. Intake eligibility is a relatively brief encounter to collect basic client information in order to open a file; the objectives of the standards for the intake process are to:

- Assess client's immediate needs
- Begin to establish a trusting client relationship.
- Collect basic client information to facilitate client identification and client follow up; and
- Collect required state/federal client data for reporting purposes;
- Establish the client's eligibility for services, including HIV status and other criteria;
- Inform the client of the services available and what the client can expect if she/he were to enroll.

The intake is conducted by an appropriately trained staff or intake worker. The staff person will review client rights and responsibilities, explain the program and services to the client, explain their agency's program confidentiality and grievance procedures and other policies to the client, assess the client's immediate service needs, and secure permission from the client through the completion of release information forms. The intake should include the client eligibility documentation such as client's HIV positive status (verified and documented), proof of insurance, income and residency. **The EMA Ryan White Universal Intake form** should be utilized to collect intake information. (Prior approval is necessary to request an alternate intake form to be used). Information below (at a minimum) should be obtained from the client:

- Name, address, social security number, phone and email (if available);
- Preferred method of communication (e.g., phone ,email, or mail)
- Emergency contact information
- Preferred language of communication
- Enrollment in other HIV/AIDS services including case management and other HIV/AIDS or support services;
- Primary reasons for seeking services at the agency

The eligibility determination process must be completed within 60 days of the initial contact with the individual and documented in the file.

Standard	Measure
<p><b>1.1 Intake and Eligibility</b></p> <p>Basic client information and social service needs (e.g. medical insurance, housing, and transportation) discussed and obtained. Focus on issues that may immediately impact on client's ability to adhere to medical appointments and/or medications.</p> <p>Client is oriented to program/clinic staff and procedures, and educated about ancillary/sub-specialty services available on-site or through referral.</p>	<p>A. Documentation of completed intake form and eligibility for medical case management services was assessed and completed at first initial visit.</p> <p>B. Immediate needs are identified during the Intake interview.</p> <p>C. Immediate needs are addressed promptly.</p> <p>D. Initial documentation includes, at minimum:</p> <p><b>Basic information</b></p> <ul style="list-style-type: none"> <li>• confidentiality concerns</li> <li>• contact and identifying information (name, address, phone, birth date, etc.)</li> <li>• current/former medications</li> <li>• demographics</li> <li>• emergency contact</li> <li>• <b>health insurance status*</b> (required for RW eligibility)</li> <li>• household members</li> <li>• language spoken</li> <li>• <b>proof Nassau/Suffolk residency*</b>(required for RW eligibility)</li> <li>• <b>proof of HIV status*</b> (required for RW eligibility)</li> <li>• <b>proof of household income*</b> (required for RW eligibility)</li> <li>• other current health care and social service providers, including other community case management providers (community based grant funded).</li> </ul> <p><b>Brief overview of status and needs regarding</b></p> <ul style="list-style-type: none"> <li>• food</li> <li>• housing</li> <li>• immediate medical concerns</li> <li>• transportation</li> </ul> <p><b>Identification of immediate issues that impact client's ability to be retained in care.</b></p> <ul style="list-style-type: none"> <li>• assessment of the patient's history regarding their continuity of medical care</li> <li>• strategies for keeping next scheduled medical appointment</li> </ul> <p>E. Documentation includes appropriate consents and releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F of the NYS Public Health Law and other releases for information as required by applicable law.</p> <p>F. Agency's Medical Case Management Policies and Procedures contain guidelines for conducting the intake as well as process for patient interview, staff responsible, supervisory oversight and distribution of client grievance procedures.</p>
<p><i>Ryan White Eligibility</i></p> <p>*As required by HRSA/HAB Policy Notice #13-02. Ryan White Eligibility and proof of documentation are required at intake/assessment and updated every 6 months.</p>	

**2) Assessment, Service Plan & Reassessment:**

**2.1 Assessment**

The assessment is a cooperative and interactive endeavor between the MCM staff and the client to identify all of the client issues such as: determine client medical status – but not limited to health insurance, HIV primary care provider, family/domestic issues, social supports, disclosure, finances, housing, nutritional needs (including food), language, religious and cultural beliefs & practices that may be needed. The assessment builds upon information from the intake and provides information to developing the initial service plan. Patient needs identified through the assessment are prioritized and translated into a Medical Case Management Service Plan. The client will be the primary source of information. With client consent, assessments may include additional information from medical, psychosocial providers, caregivers, family members, and other sources of information.

**The initial assessment should be conducted as a face-to-face within 30 days of intake. Any exception or accommodations must be well documented.**

Assessment Tools: A standardized assessment tool (developed by the QAM committee) must be used or if utilizing an electronic medical record instrument must first be approved by UWLI to ensure that the tool meets Ryan White MCM program guidelines.

<b>Standard</b>	<b>Measure</b>
<p><b>2.1 Assessment</b></p> <p>Completed assessment in the client file.</p>	<p>A. Within 30 days of initial client intake, assessment is conducted of client’s need. (Needs identified in the assessment dictate the activities developed in the service plan.)</p> <p><b>Brief overview of status and on-going needs regarding</b> (not necessarily in this order)</p> <ul style="list-style-type: none"> <li>• barriers and facilitators to access and retention in care</li> <li>• dental care</li> <li>• domestic violence/physical or sexual abuse</li> <li>• finances/benefits</li> <li>• food/clothing, other concrete needs</li> <li>• health behaviors (e.g. treatment adherence, nutrition, physical activity, tobacco use)</li> <li>• health literacy</li> <li>• history of incarceration</li> <li>• HIV and other medical conditions,</li> <li>• housing</li> <li>• legal services</li> <li>• mental health</li> <li>• prevention/risk reduction issues</li> <li>• substance use</li> <li>• support system</li> <li>• transportation</li> </ul> <p><b>Referrals needed/recommended</b>  <b>Name of the Medical Case Manager completing assessment and date completed. Signed by client, staff person, and supervisor</b></p>

## 2.2 Reassessment (6 month and Annual)

A reassessment is performed to re-evaluate patient functioning, health and psychosocial status; identify changes since the initial or most recent assessment; determine progress and new or ongoing needs. As with an assessment process it is the responsibility of the MCM staff to review and revise a client's service plan as needed, **but not less than once** every six months. As part of the service plan (SP), programs must ensure the coordination of services. Coordination of services requires: identification of other staff or service providers with whom the client may be working. As appropriate program staff will act as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. Staff members must comply with established agency confidentiality policies when engaging in information and coordination activities.

Standard	Measure
<p><b>2.2 Reassessment</b></p> <p>Reassessment of the client's service needs is <b>required every 6 months</b>, or sooner if significant changes occur in patient's needs.</p>	<p>A. Reassessment includes review, and if necessary, update of:</p> <ul style="list-style-type: none"> <li>• Personal information</li> <li>• Patient health history, health status, and health-related needs outlined in the Comprehensive Assessment;</li> <li>• Patient status and needs related to psychosocial issues and required services/referrals</li> <li>• Need for partner counseling and assistance services</li> </ul> <p>B. Name of staff completing reassessment and date of completion is noted in the patient file. (Including review of SP signed by client, staff person, and supervisor and monitor service plan progress in notes).</p>
<p><i>Ryan White Eligibility</i></p> <p>*As required by HRSA/HAB Policy Notice #13-02 Ryan White client eligibility verification is required every 6 months.</p>	<p>C. Documentation of client RW eligibility has occurred every 6 months and verification of no change has occurred. (Providers may use a signed client checklist to show eligibility review and no change.) If any change has occurred, proof of new documents must be collected and placed in client file. *Annual client eligibility update is required and current documentation collected and placed in client file.</p>
	<p>D. Documentation that grievance procedures was reviewed with the client and placed in the client chart. Evidence of client signature.</p>

## 2.3 Service Plan

A Service Plan (SP) is developed in response to the assessment and is driven by the needs identified. An update of the plan is required following a change in patient circumstances or a formal reassessment. The service plan is a mutually agreed upon course of action developed in collaboration with the client necessary for achieving the set goal of improving and maintaining their health. The medical case manager has primary responsibility for development of a medically focused plan. For clients with significant needs such as housing, legal assistance or home visits etc. the program must have linkages with community-based case management programs. The medical case manager is to refer patients in need of services outside the purview of their work. The medical case manager must track referral outcomes through coordinated efforts with a community case manager and/or other providers. *Referral without confirmation of linkage to care/service is not acceptable.* (See Referrals)

Patients receiving both medical and community case management require the managing case workers to routinely communicate. At a minimum, for patients that receive both community and medical case management services, case conferencing must occur every six months. The purpose of the Service Plan (SP) is to guide the provider and client in their collaborative effort to deliver high quality care corresponding to the client’s level of need. The service plan should include goals based upon the needs identified in the assessment, and action steps needed to address each goal. The SP should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow up. The service plan outlines incremental steps to reaching a goal and who is responsible for what activity. Outcomes of the service plan activities are documented in the client chart. Service plan should be signed by the client, medical case manager and supervisor.

Standard	Measure
<p><b>2.3 Service Plan</b></p> <p>Completed <b>Service Plan</b> in client file signed by the client, staff person and supervisor.</p>	<p>A. Within <b>30</b> days of client assessment and/or reassessment, individual service plan (SP) is developed collaboratively with the client <b>face to face</b> that identifies goals, objectives, resources to address client’s needs, and a timeline.</p> <p>B. The <b>SP</b> is reviewed and revised as needed at least every 6 months.</p> <p>C. Updated <b>SP</b> shall be signed by client, staff person, and supervisor.</p>

### 3) Treatment Adherence:

Treatment Adherence uses interventions or programs to ensure readiness for and adherence to antiretroviral treatments. The goal of this service is to provide the client with information, skills, and support to achieve optimal health. Services can be provided through educational settings. Treatment Adherence service is a customized counseling service specific to the client’s current needs, goals, and medical condition. Clients should be educated on the relationship between viral load, CD4 count, antiretroviral (ART) adherence and medical appointment compliance. In addition, the following evidence-based treatment adherence recommendations should be discussed with clients:

- Taking all medications as prescribed.
- Making and attending appointments.
- Addressing barriers to care and treatment.
- Adapting to therapeutic lifestyle changes as necessary.

Standard	Measure
<p><b>3. Treatment Adherence</b></p> <p>To assist client in attaining/maintaining adherence to treatment</p>	<p>A. Documentation in the client files of medication adherence counseling/barriers/ resolutions.</p> <p>B. Track laboratory results.</p> <p>C. Documentation in client files of laboratory results.</p> <p>D. Assist with filling prescriptions and document in chart, when appropriate.</p> <p>E. Track and document in client files client’s HIV primary care and specialty care visits.</p>

**4) Care Coordination:**

Care Coordination is a service to address client’s healthcare and service needs as identified in the client’s service plan. The goal of this service is to maintain ongoing communication with clients, medical providers, information sharing, and other service providers. The client’s progress should be assessed at **least quarterly**. The service may be performed through various forms of communication including but not limited to phone calls and face-to-face meetings. Effective strategies for communication and follow-up with the client should be identified. Coordination activities may include directly arranging access to healthcare service; reducing barriers to obtaining services such as scheduling appointments; establishing linkages and confirming service acquisition. Services can also include interventions such as home visits or alternative locations when trying to maintain and reengage client in medical care.

Standard	Measure
<p><b>4. <i>Care Coordination</i></b></p> <p>To achieve the set goal of improving and maintaining client’s health to facilitate engagement and retention in care and achieving optimal medical outcomes.</p>	<p>A. Documentation in the client files of all communications with client, medical providers, and other service providers.</p> <p>B. Document progress of client health and support needs at least quarterly and written in client file to monitor in care status.</p> <p>C. Documentation in client file of other staff within the agency or at another agency with whom the client may be working. Program staff will identify and communicate as appropriate, with other service providers to support coordination and delivery of high quality care and to prevent duplication of services.</p>

**5) Case Conference:**

Case conferencing is a formal, planned, and structured event separate from routine contacts which differs from care coordination. The goal is to provide holistic, coordinated and integrated **multidisciplinary** services across providers and to reduce duplication of services. It presents opportunities to share information that will enhance patient care and improve medical outcomes. Case conferences may include internal and external providers, the patient, family or close supports. It can be used to identify or clarify issues regarding a patient’s status, needs and goals; to review activities including progress and barriers towards goals; to delineate roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans. Case conferences may be face-to-face or by telephone. More frequently case conferences must occur during periods of significant patient change or patient absence from care. Case conferences are documented in the patient’s record.

Standard	Measure
<p><b>5. <i>Case Conference</i></b></p> <p>Staff will case conference to discuss and share client issues necessary to enhance care coordination among members of a multidisciplinary team.</p>	<p>A. Evidence of coordination activities and timely case conferencing with key providers including follow-up with case managers are documented in the progress notes in the clients chart.</p> <ul style="list-style-type: none"> <li>• Required when there is a significant decline in the patient’s health or absence from care.</li> <li>• The patient’s consent to consult with other service providers is obtained. The provider complies with Article 27-F of the NYS Public Health Law regarding confidentiality of HIV-related information.</li> </ul>

**6) Patient Education:**

Patient education provides health information to clients that can assist in altering health behaviors and/or lifestyles to improve health status in a group or individual setting. Educational topics can include: types of treatment available, health literacy, behavioral health, secondary prevention, sexually transmitted infections (STI's), Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), side effects of treatment, psychosocial issues, patient belief system, cultural beliefs, confusion and forgetfulness and provider relationship.

<b>Standard</b>	<b>Measure</b>
<b>6. Patient Education</b>  Provide and arrange client HIV/AIDS education and/or educational programs.	A. Documentation in client files of patient education discussion or attendance at sessions.  B. Documentation of education encounter provided that reinforce clients service plan.

**7) Referral:**

Referral is a service provided to clients to arrange services which promote adherence to care and treatment. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. In case of referrals, staff facilitates the scheduling of appointments, transportation, and the transfer of related information. Referral types include but are not limited to: medical appointments, laboratory tests, mental health treatment, substance use treatment, benefit coverage i.e. (Medicaid), housing, transportation, or other supportive service. Service providers should have referral/linkage agreements for clients, particularly when facilitating mental health, substance abuse, and other medical and supportive services.

<b>Standard</b>	<b>Measure</b>
<b>7. Referral</b>	A. Documentation in Policy and Procedure of linkage agreements.  B. Documentation of appropriate and current consents and releases, including authorization for the release of HIV confidential information in accordance with Article 27F of the NYS Public Health law, and other releases for information as required by applicable law.  C. Documentation of referral in client chart.

**8) Maintenance in Care:**

Maintenance in Care is a service for the retention of clients in care and minimizing clients being lost to care. Maintenance in Care activities should be a routine part of service provision. A client is considered lost to care when the client has not attended their primary medical service appointment for a period of 6 months or more. Depending on the clients MCM service plan, this may include medical care, substance abuse counseling, dental care, mental health counseling, etc.

Reengagement strategies are aimed at patients who are lost to care or those who are only episodically involved in care. Proactive measures should be instituted and maintained to achieve both retention in care and treatment adherence. Reengagement interviews should initiate a reassessment/service plan update and, when appropriate, a case conference. **Reengagement** into care is the responsibility of the entire health care community. Medical Case Managers maintain a unique relationship with clients and are well- positioned to guide clients back into care. The MCM program is encouraged to develop internal policies to both retain and re-engage clients into care.

Standard	Measure
<p><b>8. Maintenance in Care</b></p> <p>Retention policy to engage clients in medical care.</p>	<p>A. Documentation of Retention Policy and Procedure for reengaging clients lost or sporadic to care (6 months without a medical visit).</p> <p>B. Documentation in client files of retention activities and follow-up with client and providers.</p> <p>C. Documentation of case conference in client chart.</p>

**9) Case Closure:**

Clients who are no longer engaged in HIV treatment and care services should have their cases closed based on the criteria and protocol outlined in the agency’s Medical Case Management Policies and Procedures Manual. All required activities, responsible individuals, supervisory review and the number of attempts for required activities must be documented in the Medical Case Management Policies and Procedures (e.g., phone call, letter, home visit, and alerts to community based case managers).

Reasons for case closure may include:

- Client lost to care, does not re-engage in service.
- Client chooses to terminate service.
- Client relocates outside of service area.
- Agency terminates Client from services due to issues defined in the agency’s Medical Case Management Policies and Procedures Manual.
- Client is referred to another facility better able to address patient’s needs.
- Client is deceased.

Standard	Measure
<p><b>9. Case Closure</b></p> <p>Upon termination of active HIV treatment and care, a client’s case is closed and the case record contains a closure summary.</p>	<p>A. Documentation of all reengagement attempts conducted prior to case closure.</p> <p>B. Documentation stating the reason for closure and a closure summary, including facility to follow up with the patient’s medical treatment (if appropriate).</p> <p>C. Documentation of agency’s Medical Case Management Policies and Procedures Manual outlines the criteria and protocol for case closures.</p>

**10) Program Staffing Qualifications/Training:**

All Medical Case Management personnel (including supervisors, medical case managers, and peer counselors) shall have sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population. Programs should employ full-time staff when possible to provide direct client services, rather than supporting multiple partial full-time equivalents (FTE’s). All medical case management, care coordination and treatment adherence activities may be performed by one or more “medical case managers” or “care coordinators”. (Alternate titles may be proposed for all positions). Required staff credentials or qualifications are at the provider’s discretion, but should be included in the position descriptions.

Standard	Measure
<p><b>10. Program Staffing Qualifications/Training</b></p> <p>Personnel file has copies of degrees, resumes/applications, evidence of experience, completion of orientation, job description and signed annual evaluation.</p> <p>Provider maintains a current policy and procedure manual that addresses staffing qualifications and licensing.</p> <p>Personnel file of staff, volunteers, and /or sub-contractors staff reflect minimum of 10 hours of training annually (including annual HIV confidentiality and cultural competency updates).</p>	<p>A. Service provider shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to clients within ninety (90) days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum:</p> <ul style="list-style-type: none"> <li>• Annual signed staff evaluation</li> <li>• Client Rights and Responsibilities</li> <li>• Clinical protocols and standards for pharmacological treatment of HIV</li> <li>• Confidentiality (with signed confidentiality agreement)</li> <li>• Cultural and Linguistic Competency</li> <li>• Eligibility verification process and policy</li> <li>• Emergency and safety procedures</li> <li>• Grievance Procedures/Process</li> <li>• HIV and Psychosocial Issues</li> <li>• Infection control and universal precautions</li> <li>• Listing of drug access programs</li> <li>• Privacy and Confidentiality</li> <li>• Professional ethics</li> <li>• Programmatic requirements including applicable Standards of Care and protocol for assessing treatment adherence</li> <li>• Proper documentation in case records</li> <li>• Review of job description (should include line of supervision)</li> </ul> <p>B. Providers must have documentation of Annual HIV Confidentiality and Cultural Competency Updates.</p> <p>C. Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of <b>ten (10) hours</b> of job-related educational programs/in-services annually, as determined by agency personnel policy. Appropriate and professional-training priorities should include but not be limited to: current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, domestic violence, etc.)</p> <p>D. Documentation in Policy and Procedures manual of program staffing, qualifications and training requirements.</p> <p>E. Documentation of trainings in Personnel files or sign in sheets</p>

### ***Best Practices:***

**Team:** A provider may also proposed a combination team provided that-regardless of program position titles clients are able to receive the required mandated MCM services. Providers must identify their program team and how the participation of a multidisciplinary health and social services team including, but not limited to- (medical) case managers, care coordinators, treatment adherence counselors/coordinators, physicians, physician assistants, nurse practitioners, and mental health and substance use counselors- who have treatment adherence, and supportive services.

**Peers:** The utilization of peers in MCM is allowable and propose peer models must be evidence based with clear goals and objectives that directly support program outcomes. Training and supervision of peers must be clearly addressed.

**Caseload:** Caseloads should be reflective of program staffing, funding projection and number of clients to be served and units of service. Units of service activities should be relevant to the required MCM subservices and comparable to the number of clients to be served in a contract year.

### **HRSA/HAB Performance Measures:**

Programs are required to assess, document and report on the client's connection to HIV primary care and treatment.

Programs must collect and record the following in CAREWare (the regional client level data reporting system):

1. Type of provider and most recent primary care provider and date of the last visit;
2. Whether the client is on ARV therapy and, if so, the approximate treatment start date of the last visit;
3. Dates and results of the most recent viral load and CD4 tests.

Clients found not to have a medical provider or not to have visited a medical provider during the last six months prior to the assessment must be referred for services. Clients must be reassessed every six months, if not more often, to determine "in care" status, documenting any referral appointments, the outcomes, and the date of follow-up. **Includes HRSA HIV/AIDS Performance Measures. (See Attachment)**

### **Data Reporting:**

All Part A medical case management activities on Ryan White Program Data/Client information, units of service and client health outcomes must be entered into CAREWare. Reporting units of service are a component of each agency's approved work plan. Please refer to the most current work plan, including any amendments, for guidance regarding units of service.

Summaries of service statistics by priority will be made available to the Planning Council by the Grantee for priority setting, resource allocation and evaluation purposes.

There are reports required to be analyzed for health care providers or agencies which include:

1. Percentage of patients who are retained in medical care in the measurement year.
2. Percentage of patients on antiretroviral therapy for whom it is indicated in the measurement year.
3. Percentage of patients who are adherent to their treatment regimen in the measurement year.

## **Grievance Procedures:**

For Ryan White Part A programs, each agency is required to maintain and distribute a Grievance Procedure Policy to each client served under the program. In the event that a client wishes to file a complaint about the Ryan White services provided, the client must follow the agency Grievance Procedure to bring their complaint to the attention of the appropriate administrative staff person. Client should receive a copy of the policy every 6 months and sign a form indicating receipt. The policy should include the steps available to the client as listed in the Policies and Procedures Manual. This resolution process may include the following:

- All grievances should be brought to the attention of the Program Coordinator/Director. It should include the following information: client information (name, address, phone number & signature), date, time and nature of the complaint. Grievances should be submitted in writing or by calling the agency. It should list a timeframe for initial verbal or written response (5-7 days) and a timeframe listing the number of days in which the matter should be resolved.
- If the complaint cannot be resolved on the first level of management, it should be elevated for review by the next level of management or taken to the Executive Director or Chief Executive Officer. If a resolution is not reached through the agency's process, the person filing the grievance may contact the Ryan White Contract Administrators at United Way of Long Island.