HIV COMMUNITY SERVICES PROGRAM

HIV Case Management: Standards of Services

County Based Model

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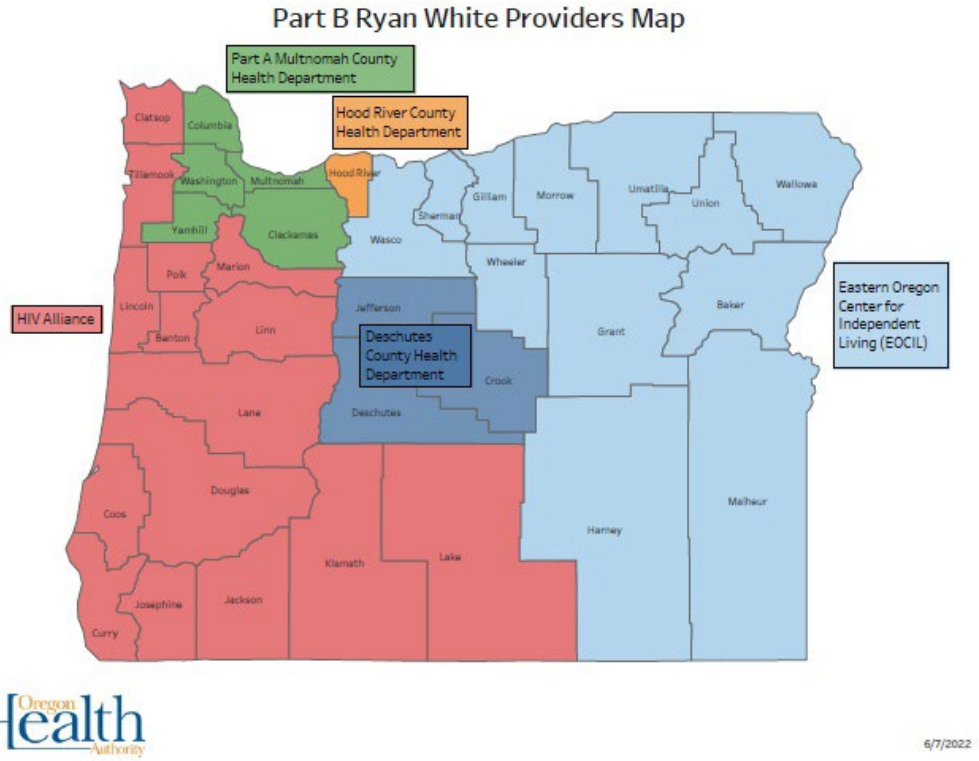
The Oregon Health Authority, HIV/STD/TB Program, HIV Community Services gratefully acknowledges the work of the Oregon HIV Case Management Task Force in providing the recommendations for edits changes and improvements in this document.

Special thanks are also extended to all of the Ryan White HIV medical and psychosocial case managers throughout the State of Oregon who have given valuable input and advice over the years resulting in improvements to the Standards of Service.

Introduction

Oregon HIV Case Management Program Overview

The Oregon Health Authority, HIV Care and Treatment Program, is the Part B Ryan White grantee of the Department of Health and Human Services, HIV Bureau (HAB). The HIV Care and Treatment program provides high quality, cost effective services that promote access to and ongoing success in HIV treatment for people with HIV. Through successful case management, access to important support services , and assistance through Oregon's AIDS Drug Assistance Program, CAREAssist, people living with HIV are empowered to effectively manage their HIV disease and improve their overall health and quality of life. The Oregon Health Authority contracts with local health departments and community-based organizations throughout the 31 counties outside of the Portland metropolitan area to deliver case management and supportive services. These services are delivered through two service delivery models, a county based and a regional based model. HIV Alliance serves counties in red, EOCIL serves counties in light blue, and county health departments serve the remaining counties as indicated below (Hood River in orange, Deschutes in dark blue.) Counties in the Transitional Grant Area in green are served by Ryan White Part A funds which are granted to Multnomah County.



Oregon Health Authority

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Client Rights

Individuals applying for or clients enrolled in the HIV Case Management Program have the following rights:

(1) To receive HIV case management services free of discrimination based on race, color, sex, gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.

(2) To be informed about services and options available in the HIV Case Management Program.

(3) To have HIV case management services and other program records maintained confidentially in accordance with OAR chapter 943, division 14.

(4) To have access to a written grievance process provided by the agency.

(5) To receive language assistance services including access to translation and interpretation services, at no cost if the individual or client has limited English proficiency, in order to access HIV case management services.

Education Requirements & Training

As the front line in providing service linkages for people living with HIV, Case Managers must be adequately and appropriately experienced and trained. Minimum education and/or training requirements for HIV case managers are:

Role	Requirements & Training
Medical Case Manager	Oregon licensed RN (BSN preferred)
Psychosocial Case Manager	Bachelor of Social Work or other related health or human service degree from an accredited college or university; OR related experience for a period of 2 years of full time (or equivalent), regardless of academic preparation.

Staff who provide HIV case management services to clients will be qualified and properly trained in health department policies and procedures, the Oregon HIV Medical Case Management Standards of Service, all required forms, CAREWare, confidentiality policies and procedures and basic case management skills. Providers should comply with all state and local laws, ordinances and rules governing the jurisdiction in which they practice. Supervisors are responsible for ensuring that new Ryan White Part B funded staff complete the online training within 30 days of start date. A certification with a supervisor's signature is required upon completion and supervisor signature. All HIV Case Managers must complete OHA-designated on-going training as required.

HIV Case Management Program

The HIV Community Services Program addresses the needs of persons with HIV by funding case management and support services that enhance access to and retention in HIV medical care and treatment. The goals of case management are to help individuals living with HIV access primary medical care and medications, identify and remove barriers to medical care, and ensure adherence to a prescribed treatment plan.

HIV Case Management is a range of client-centered services that ensure timely and coordinated access to primary medical care, medications, and other support services, including treatment adherence. Core services link a person to primary medical care or services. Support services may be needed for HIV-positive individuals to achieve their medical outcomes and must have a direct relationship to an individual's HIV clinical outcomes.

Core services of HIV Case Management include assistance and support applying, accessing, and adhering to HIV medical services and treatment by providing:

- Assistance accessing health insurance/medical treatment payment programs such as the Oregon Health Plan (Medicaid), Medicare, and CAREAssist.
- Assistance accessing primary and HIV-specific medical care, including HIV medications.
- Screening, assessment, complete referral and appropriate intervention for oral health care, medical nutritional services, mental health services and outpatient substance abuse treatment.
- Nurse assessment, nurse plan and appropriate nurse intervention focusing on treatment adherence, nutrition, oral health, HIV transmission risk reduction and liver health.

Support services of HIV Case Management include assistance with applying for and accessing a variety of services, including but not limited to:

- Housing assistance
- Medical transportation
- Food and nutrition
- Linguistic/translation service

Roles and Responsibilities

Medical Case Managers

In the county based model of HIV Case Management, the majority of case managers are public health nurses who provide both the medical and psychosocial components of HIV case management. In a few health departments, the nurse is responsible only for the required nursing components in this program: nursing assessment/assessment, RN consultation, developing nursing plans, performing nursing interventions and providing client advocacy with the medical care system. Some may use psychosocial case managers to assist the nurse with the intake/eligibility review process, psychosocial screenings, care planning and the complete referral and follow-up activities. Annual completion of the REALD Questionnaire and SOGI Form are the medical case manager's responsibility if there is not a Psychosocial Case Manager. Nurses are responsible for identifying the need for and facilitating access to appropriate interventions. The nurse will either directly provide the intervention in the form of counseling, education and training, or will refer the client to an appropriate resource to receive the intervention (for example, referral to a mental health counselor, a dietician, a substance abuse counselor, etc.)

Functional roles of the nurse:

- Face-to-face (in person or over video), or over the telephone nursing assessment, REALD data collection, SOGI Data Collection and psychosocial assessment, to include history taking and an appraisal of the client's health status and needs.
- Development of an individualized Nursing Plan

- Referral for medical evaluation and treatment.
- Education and counseling about HIV transmission, disease management, risk reduction and harm education.
- Case management of HIV medication therapy to include client education concerning risks and side effects, monitoring disease process to include lab values, monitoring client adherence and tolerance of medications.
- Evaluation of adherence, nutrition, liver health and oral health assessment and associated interventions to include counseling, education and referral, as appropriate.
- Nursing interventions and education about a variety of issues, including not limited to:
    - Healthful living habits and holistic approaches to good nutrition, adequate sleep, regular exercise, stress management, appropriate immunizations, age appropriate health screenings etc.
    - Safer sex practices, sexually transmitted diseases and partner notification services
    - Prevention of exposure to opportunistic pathogens
- Providing information about available resources and services for clients and their support system.
- Follow up on the telephone triage when appropriate. The nurse will need to determine the seriousness of the encounter and decide on a plan of action.
- Regular communication and client advocacy with the client's medical providers and other health and human service providers as appropriate.
- Documentation in progress notes, on the required forms and in the CAREWare data base.

- Offer language assistance services including access to translation and interpretation services, at no cost, if the client has limited English proficiency, in order for the client to access HIV case management services

Psychosocial Case Managers

Some health departments may also use psychosocial case managers. Psychosocial case management is provided by social workers, mental health counselors, health educators or other professionals with related health and human service experience. The psychosocial case manager works in partnership with the nurse to assess the needs of the client, develop an individualized client care plan, and arrange, coordinate, advocate, monitor, and evaluate a comprehensive package of services to meet the specific client's complex needs.

Functional roles of the psychosocial case manager:

- Intake/Eligibility Review (Intake/Eligibility Review Form as well as informed consent, confidentiality, grievance, release of information, and rights & responsibilities forms are required.)

- Face-to-face (in person or over video), or over the telephone psychosocial screening, REALD data collection, SOGI Data Collection (Psychosocial Screening form is required.)

- Development of a comprehensive individualized Care Plan (to include the Nursing Plan and the Housing Plan, if appropriate.)

- Coordination of the services and activities required in implementing the Care Plan.

- Referral to appropriate agencies required to assist the client in achieving the goals and objectives identified in their Care Plan.

- Client monitoring to assess the efficacy of the Care Plan.

- Periodic re-evaluation and revision of the Care Plan as necessary over the life of the client.

- Client-specific advocacy.
- Review of client utilization of services.
- Outreach and case finding activities.
- Health education and risk reduction education and counseling.
- Transfer and inactivation processes.
- Documentation in progress notes, on the required forms and in the CAREWare data base.
- Offer language assistance services including access to translation and interpretation services, at no cost, if the client has limited English proficiency, in order for the client to access HIV case management services

Client-Centered Approach to HIV Case Management

The client-centered model contains the key ingredients of a helping relationship: empathy, respect and genuineness. The fundamental tenet of the approach is that all people have an inherent tendency to strive toward growth, self-actualization, and self-direction. A client-centered approach places the needs, values and priorities of the client as the central core around which all interaction and activity revolve. Understanding how the client perceives their needs, their resources, and their priorities for utilizing services to meet their needs is essential if the relationship is truly going to be client-centered.

Each client has the right to personal choice though these choices may conflict with reason, practicality or the HIV case manager's professional judgment. The issue of valuing a client's right to personal choice is a relatively simple matter when the HIV case manager's and client's priorities are compatible. It is when there is a difference between the priorities that the HIV case manager must make a diligent effort to distinguish between their own values and judgments and those of their client. One of the most difficult challenges for an HIV case manager is to see their client making a choice that will probably result in negative outcomes. In these situations, the HIV case manager must be willing to let the client experience the consequences of their choices, and hope that the relationship with the HIV case manager will be a place to which the client can return to for support without being judged. The one exception is if the client is planning to harm themselves or others.

It is the HIV case manager's responsibility to:

- Offer accurate information to the client.
- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions.
- Present options to the clients from which they may select a course of action or inaction.
- Offer direction only when it is asked for, or when to withhold it would place the client or someone else at risk for harm.

Chronic Disease Management

Chronic disease management is an approach to health care that involves supporting individuals to maintain independence through effective management of chronic conditions that prevents deterioration, reduces risk of complications, prevents associated illnesses and enables people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes and access appropriate support are all factors that influence successful management of an ongoing illness.

People with HIV need support and information to become effective managers of their own health. Chronic conditions require not just medical interventions, but behavioral intervention as well. Clients with chronic conditions, such as HIV, play a large role in managing their conditions. Each client is at a different place in the process, and appropriate interventions are driven, to a large extent, by each client's desired outcomes. In order to meet these needs, it is essential for clients to have the following:

- Basic information about HIV and its treatment
- Understanding of and assistance with self-management skill building
- Ongoing support from members of the health care/case management team, family, friends, and community.

Improving the health of people with chronic illness requires transforming a health care system from one that is reactive and only responsive when someone is sick, to one that is proactive and focused on keeping a person as healthy as possible. This requires not only determining what care is needed, but spelling out roles and tasks in a structured way to ensure that everyone involved as part of the client's care team understands their role. This requires making coordinated follow-up a part of standard procedure, so clients aren't left on their own once they leave the doctor's or case manager's office. Complex clients need more intensive case management to optimize the clinic care, the effectiveness of their treatment regimen and their self-management behavioral skills.

Effective self-management support means more than telling clients what to do. It means acknowledging the clients' central role in their care, and fostering a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. Using a collaborative approach, case managers and clients work together to define problems, set priorities, establish goals, create care plans and solve problems along the way.

Key principles of chronic disease management & client self-management: Emphasis on the client's role

- Standardized assessment
- Effective, evidence based interventions
- Care planning (goal-setting) and problem solving
- Active, sustained follow-up

Self-Management Guidelines

Step	Actions
STEP #1: Define the problem (*the assessment and screening process*)	✓ Impact of the illness ✓ Symptoms of the illness ✓ Medication side-effects ✓ Lifestyle factors ✓ Strengths and barriers ✓ With the client, determine factors that will affect their capacity for self-management
STEP #2: Planning *(care planning)*	✓ Determine stage of change ✓ Determine specific goals ✓ Prioritize goals ✓ Identify outcomes ✓ Determine realistic timeframes ✓ Select interventions ✓ Document the care plan
STEP #3: Management *(referral and follow-up)*	✓ Achievement of goals ✓ Availability of resources ✓ Quality of resources

	✓ Personal capacity

"People are generally better persuaded by the reasons which they have themselves discovered then by those which have come into the mind of others"

Stages of Change	Goals	Strategies	Example Language
Pre-contemplation: **Not thinking of change**	Keep the door open for future discussions 1) Build rapport by joining with client 2) Bring awareness to the surface 3) Keep client engaged in process	1) Listen to concerns (reflective listening) 2) Elicit information (past and current strengths) 3) Communicate caring (empathy and non-judgment)	What would you like to be different? What do you want your life to look like next year/in 5 years? Tell me one thing I wouldn't know by looking at you.
Contemplation: Thinking about change	Keep the client thinking about change 1) Increase perceived benefits of change 2) Boost awareness of options for change 3) Keep client talking	1) Develop discrepancy (reflect ambivalence) 2) Role with resistance (step back if client becomes defensive) 3) Past successes and optimism 4) Explore extremes 5) Measure commitment to change 6) Support autonomy	How concerned are you about X right now? What has worked for you in the past? What would have to happen to make you tell yourself 'okay, that's enough'? You decide, you are in charge. On a scale of 1 to 10, how concerned/ready/confident are you? What would be the best thing about making this change?
Preparation: Preparing for change	Help client prepare for change	1) Clarify goals 2) Negotiate change plan 3) Encouragement, and with permission, advice offering	What are you willing to do now? What is a good first step? What have you seen work for others?
Action: Changing behavior	Decrease barriers to change 1) Increase confidence 2) Helping to problem solve	1) Coach on process of change 2) Reduce barriers 3) Restrain excessive change	How are things going? What's working/not working? Is there anything I can help you with?

Maintenance: Maintaining change and preventing relapse	Sustain gains made 1) Help client stay focused 2) Reduce chance of relapse 3) Normalize relapse.	1) Predict ups and downs 2) Enlist support 3) Plan for relapse prevention 4) When relapse occurs, reassess	How are things going? What's working/not working? Is there anything I can help you with? What is your plan if you feel you might be at risk of….?

Trauma Informed Care

Trauma is a term used to describe a distressing event or events that may have long lasting, harmful effect on a person's physical and emotional health and wellbeing. It can stem from experienced or witnessed physical, emotional, or sexual abuse, natural disasters, violence, or childhood neglect. People who are living with HIV are more likely to have experienced trauma during their lifetime. People who identify as LGBTQ are more likely to have experienced childhood maltreatment, interpersonal violence or bullying when compared to persons who identify as heterosexual and cis gender. They are also more likely to have experienced childhood maltreatment, interpersonal violence, trauma to a close friend or relative, and an unexpected death of someone close when compared to persons who identify as heterosexual and cis gender. Persons with a history of substance use disorder or unstable housing or homelessness are also more likely to have experienced trauma. While most people are able to recover from the effects of trauma, a small, but not insignificant percentage experience long-term, intrusive and severe responses.

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, which emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. Traditional approaches see problems or symptoms as discrete and separate, client behavior as "working the system" and clients as broken and vulnerable. Instead, trauma informed care sees problems or symptoms as coping mechanisms for dealing with trauma and client behavior as a way to get needs met. The HIV Community Services Program encourages case managers and health departments to embrace trauma informed care and to apply a Universal Precautions approach in work with clients. In the context of trauma informed care, universal precautions means assuming that all individuals presenting for services have experienced or been exposed to trauma and may have symptoms from this exposure that are not immediately obvious.

Briefly, a trauma informed system believes that:

- Recovery is possible
- Healing happens in relationships
- It's critical to understand trauma and its impact
- Ensure cultural competence
- Promote safety
- Support client control, choice and autonomy
- Share power and governance
- Integrate care

A tool that provides trauma informed explanation and responses to a variety of common client scenarios can be found here.

HIV Case Management Program Policies

1. All people accessing HIV Medical Case Management must participate in an intake & eligibility review process, a Psychosocial Screening and a Nursing Assessment.

2. All clients must have their income, residence in the agency's jurisdiction and insurance status verified annually.

3. New clients cannot receive financial assistance before they have completed the Intake/Eligibility Determination. Exceptions may be made if a client is in need of medical transportation assistance in order to meet with the Medical Case Manager and/or medical provider.

4. All clients must have an identified medical insurance provider documented in their client record or clear documentation in the CAREWare case notes about why this program expectation was not met and what is being done to accomplish this priority.

5. Clients are required to receive HIV case management services in the county where they reside. Program approval must be received prior to providing any case management services to a client who does not live in the county.

Case Management for Reentry to Community

Many individuals living with HIV fail to adhere to HIV care and treatment upon release from a correctional facility due to lack of transition planning. Therefore, HIV case managers are expected to provide case management services to facilitate an HIV positive inmate's transition from a correctional facility to the community, up to 180 days prior to release.

Transitional Case Management may include commencement of Intake, Screening, Assessment and the development of a care plan which may include complete referral and/or application to medical insurance, CAREAssist, OHOP, and substance abuse/mental health treatment. Upon referral from the HIV Community Services Program, or directly from the releasing facility, HIV case managers are expected to communicate with federal, state and local correctional staff, and maintain a working relationship in order to facilitate the transition of PWLH from jail/prison to the community. Because release dates and plans are subject to change, if it is determined that the incarcerated individual will be released to another case management jurisdiction, the HIV Case Manager will facilitate the transition and referral. VineLink may be used to track release information. Finally, CAREAssist may be able to provide assistance with prescription medication for up to 90 days for someone who is temporarily in a county or local jail. If an existing client is facing barriers in securing HIV medications while incarcerated, contact the CAREAssist program for information. With the exception of CAREAssist-supported medications, no other support services may be provided while a client is incarcerated.

HIV Case Management Standards

These standards are intended to provide direction to the practice of county based HIV Case Management in Oregon. They are also intended to provide a framework for evaluating the practice of HIV Case Management and to define the professional case manager's accountability to the public and to the client to whom the profession is responsible.

The core standards of case management are addressed below:

- Intake/Eligibility Review
- Assessment/Screening
- Triage
- Acuity Assignment
- Care Planning
- Referral and Advocacy
- Case Conference
- Assessment/Screening
- Transfer, Discharge and Termination

The following defines the purpose of each Standard, the process or main activities of the standard and what documentation is required

Intake

Each prospective client who requests HIV Case Management Services will receive a comprehensive intake process in order to determine eligibility, gather required information, introduce the client to the agency, and assist in determining immediate needs. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Purpose

The initial Intake serves as the primary source of demographic and eligibility information. It provides the case manager with important first impressions about the client and helps determine whether the client is in a crisis situation and requires immediate referral. Also, it allows the client to interact with agency staff and consider the ramifications of their participation in the program. The first contact between the client and the case manager also establishes the basis for rapport and trust, which are essential elements of successful case management. Clients who are transferring to an agency within the Part B network or are returning to the same agency within 6 months are not required to complete a new Intake.

Forms

There are several forms that must be provided to and/or signed by the client during intake.

- A copy of the **HIV Care and Treatment Program Information Sheet** (OHA provided) must be provided to each client so they are made aware of the various data requirements associated with the program.

- The client's **Informed Consent** (agency provided) to participate in the case management program should be obtained at this time.

- Clients should understand the **Grievance Procedure** (agency provided) and Hearings Process as well as the right to refuse any and all services at any time during their participation in the case management program.

- A **Release of Information** form (agency provided) (as required under ORS 192.553 to 192.) in which a client authorizes in writing (ink or electronically) the disclosure of certain information about their case to another party (including family members). Included in the form are the purpose of the disclosure, the types of information to be disclosed, entities to disclose to and the expiration date of client authorization. Because this program requires an annual assessment, it is expected that a Release of Information will be obtained annually. Part of the discussion should include information about the intent of the Release of Information, its components, and ways the client can nullify it. Clients should be informed of their right to **Confidentiality**. It is important not to assume that anyone - even a client's partner or family member - knows that the client is HIV positive. Part of this discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone, etc.) Case managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual has HIV or receiving social services.

- **Client's Rights and Responsibilities** (agency provided) form. The case manager reviews client rights and program responsibilities as part of the overall discussion of a client's participation in the case management system (in accordance with ORS 431.250, and 431A.625). A signed copy (by the client) of the Client's Rights and Responsibilities Form should remain in the client's file and a copy should be given to the client to keep.

- **Race, Ethnicity, Language, and Disability (REALD) Questionnaire** (OHA Provided). The REALD rules (Chapter 950, Division 30) implement the Race, Ethnicity, Language, and Disability Demographic Data Collection Standards mandated by House Bill 2134 (2013). REALD is an effort to increase and standardize race, ethnicity, language, and disability data collection across the Oregon Department of Human Services (ODHS) and OHA. Collecting REALD information helps OHA better understand who is most impacted by health inequities and how to best support these community members access the services and resources they need to be healthy and thrive.

- **Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum** (OHA provided) The SOGI Data Collection addendum rules (House Bill 3159, 2020) implement the Sexual Orientation and Gender Identify questions be added to the current data collection standards. SOGI is an effort to increase and standardize sexual orientation and gender identity data collection across ODHS and OHA.

Eligibility Determination

The Ryan White Program requires all service providers who receive Ryan White funds to screen clients and certify their eligibility for services based on (a) an HIV+ diagnosis; (b) proof of identity; (c) proof of residence in Oregon; and (d) proof of income. If documentation subsequently determines that a client is not eligible, the client is not considered a Ryan White client and may not receive any services funded by the Ryan White Program. For more information on eligibility determination, see **Support Services Guide.**

Process

1. The Intake is initiated by a prospective client, their representative, or by a third party referral (verified at least verbally by client) to the case management agency.

2. Prior to the Intake, the client should be provided a list of information/documentation they will need to bring to the Intake. Some level of crisis triage screening should be done with the client on the first contact. If the client is experiencing a medical crisis or is facing eminent interruption of HIV medication therapy, some level of case management intervention may need to happen prior to Intake.

3. The client should receive an Intake within 2 weeks of referral or initial client request. Final eligibility is determined once all supporting documentation has been received and verified. The Intake process will be expedited for clients who are newly diagnosed or homeless. It will also be a local decision whether to allow drop-in Intake, whether to combine Intake, the Psychosocial Screening and the Nurse Assessment, and whether to have multiple sessions based on agency particulars and on client need. Clients who are transferring to an agency within the Part B network or are returning to the same agency within 6 months are not required to complete a new Intake.

4. Income eligibility for Ryan White funded services (except case management or medical case management) is 300% of federal poverty level or less. Except for case management services, the client cannot receive any other Ryan White funded support services until the final eligibility is verified.

5. The client will be provided with an explanation of services offered by the case management program and of the role of the case manager. It is important for the case manager to make the client aware of the limitations of the program as well as its offerings. This information must be provided during the Intake in order to avoid problems that inappropriate expectations can cause the client and the agency later on.

6. Upon determining eligibility, a client will be referred to the Psychosocial Screening and the Nurse Assessment.

Documentation & CAREWare Entry	
Paper Forms	Information collected during intake should be documented on the **Intake/Eligibility Review Form** and **Race, Ethnicity, Language, and Disability (REALD) Questionnaire**
Create CAREWare Record	Create the CAREWare record at the time of Intake. The official enrollment date will be the date informed consent was received.
Demographics	Complete the Demographics tab.
Annual Review	Complete the Annual Review tabs.
Services	Enter staff time under "Intake/Eligibility Review". When you leave a voicemail for a client, use "Attempted Clt. Contact"
Case Notes	Enter a case note for every client contact.
Attachments	Intake forms may be uploaded on the attachment tab.
Referrals	Document referrals and follow-up/outcomes in a CW Care Plan case note.
Contacts/ROI	Any Contacts collected must be entered under the Contacts/ROI tab, and ROIs uploaded as appropriate.

Annual Eligibility Review

Eligibility must be verified every year while the client is actively engaged in Ryan White services. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Process

1. Clients are required to complete a full update annually from the date of enrollment. Annual updates are considered on time and in compliance if they are completed between 10-12 months from the previous annual update. Annual updates completed more than 1 year from the previous annual update are considered not in compliance.
2. All sections of the REALD Questionnaire and intake/eligibility review form must be completed with the exception of HIV and Identity verification which are only required at intake. For clients on CAREAssist, the Client Eligibility Review can be submitted as verification of eligibility. For clients not on CAREAssist, appropriate documentation for residency and income verification must be submitted. Other agency forms, such as ROIs, should be updated as appropriate.

Documentation & CAREWare Entry	
Paper Forms	As appropriate, the CAREAssist Eligibility Report, Race, Ethnicity, Language, and Disability (REALD) Questionnaire and/or appropriate documentation should be included in the client file.
Demographics	Update the Demographics tab as needed. Ensure clients who consent to receive mail have the box "Include in labels report" checked.

Annual Review	Update the Annual Review tab as needed.
Services	Enter staff time under "Intake/Eligibility Review". When you leave a voicemail for a client, use "Attempt Clt. Contact".
Case Notes	Enter case note and any other relevant data.

Triage

Clients with acuity 1 or 2 may complete a triage at the time of the annual update. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Purpose

The triage is a process used for low acuity clients to determine if there are existing or emerging needs and identify clients who may need a full screening or assessment.

Process

1. The triage should be completed at the same time, and in conjunction with, the annual update and eligibility review and Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum.
2. Verify that client was an acuity 1 or 2 at last evaluation, and that there is evidence in CAREWare of a viral load lab test in the last 15 months. If there is no evidence of a viral load lab within the last 15 months, OR the last viral load lab was unsuppressed (>200 copies/mL) regardless of how long ago, OR there is any other indication from the Case Notes that the client should have a full, in–person screening and/or assessment, the triage should not be used. If the client's last viral load was unsuppressed, the client should be assigned an Acuity 3 and follow-up provided accordingly.
3. The triage can be administered by face-to-face (in person or over video), over the telephone, secure email (per agency policy) and mail. If using triage by mail, a letter describing the purpose and directions for completing the triage should be enclosed, along with a self-addressed stamped envelope. The client should be asked to return the form within 7 – 10 business days. If the client has not responded within 7 – to 10 business days, phone based follow-up should occur to ensure client received and understood form.
4. If client responds positively (yes to "1 or more"), the Case Manager will determine whether a full, in person screening and/or assessment is warranted, and contact the client within 7 business days.

Ongoing, clients with an acuity 3 or 4 are required to have a full screening and assessment annually (within 12 months of the last one.)

Documentation & CAREWare Entry	
Paper Forms	Completed triage form should be saved in paper client file and/or uploaded into CAREWare. Complete Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum.
Services	Enter staff time under "Triage". When you leave a voicemail for a client, use "Attempt Clt. Contact".
Case Notes	Enter case note, using the triage case note template. Case note should document both justification for use of triage and any outcomes of the completed triage process. Case note templates for triage required if not accompanied by paper form. If forms are uploaded, case note templates are not required.

Psychosocial Screening and Nurse Assessment

Upon intake, and annually thereafter, case management client with acuity 3 or 4 will participate in a face-to-face (in person or over video), or over the telephone psychosocial screening and nurse assessment, which includes completion of the Psychosocial Screening form and Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum. While not required, a face-to-face option should always be allowed and offered in a client centered manner per the clients care plan, and in accordance with what the client identifies as least burdensome and most accessible for them. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Purpose

The Psychosocial Screening and Nurse Assessment provide an information gathering process through a face-to-face (in person or over video), or over the telephone interview between a client and a case manager. This includes completion of the Psychosocial Screening form and Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum. It is a cooperative process during which a client and case manager collect, analyze, synthesize and prioritize information which identifies client needs, resources, and strengths. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination. In HIV case management programs where the nurse is the only case manager supporting the client, the nurse is responsible for both the Screening and the Assessment. In programs with multidisciplinary teams of both nurses and psychosocial case managers, the appropriate professional completes their component of the Screening or Assessment.

Process

1. If the Screening and Assessment were not scheduled during the Intake process, the client is contacted to schedule an appointment. The Screening/Assessment must be conducted within thirty days of Intake completion. There may be factors which require a longer period of time to complete the Screening/ Assessment and these should be documented in the client record.

2. The Screening and Assessment should be completed by the appropriate parties and performed in accordance with the standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements.

3. Screening and assessment is conducted at a site mutually acceptable to the client and case manager and does not necessarily have to take place in the case manager's office.

4. The process of screening and assessment should encourage active participation by the client and/or significant others, such as legal guardians, parents of minor children, as well as partner or spouse. The process of screening and assessment may involve the collaboration between case manager, nurse and other health and human service providers, and individuals actively involved with the client. The client record may also be used to gather information for the screening/assessment process.

5. Ongoing, clients with an acuity 3 or 4 are required to have a full screening and assessment, which includes completion of the Psychosocial Screening form and Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum, annually (within 12 months of the last one.)
   The purpose is to identify unresolved and or emerging needs, guide appropriate revisions to the care plan, and inform decision making regarding discharge from case management services and/or transition to other appropriate services. Clients may be screened or assessed more frequently in the event of significant

changes in the client's life that may result in a different acuity or significant update to the care plan.

Documentation & CAREWare Data Entry	
Paper Forms	Document assessment and screening using the Nurse Assessment Form, Psychosocial Screening Form and Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum.
Demographics	HIV Status and Risk Factor must be indicated on demographics tab.
Annual Review	The Screening will reassess information previously collected, which may include changes to the client's housing arrangement, health insurance or income. This information must be entered and updated under the Annual Review tab. Mental health and substance use fields should now be updated based on outcome of screening. o Mental Health Yes – Mental health need identified at last screening or triage. No – Mental health need not identified at last screening or triage. Not medically indicated – Do not use. o Substance Use Yes – Substance use need identified at last screening or triage. No – Substance use need not identified at last screening or triage. Not medically indicated – Do not use.
Services	Time associated with the completion of the Psychosocial Screening Form must be entered as a "Screening" and/or "Assessment". This includes time associated with documentation and the collection of information from the client of other sources. When you leave a voicemail for a client, use "Attempt Clt. Contact".

Case Notes	Case note templates for the screening and assessment are required if not accompanied by paper form. If forms are uploaded, case note templates are not required.
Contacts/ROI	If the screening process includes the collection of any client Contacts they must be entered under the Contacts/ROI tab.
Attachments	Screening and Assessment forms may be uploaded under this tab.
Referrals	Referrals provided during the screening process must be documented in a CW Care Plan case note.

Acuity

Each case management client will have an updated Acuity documented in their file. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Purpose

The HIV Community Services Program strives to provide the greatest level of support to clients with the greatest need. The Acuity Scale translates the Screening and Assessment processes into a level of programmatic support designed to provide assistance appropriate to the client's assessed need. The Acuity Scale helps provide consistency from client to client and provides objective assessment, thereby minimizing inherent subjective bias.

Process

1. Upon completion of the Screening and Assessment, an acuity level should be assigned for each life area. Total points should be calculated according to the instructions to calculate the overall acuity level.

2. The Case Manager may change the client's acuity either up or down without an Assessment or Screening unless it has been longer than a year since the last Assessment, or the client's annual RN assessment is due within 30 days.

3. If any of the following conditions apply, the acuity is automatically a 4 and should be reassessed in 60 days: incarcerated within the last 90 days, diagnosed with HIV in the last 180 days, or currently homeless.

4. If client is virally unsuppressed (>200 copies/mL) regardless of how long ago, or it has been more than 15 months since last reported viral load, the nurse acuity level is automatically 3 and the acuity must be reassessed in 60 days.

5. Follow up and monitoring guidelines are determined by the assigned acuity level. See following table.

Acuity Level Guidelines

Level	Guidelines
Level 1: 13 – 22 points	• Eligibility verification and READLD completed for new clients within 30 days of enrollment, then annually between 10 and 12 months after the last eligibility review. • Annual triage, Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum • Care Plan developed and appropriate interventions identified with follow-up provided (telephone or face to face) for newly enrolled clients
Level 2: 23 – 42 points	• Eligibility verification and READLD completed for new clients within 30 days of enrollment, then annually between 10 and 12 months after the last eligibility review. • Annual triage, Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum • Care Plan developed and appropriate interventions identified with follow-up provided (telephone or face to face) for newly enrolled clients
Level 3: 43 – 63 points	• Eligibility verification and READLD completed for new clients within 30 days of enrollment, then annually between 10 and 12 months after the last eligibility review. • Annual nursing assessment and psychosocial screening, Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum • Care Plan developed and reviewed, appropriate interventions identified and follow-up provided (telephone or face to face) every 30 days • Case Conferencing recommended every 30 days.
Level 4: 64 – 84 points	• Eligibility verification and READLD completed for new clients within 30 days of enrollment, then annually between 10 and 12 months after the last eligibility review. • Annual nursing assessment and psychosocial rescreening, Sexual Orientation and Gender Identify (SOGI) Data Collection Addendum • Care Plan developed and reviewed, appropriate interventions identified and follow-up provided (telephone or face to face) every 2 weeks • Case Conferencing recommended every 2 weeks.

Documentation

Documentation & CAREWare Data Entry	
Paper Forms	Medical and psychosocial acuity forms may be completed and placed in the client file.
Forms	Acuity data will be entered in the "Acuity Form" and automatically imported into the Encounters tab.
Services	When the acuity is updated in connection with completing a full Screening or Assessment, the service will be entered using the "Screening" or "Assessment" service. When the acuity is changed outside of a screening or assessment, "Case Management" should be used to record the service. When you leave a voicemail for a client, use "Attempt Clt. Contact".
Case Notes	A case note should be made in accordance with the service. If an acuity change is made without a full screening or assessment, the "Acuity Change" case notes template must be completed documenting the reasons for the change.

Care Plan

Every client in HIV Case Management will have a comprehensive, individualized Care Plan that is reviewed and regularly updated with the client in compliance with the acuity requirement. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Purpose

The Care Plan provides the basis from which the case manager and the client work together to access the resources and services which will enhance the client's quality of life and their ability to cope with the complexity of living with HIV. The process supports client self-determination and empowers a client to actively participate in the planning and delivery of services. The client is assisted to create goals and activities that are SMART (specific, measurable, attainable, realistic and time-based). With proper support, many clients are able to increase their coping skills and stabilize their life situation to avoid the cycle of moving from one crisis to another.

It is through systematic follow-up that the case manager and client discover whether the care planning effort is working and when revisions are needed. The goals and activities developed during the care planning process should be reviewed to determine whether any changes in the client's situation warrant a change in the plan and to determine whether the goals and activities are being completed in a timely manner and, if not, why not. Monitoring client outcomes is an ongoing process throughout the delivery of case management services. It determines whether the mutually agreed upon goals of the care plan are truly meeting the needs of the client..

Process

1. The initial Care Plan should be developed after the intake, screening and assessment process have been completed.

2. The client is assisted to prioritize their goals. Expecting a client to accomplish a large number of goals in a short period of time will only frustrate both the case manager and the client. Aim to accomplish one or two activities at a time while acknowledging the next tasks to be accomplished. The case manager and client work together to decide what actions are necessary to accomplish their goals and who will take responsibility for each. The case manager encourages the client to act on their own behalf whenever possible.
3. The method for Care Plan documentation should be identified in agency policy and procedure. The Care Plan can be stored in either CAREWare or paper form. At a minimum, the Care Plan should include the client's name, goals, the specific activities for completing the goal, the person responsible for completing the activity, proposed deadline, any required referrals, status of both activities and overall goals, and date of most recent update. If the client is referred to OHOP, the Care Plan should address housing stability. If the client is most comfortable communicating in another language, indicate in the Care Plan how staff will communicate with the client (i.e. interpreter, translation services.) A copy of the Care Plan should be offered to the client at every update. Documentation includes CAREWare Case Notes that Care Plan has been reviewed, CAREWare referrals as appropriate and CAREWare services. If care plan document is not in CAREWare, an uploaded copy is recommended.
4. The Care Plan should be developed and monitored to in accordance with client's acuity to coordinate services, implement the plan, assess the efficacy of the plan, and provide periodic evaluation and adaptation. The case manager will initiate follow-up. Clients should be encouraged to contact the case manager when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems.
5. Follow-up and monitoring activities can occur with the client either through face-to-face meetings or telephone or email communications. To build a client-centered relationship, it is important that at least some of the follow-up and monitoring happen as face-to-face meetings with the client. Client contact with the case manager can occur on regular, an ad hoc or a drop-in basis. Follow-up can

occur in the case manager's office, at the client's home or temporary residence, in the hospital or at other sites in the community.

6. The client and case manager will regularly reassess the care planning goals and activities. The case manager will document any review of care planning activities that happened with the client per agency policy and in CAREWare case note.

Documentation & CAREWare Data Entry	
Demographic	Any data collected during follow up and monitoring (change in phone number, address, HIV status, contacts, income, household size, medical provider, housing or insurance status) should be entered on the demographic tabs.
Services	Time associated with care planning should be recorded as "Care Plan". Time associated with follow up and monitoring that does not directly change the Care Plan must be entered as "Case Management". When you leave a voicemail for a client, use "Attempt Clt. Contact".
Case Notes	Documentation of the service must be entered in the case notes. A Care Plan template is available in the case notes feature.
Referrals	Referral and follow-up/outcomes in a CW Care Plan case note. within 6 months of initial referral.

Referral & Advocacy

Each client receiving HIV Case Management services will receive complete referrals to services critical to achieving optimal health and well-being, including advocacy assistance to help problem solve when barriers impede access. For more information, see Appendix D: HIV Care and Treatment Review Tool.

Purpose

Referral and advocacy are often needed in order to meet planning goals. Referral is the act of directing the client to a service, in person or through telephone, written, or other type of communication. Referrals must be completed in full. Referrals may be made (1) from one clinical provider to another, (2) within the HIV case management system, (3) by other professional case managers, (4) by program staff or (5) as part of an outreach program.

Advocacy is the act of assisting a client to obtain necessary services, especially when the individual has had difficulty obtaining them on their own. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Process

1. The role of the case manager is primarily one of resource coordination. When, during care planning, specific knowledge or skills are needed beyond those of the case manager, consultation with other professionals should be sought after appropriate releases of information are obtained.

2. The HIV case manager will maintain a working knowledge of community resources and, when necessary, will conduct outreach to identify needed services. Referral agencies should be assessed for appropriateness to the client situation, lifestyle and

need. Agency eligibility requirements should be considered as a part of the referral process.

3. Clients will be provided referral information that is relevant to their needs, is up-to-date, and in a format/language that they understand.

4. Wherever possible, the client will be encouraged and supported to make their own appointments for referrals, to act on their own behalf and to report back to the HIV case manager about the status of the referral.

5. The referral process should include timely follow-up to ensure that services are being received. The HIV case manager and the client will identify how and when follow-up will occur. Clients who have difficulty with follow-up to referrals will be assisted to make appointments and to complete the referral recommendations.

Documentation & CAREWare Data Entry	
Services	Time associated with referrals and/or advocacy must be entered as "Case Management". When you leave a voicemail for a client, use "Attempt Clt. Contact".
Case Notes	Documentation of client contact or contacts made on the client's behalf must be documented in the case notes. Document referrals and follow-up/outcomes in a CW Care Plan case note.
Referrals	Referrals required to be documented include: outpatient/ambulatory care, CAREAssist, oral health care, mental health services, medical nutritional therapy, substance abuse services outpatient, housing (including complete OHOP referrals), employment, tobacco cessation, and food banks. Ongoing referrals or referrals where no follow-up or tracking is required do not have to be entered into the Referral Tab. See Referral Section in the CAREWare User Guide for more information. All referrals require a final status to be documented within 6 months from initial date of referral. • Pending – Status of all new referrals. If referral is

	pending, follow up with the client every two weeks with regards to the status of the referral. • Completed – When you have evidence that client has made initial contact with the agency to which you referred the client. • Lost to Follow up – After a reasonable amount of time, or a maximum of 3 months, during which time you have been usable to verify the outcome of the referral. • Rejected – If at any point in the referral process, the client informs you that they no longer need or desire the referral you provided.

Case Conferencing

Case managers are required to case conference for clients who are an acuity 3 or 4, in accordance with the standards. Case managers are required to case conference with OHOP Housing Coordinators for clients who are enrolled in OHOP.

Purpose

Ongoing communication and case conferencing happens as part of coordinating client care. Case conferencing is a formal, planned, structured activity, separate from routine contact, which brings together individuals providing specific services to a client for the purpose of assuring unduplicated, integrated and well-coordinated services. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication of services. Case conferences can be used to identify or clarify issues regarding a client's status, needs and goals; review activities including progress and barriers towards meeting the goals; map roles and responsibilities of the participants; resolve conflicts or strategize solutions; and create a Care Plan. Regular case conferences are strongly encouraged for clients who are virally unsuppressed, newly diagnosed, or have high overall acuity or in life areas of housing, mental health and substance use. Case conferences can help ensure that all providers involved in a client's care treatment work together to achieve coordination of services and avoid duplication. Regular case conferencing about the care plan is especially important within a multi-disciplinary team where both a psychosocial case manager and a medical case manager are working with the client to accomplish the goals in a joint care plan. Building strong communication between the HIV medical case manager and the client's primary care provider is important to the client's overall quality of life, the client's ability to adhere to treatment regimens and the success of care coordination on behalf of the client.

Process

1. Case conferences can be internal to your agency, external to your organization (OHOP, CAREAssist, Insurance Assister, MDs, pharmacist, parole officers,

mental health providers, caregivers, family members, etc.) or a combination of both.

2. The frequency of case conferencing is dependent upon the client's acuity. A case conference (either internal or external) is recommended at least once every 30 days for acuity 3s and once every 2 weeks for acuity 4s.
3. It is the MCM's responsibility to schedule and document the Case Conference, and update the Care Plan as necessary. Case Conferences can occur through staff meetings, telephone contact, written reports and letters, review of client records, and through client and/or agency staffing.
4. It is the case manager's responsibility to ensure that clients enroll in insurance either directly through the whole process of enrolling or with assistance from CAREAssist or the Insurance Assister.
5. When appropriate, the client should be involved in the case conference.
6. Clients who are receiving assistance through OHOP must also have a copy of their "Housing Stability Plan" in the client file.

Documentation & CAREWare Data Entry	
Paper Form	Case conferencing activity should be documented on the Case Conference form.
Services	Time associated with the case conferencing must be entered as "Case Conference".
Case Notes	Documentation of the case conference must be entered in the case notes. The case conference template may be used.

Transfer, Discharge & Termination Standards

The transfer, discharge/referral, and termination process guides the transfer of the client to another program case management program or termination from case management services.

Transfer

The purpose of a transfer process is to minimize disruption and assist a client moving between case management programs. The intent of this Standard is to require case managers to work with the client and the new case manager; to forward copies of appropriate chart documentation; to assist the new case manager in understanding the client's needs; and to reduce barriers and "red tape" to the client's ongoing access to care.

Transfer will occur when:

- Client moves out of the case manager's geographic service area
- Client needs are more appropriately addressed in other programs

Process

If a client informs a case manager that they will be moving outside of your service area and wishes to continue receiving case management services, the following should occur:

1. Communication between the two case management programs occurs to facilitate transfer of care. Both case management programs must have a current Releases of Information (ROI) from the client.

2. At a minimum, a copy of the most current Intake/Eligibility Review Form, Psychosocial Assessment/Assessment Form, Nurse Assessment/Assessment Form, HIV verification documentation and physician's notes (if applicable) should be sent

via fax or mail to the new case management program. Case notes from the previous provider are viewable once client is active in new case management domain of CAREWare.

3. If the client is moving to another Part B provider, the new case management program may choose to not complete the entire process (Intake/Update, Assessment and Screening) if it has been less than six (6) months since last completed. They may choose instead to do a modified intake process, and obtain enough additional information to assist them in developing an understanding of the current Care Plan. If the Intake/Update and Assessments/Screening were completed more than six (6) months prior to the transfer, the new case management program should complete a new Intake, Psychosocial Screening and Nurse Assessment

Discharge/Referral

A client may be discharged/referred from the program, if any of the following situations occur:

1. A client is considered "lost to follow-up" when a case manager has made a minimum of 6 attempts to contact the client over a period of 60 days, with no response from the client. A minimum of 4 different communication methods must be used. These methods may include, but are not limited to: phone calls, text messages, certified letters, email, home visits, and/or information provided by medical providers, pharmacists, emergency contacts, social media sites, jail rosters, CAREAssist, and OHOP. Communication methods must be consistent with local case management agency policy and procedure. In cases where there has been no response from the client after 60 days, a certified letter indicating intent to close out the client file should be mailed to the client's last known mailing address. The letter should state that if the client does not respond within 2 weeks, or at the discretion of the case manager, their file will be closed. The letter should inform the client of the grievance and hearing options, as well as requirements for their return to case management services.

2. Identifying and contacting people with HIV who were previously enrolled in HIV Community Services, and have been lost to follow-up or are not responding, is a component of monitoring. This is accomplished through periodic review of client files, requests from medical provider or referral from other outreach activities.

   CAREAssist and/or OHOP should be notified of change in client status as necessary.

Termination

Termination can only occur if a client's circumstances meet specific criteria, limited to the following:

- Client submits false, fraudulent or misleading information in order to retain benefits
- Client uses support services fraudulently
- Client consistently violates program responsibilities outlined in OAR 333-022-2070.

Process

Termination requires clear documentation of the reason(s) for termination, and notifying client of termination and the grievance and hearings process.

3. When possible, the reason for termination should be discussed with the client and options for other service provision are explored and documented.

4. In instances where the case management agency initiates termination:

- The case manager should consult with supervisor about their intent to inactivate client.
- The client must be informed of intent to inactivate via mail. The letter should inform the client of the grievance and hearing options, as well as requirements for their return to case management services.

- The client must be informed of other community resources available that may be able to meet their needs.

Documentation & CAREWare Data Entry	
Demographics	Information on demographics tab should be up to date prior to closing client. Ensure enrollment status is documented appropriately with a case closed date. • Referred or discharged indicates that you have o Referred the client to another Part B funded provider. o Closed the client because they requested closure from case management. o Lost contact with a client and they are considered to be "lost to follow up". o Been notified that client is deceased. • Removed indicates that the client was removed from your agency due to violation of rules. • Incarcerated indicates that the client is serving a criminal sentence in a correctional institution (prison or jail) • Relocated indicates that the client has moved out of the Part B Service area (to the Part A service area/Portland metro area or out of state or country).
Annual Review	Ensure information on annual review tab is as up to date as possible.
Services	Time associated with Transfer and Discharge must be must be entered as "Transfer/Discharge". When you leave a voicemail for a client, use "Attempt Clt. Contact"

Case Notes	Documentation of the service includes a case note summarizing the effort made to contact the client through use of the Lost to Follow up template, and a note that CAREAssist has been notified of the change in the client's status.
Referrals	All Pending referrals should be closed accordingly.

Home Visit Safety Protocol

A written "Home Visit Safety Protocol" is required for every HIV case management agency funded by the HIV Community Services Program. A copy of this written protocol must be available upon request.

Purpose of a Home Visit Safety Protocol

Home visits are not required by this program. However, HIV case managers in the Ryan White Program may do home visits for clients who are too ill to travel, have difficulty getting to the case manager's office, or who have been non-responsive to case management requests. Therefore, a written safety protocol is required for every HIV case management program in Oregon. HIV case managers doing home visits have a duty to ensure that reasonable care for their own health and safety and that of their colleagues is enforced. A safety protocol that clearly delineates the required standards and activities will assist HIV case managers in Oregon to safely provide home visits to clients.

Process

If the local HIV case management agency does not have a "Home Visit Safety Protocol" already developed, then one must be written and approved through the local approval mechanisms at the contractor site.

Suicide Threat Protocol

A written "Suicide Threat Protocol" is required for every HIV case management agency funded by the HIV Community Services program. A copy of this written protocol must be available upon request.

Process: All contracted agencies should work with their own agency management and legal counsel to develop a written document that meets the requirements of the agency.

Appendix A: Tuberculosis (TB) Policy for Licensed Health Care Workers

The following policy is required for all licensed health care workers, program staff and volunteers.

1. TB testing requirement for staff and volunteers

a. All new staff and volunteers are required to have a baseline two-step TB skin test (two TSTs placed 1-3 weeks apart) or single IGRA (QuantiFERON or T Spot) within 30 days of first client contact. If the staff or volunteers have a documented skin TB test that was within the year, a single TB test skin test is sufficient

b. Staff/volunteers who have a newly positive test for TB should have a single chest x-ray to rule out TB disease.

c. Staff/volunteers who have a previously positive TST or IGRA will provide documentation of a chest x-ray taken after their diagnosis of LTBI or a new chest x-ray will be required.

d. Staff/volunteers who develop signs and symptoms of TB disease at any time must notify their supervisor

2. Clients with symptoms of tuberculosis

a. The symptoms of TB disease may include cough for 3 weeks or longer, coughing up blood, fever, weight loss, fatigue and night sweats.

b. If the client has TB symptoms and risk factors for TB exposure (example: being foreign born or having a history of homelessness or incarceration) do the following:

1. If available, put on a surgical mask while discussing situation with patient. Do not visit patient again at home until they are medically cleared of tuberculosis

2. Contact the patient's medical provider and make them aware of your concern for TB. Ideally the medical provider will at minimum assess the resident's status by obtaining a chest x-ray.
3. If additional assistance is needed, contact the local health department where the client lives.

3. Exposure to tuberculosis

In the event an employee or client is exposed to TB disease, consult with the local health department to determine appropriate follow up.

4. Client TB testing

a. Newly diagnosed HIV clients should be tested for TB at diagnosis. If this test is negative, the client should be tested again when their CD4 is above 200. (Below 200, the immune system is compromised and makes the TB test unreliable.)

b. For all clients (regardless of CD4), annual testing should occur if there is an ongoing risk of exposure to TB disease such as homelessness or ongoing travel to a TB endemic country.

c. If a client is not experiencing ongoing risk to TB exposure, there is no need to test annually.

Appendix B: Helping Clients Get to Work

The HIV Community Services Program is committed to working with clients who are assessed as ready to seek employment and providing assistance in their transition to (re) employment. At a minimum, HIV case managers should:

- Assess their clients' readiness for employment (as part of the annual Psychosocial Screening);
- For clients who receive SSI/SSDI, complete a Risk-Benefits Analysis (use the Benefits Calculator Tool provided by HIV Community Services) to help the client determine the impact of employment;
- Help clients to evaluate the impact of HIV-related and other medical symptoms, as well as medication side effects, on their physical capacity to work.
- Help clients assess their prospects for sustained good health, including review of current and historical medical indicators such as CD4 count, viral load measures, and other serologic markers;
- Help the client to identify barriers to being employed and incorporate activities to overcome these barriers into their Care Plan;
- Refer the client who is assessed as ready for employment assistance programs. See the Employment Resource Guide webpage.
- Complete required trainings on employment services for PLWH.

Appendix D: HIV Care and Treatment Review Tool, OHA form 9803a

Local public health authority: _____ Reviewer: _____

LPHA administrator: _____ Review participants: _____

Dates of on-site review (mm/dd/yyyy): _____ Date of report (mm/dd/yyyy): _____

Program Element 08 states: All Ryan White Program, Part B HIV/AIDS Services that are supported in whole or in part with funds provided under this Agreement must be delivered in accordance with OAR Chapter 333, Division 022 "Human Immunodeficiency Virus", the HIV Community Services Program HIV Case Management: Standards of Services (*Standards*) County Based Model, and the HIV Community Services Program Support Services Guide located at: www.healthoregon.org/hiv.

Shaded cells indicate items reviewed for quality assurance only.

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
Protocol requirements: Required protocols are included in the agency's policies and procedures or in other documentation and are available to case managers. *Public Health Modernization Manual (PHMM), Policy and planning*				
The Local Public Health Authority (LPHA) has a written Home Visit Safety protocol. (*Standards, "Home visit safety protocol"*) Reviewer: LPHA protocol or policy has been submitted: ☐	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
The LPHA has a written Suicide Threat protocol. (*Standards, "Suicide threat protocol"*) Reviewer: LPHA protocol or policy has been submitted: ☐	☐	☐	☐	
The LPHA must establish a grievance policy for recipients of Ryan White, Part B HIV/AIDS Services supported in whole or in part with funds provided under this Agreement and shall make this policy known and available to individuals receiving the services. (*PE 08(4)(d)(3); Standards, "Intake"*) Reviewer: Protocol or policy has been submitted: ☐ Ask the LPHA how they make this policy known and available to clients receiving services: ☐	☐	☐	☐	
The LPHA has a written Client Termination Policy that includes the following information: *If an agency proposes to terminate an individual from the program it must notify the individual in writing, and the individual must be informed of their hearing rights per ORS 183.415 A client who has been terminated has a right to a contested case hearing in accordance with ORS chapter 183.* (*OAR 333, Division 22, 2110*) Reviewer:	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
LPHA protocol or policy has been submitted and includes the above information: ☐				
The LPHA has a written Care Plan protocol and includes the following information: Every client in HIV Case Management will have a comprehensive, individualized Care Plan that is reviewed and regularly updated with the client in compliance with the acuity requirement. The client will be offered a copy of their Care Plan. (*Standards "Care Plan"; PHMM, Prevention and health promotion, Implement policies, programs, and strategies*) Reviewer: LPHA protocol or policy has been submitted and includes the above information: ☐ Ask the LPHA if they offer the client a copy of their Care Plan: ☐	☐	☐	☐	
The coordination and follow-up of medical treatments is a component of Medical Case Management provided by the LPHA. Medical Case Management includes the provision of medical treatment adherence counseling to ensure readiness for, and adherence to, HIV/AIDS medication regimens and treatments. Additionally, Medical Case Management includes liver health, nutritional and oral health assessment and	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
education. (*PE 08(2)(a); Standards, "Roles and Responsibilities"; PHMM, Prevention and health promotion*) Reviewer: A written job description or other documentation was submitted to the reviewer outlining that Medical Case Management (MCM) provided by registered nurses (*licensed in Oregon*) aligns with the stated roles and responsibilities in this section: ☐ There is evidence of the provision of MCM services provided documented in the client files when appropriate: ☐				
Staffing Requirements and Staff Qualifications *(PE 08 (4) (f))*				
A. Medical Case Management (MCM) must be provided by a registered nurse licensed in Oregon. (*PE 08(2)(a)*) Reviewer: Oregon RN License was verified as current for every RN providing MCM services (http://osbn.oregon.gov/OSBNVerification/): ☐	☐	☐	☐	
LPHA must employ a Registered Nurse trained in the use of the Standards for the delivery of Ryan White Program, Part B HIV/AIDS Services. Any additional staff must also be trained in the use of the Standards. (*PE 08(4)(f)(1);*	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
PHMM, Leadership and organizational competencies, Human resources) Reviewer: Verified all new staff providing services have submitted their completed training certificate within 30 days to the OHA program: ☐ Verified with LPHA an MCM with a RN license is currently employed and providing services: ☐ If there is a MCM RN vacancy, verified with the LPHA Program Supervisor there was a plan submitted to the OHA program for MCM RN coverage and the plan is being followed: ☐				
LPHA must provide staffing for Case Management Services as identified in the Care Services Budget and in accordance with the Standards. (*PE 08(4)(f)(2); PHMM, Leadership and organizational competencies, Financial management, contracts and procurement services, facility operations*) Reviewer: Verified that documentation from LPHA of current FTEs and types of Case Management staff (*Medical Case Manager, Psychosocial Case Manager, and any additional staff*) aligns with the most recent OHA Program Award Letter or FTE staffing documentation provided to OHA program fiscal department: ☐	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
All LPHA and Subcontractor staff who provide Ryan White Program, Part B HIV/AIDS Services must attend training sessions and be appropriately trained on the delivery of such services, as reasonably designated by OHA. OHA will inform LPHA of the schedule and locations for the training sessions. (*PE 08(4)(f)(3); PHMM, Prevention and health promotion*) Reviewer verified: The LPHA staff providing services attended all requested trainings since the last Triennial Review: ☐	☐	☐	☐	
LPHA must provide an Information Technology (IT) contact to execute and ensure compliance with the RW CAREWare Client Tier Installation Instructions, which are available from OHA upon request. (*PE 08(4)(f)(4); PHMM, Leadership and organizational competencies, Information technology*) Reviewer verified: The LPHA provided their IT contact person to OHA program: ☐ The LPHA has executed and ensured compliance with the RW CAREWare Client Tier Installation Instructions: ☐	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
Case Management and Supportive Services: Contract agency staff provide services that show evidence of the underlying principles outlined in the HIV Community Services Program HIV Case Management: Standards of Services (*Standards*).				
A. LPHA must provide Case Management and Support Services in accordance with OAR Division 333 Chapter 022 to all eligible individuals within LPHA's service area who seek such services and must be delivered consistently throughout the period for which financial assistance is awarded under this Agreement for Ryan White Program, Part B HIV/AIDS Services. (*PE 08(4)(d)(1); PHMM, Prevention and health promotion, Implement policies, programs and strategies; PHMM, Communicable Disease control, Communicable Disease intervention and control*) Reviewer: Ask LPHA: were there any instances in the last year when an eligible client was not provided case management or supportive services upon request? ☐ Ask LPHA: how do they ensure they are delivering services consistently to eligible clients? ☐	☐	☐	☐	
LPHA must deliver all Case Management and Support Services in accordance with the Standards. (*PE 08(4)(d)(2); PHMM, Prevention and health promotion, Implement policies, programs and strategies*)	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
Reviewer: Verify there is evidence of the provision of services being delivered in accordance with the HIV Standards of Services in the client files: ☐				
C. All materials related to the delivery of Ryan White Program, Part B HIV/AIDS Services that contain names or other identifying information of individuals receiving services must be kept in a locked and secure area/cabinet, which allows access only to authorized personnel, and all computers and data programs that contain such information must have restricted access. Staff computers must be in a secure area not accessible by the public, and computer systems must be password protected. Subcontractors of Ryan White Program, Part B HIV/AIDS Services must comply with all county, state and federal confidentiality requirements applicable to the delivery of Ryan White Program, Part B HIV/AIDS Services. (*PE 08(4)(e)(2)' PHMM, Leadership and organizational competencies, Information technology*) Reviewer: LPHA described in detail or provided documentation regarding how they ensure they are following all of the confidentiality requirements above: ☐ LPHA showed reviewer the locked and secure area/cabinet where they keep client confidential information and how	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
they ensure only authorized personnel can access this area: ☐ LPHA showed reviewer how they restrict access to computers and data programs with client and confidential information to a secured area not accessible by the public, and is password protected. This information is also not viewable to unauthorized personnel or public. ☐				
Chronic Disease Management and Client Self-Management Services are delivered in accordance with key principles of chronic disease management, client self-management and stages of change behavioral interventions. (*Standards, "HIV Medical Case Management Program"; PHMM, Access to clinical preventive services*) Reviewer: There was evidence of these principles being applied in the client files: ☐	☐	☐	☐	
Trauma Informed Care Trauma Informed "Universal Precautions" as outlined in the HIV Standards of Service is applied throughout client services and includes implementation of the following trauma informed service principles: safety, trust, empowerment, choice, and collaboration. (*Standards, "Trauma Informed Care"*)	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
Reviewer: Ask the LPHA how above is applied and implemented through client services: ☐ There was evidence of these principles being applied in the client files: ☐				
Case Management for Reentry to Community Transitional case management services are provided to clients prior to and after a client's release from a correctional facility when necessary and may include referrals to specialty programs. (*Standards,* "Case *Management for Reentry to Community"*) Reviewer: Ask the LPHA how the above is applied and implemented through client services: ☐ There was evidence of these principles being applied in the client files: ☐	☐	☐	☐	
Reporting Requirements: The LPHA and any Subcontractors must submit the following reports and information to OHA. (*PE 08(7)*) Reporting forms are found at www.healthoregon.org/hiv (*PE 08(7)(a); PHMM, Leadership and organizational competencies*)				
A. Semi-annual Progress Reports must be submitted to the HIV Care and Treatment program no later than January 31and July 31 for the six-month period ending September 30 and June 30	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
in each fiscal year. Semi-annual Progress Reports include performance measure and program narratives. Reviewer: Were the last two bi-annual Progress reporting forms complete and submitted on time to the OHA program? ☐ Was there a written plan to reach unmet performance measure goals on the last two semi-annual Progress reports submitted to the OHA program? ☐				
Administrative Fiscal Reports must be submitted to the HIV Care and Treatment program no later than as stated in the PE 08. Reviewer: Were Administrative Fiscal reports complete and submitted on time in the last year to the OHA Program? ☐	☐	☐	☐	
LPHA must conduct a local chart review utilizing the approved program review tool found at www.healthoregon.org/hiv. The results of this review will be compiled into the Client Chart Review Summary report and submitted to the Program not later than October 31st of each fiscal year. (*PE 08(7)(b); PHMM, Communicable disease control, Critical tools and resources*) Reviewer: Was the last Client Chart Review report completed and submitted on time to the OHA program? ☐	☐	☐	☐	

Performance measures (*Quality assurance measures*)

If LPHA uses funds provided under this Agreement to support HIV Case Management, the LPHA must operate its program in a manner designed to achieve Ryan White Performance Measure goals and to foster health equity.
(*PE 08(8); PHMM, Leadership and organizational competencies, Performance management, quality improvement and accountability; PHMM, Health equity and cultural responsiveness, Foster health equity*)

Reviewer:
Run CAREWare Performance Measure report as of the last day of the month that is at least 30 days prior to the site visit and enter data below. For example, if the Triennial onsite review is July 20th, the "as of" date for the data will be May 31st.

Performance measures	Recommendations for improvement
Goal: 90% of clients must have a HIV viral load less than 200 copies/mL at last HIV viral load test. Outcome on (date:): % Goal met?	
Goal: 90% of clients have a medical visit in the last 12 months. Outcome on (date:): % Goal met?	
Goal: 90% of Medical Case Management clients have an RN care plan developed and/or updated 2 more times a year. Outcome on (date:): % Goal met?	
Goal: 95% of clients have stable housing. Outcome on (date:): % Goal met?	

Comments:

Chart Review

OHA conducts a chart review to ensure HIV Case Management Standards of Services, Support Services requirements are followed, and documentation is obtained. Standards of Services are intended to provide direction to the practice of county-based HIV Case Management in Oregon. The chart review is also intended to provide a framework for evaluating the practice of HIV Case Management and to define the professional case manager's accountability to the public and to the client to whom the profession is responsible. The core standards of case management identified in the Standards of Services are outlined by section in the chart review section. Charts are randomly selected by the reviewer based on clients who received a service in the year prior to the review. A minimum of 10 HIV case management program client files or 20% of the total HIV Case Management program client files, whichever is more, will be reviewed. Agencies with 10 or fewer clients in the HIV case management program will have all of their client files reviewed.

Any chart item below 80% compliance for all charts reviewed will receive a compliance finding. Data entry criterion requirements in shaded rows are reviewed for Quality assurance only. Data entry criterion are reviewed in the CAREWare database.

"N/A" is checked when the client is excluded from this chart review criterion.
"Yes" is checked to indicate the client file and/or client database does meet the compliance requirement for that item.
"No" is checked to indicate when the client file and/or client database does not meet the compliance requirement for that item

Chart Review Summary of Outcomes (*Program and Data criterion*):	**%**
Program criterion compliance of all charts: **%**	**Number of Program criterion compliance findings:** (*Each item will be highlighted in yellow by reviewer.*)
Data criterion quality assurance of all charts: **%**	**Number of Data criterion quality assurance recommendations:**
Comments:	

CHART REVIEW TOOL

Time period chart review covers: - Client URN#: Enrolled CAREWare date: Re-enrolled date:

Closed: Acuity: Acuity date: New HIV diagnosis?

Virally Suppressed? Current VL/CD4 labs (*within 12 mo.*)? Homeless? Special needs/issues?

(*PE 08, OAR 333, Division 22, HIV Community Services Program Support Services Guide, and HIV Community Services Program HIV Case Management: Standards of Services (Standards)*). All HIV Care and Treatment forms are found here: www.healthoregon.org/hiv

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
I. INITIAL INTAKE ~~and SIX-MONTH ELIGIBILITY REVIEW~~ New Clients only (*client was enrolled for the first time at this agency less than 12 months ago*) (*PE 08(4)(a: Eligibility)*)				
A. LPHA Informed Consent form signed at the Initial Intake and before the client was added to CAREWare.	☐	☐	☐	
LPHA Client Rights and Responsibilities form is signed and dated by client and case manager. (*Ensure Agency form complies with OAR*)	☐	☐	☐	
Current LPHA ROI form signed and dated. (*Current per agency written policy on frequency of updating the ROI.*)	☐	☐	☐	
Proof of a confirmatory HIV test or diagnosis must be obtained within 30 days of intake (as specified in the Support Services Guide). Documentation is in the chart. (*Intake/Eligibility Review Form # 8395*)	☐	☐	☐	
Intake/Eligibility Review form and documentation at Initial (*new*) is complete: Intake/Eligibility Review form # 8395	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Verification Income and supporting documentation match the forms: 1. *Intake/Eligibility Review Form # 8395* **or** if no income, the No Income Affidavit section/form is complete and signed: ☐ If CAREAssist (CA) client, the CAREAssist Client Eligibility Verification (CEV) report form is in the chart and attached to the Intake/Eligibility Review form: ☐	☐	☐	☐	
Verification of Residency and supporting documentation match the forms: 1. *Intake/Eligibility Review Form # 8395* **or** Homeless/Residency affidavit section/form is complete and signed: ☐ 2. If CA client, CEV report form is in the chart — address on CEV is used as proof of residency: ☐	☐	☐	☐	
Initial first Intake/Eligibility Review Timeline met: intake eligibility review completed within 30 days of first contact (CW *enrollment date*).	☐	☐	☐	
Verification of Identity and supporting documentation match the Intake/Eligibility Review Form # 8395.	☐	☐	☐	
HIV/AIDS risk factor is entered in CAREWare (CW) on demographic page and matches documentation.	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Full legal name entered in CW matches identity documentation.	☐	☐	☐	
Demographic information entered in CW (*address/phone/ email, mail preference, race(s)*) matches documentation.	☐	☐	☐	
The **Initial Intake/Eligibility Review** data in CW Annual Review tab (*Annual sub-tab*) matches the form (*#8395*) and the supporting documentation for: 1. Insurance (*Primary and Other*): ☐ Household Income: ☐ Household size: ☐ HIV Primary Care: ☐ Housing Arrangement: ☐ HIV Status and date (***Initial***): ☐	☐	☐	☐	
The **Intake/Eligibility Review service** entry in CW was used for the initial intake, there was a charted CW case note, and the service date matches the case note and form date.	☐	☐	☐	
II. ANNUAL UPDATE ELIGIBILITY REVIEW ~~and SIX-MONTH ELIGIBILITY REVIEW~~ **Established Clients only** (*client has been in your program 12 months or longer*): complete this section and check "N/A" for the "Initial Intake" section above. *[PE 08(4)(a: Eligibility)]*				
A. Current LPHA ROI form signed and dated. (*Current per agency written policy on frequency of updating the ROI.*)	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Annual update Intake/Eligibility Review form and documentation completed: *Intake/Eligibility Review Form # 8395*	☐	☐	☐	
Annual update Intake/Eligibility Review was completed between 10 and 12 mo. after the last Eligibility Review .	☐	☐	☐	
Annual update Eligibility Review Verification Income and supporting documentation match the forms: 1. *Intake/Eligibility Review Form # 8395* **or** if no income, the No Income Affidavit section/form is complete and signed: ☐ If CA, CEV form is attached: ☐	☐	☐	☐	
Annual update Eligibility Review Verification of Residency and supporting documentation match the forms: 1. Intake*/Eligibility Review Form # 8395* **or** Homeless/Residency affidavit section/form is complete and signed: ☐ If CA, CEV form is attached — address on CEV is used as proof of residency: ☐	☐	☐	☐	
Annual Eligibility Review data in CW Annual Review tab (*Annual sub-tab*) was updated and matches the form (#8395) and supporting documentation for each of the following: 1. Insurance (*Primary and Other*): ☐	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Household Income: ☐ Household size: ☐ HIV Primary Care: ☐ Housing Arrangement: ☐ HIV Status and date (*if changes occurred*): ☐				
The Annual Eligibility Review service entry in CW was used for the annual update/eligibility review, there was a charted CW case note, and the service date matches the case note and form date.	☐	☐	☐	
~~**Six-month Eligibility Review Client Self-Attestation form and documentation completed:**~~ ~~1. Self-Attestation Form #8395a completed: ☐~~ ~~If CA, CEV form attached: ☐~~ ~~If not CA, supporting documentation is in the chart: ☐~~	☐	☐	☐	
~~**Six-month Eligibility Review** was completed between 5 and 7 months after the last Annual Update/Eligibility Review.~~	☐	☐	☐	
~~**Six-month Eligibility Review** data in CW Annual Review tab (*Annual sub-tab*) was updated if there were changes on the form or on the CEV.~~	☐	☐	☐	
~~**Six-month Eligibility Review** service entry in CW was used, there was a charted CW case note, and the service date matches the case note and form date.~~	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
LOW ACUITY TRIAGE **Acuity 1 and 2 clients only** (*if a Triage was not needed because a Psychosocial Screening or Medical Assessment was done, mark "N/A" for each item in this section*). *[PE 08(4)(d: Case Management and Supportive Services)(2)]*				
A. The Triage was completed annually within ~~11~~ 10 to ~~13~~ 12 months from the previous one, or at the next Annual Eligibility Review after changing the acuity to a 1 or 2.	☐	☐	☐	
B. If a Triage was completed, the client met all of the following criteria for a Triage based on documentation in CW: VL lab test was within last 15 months: ☐ VL lab test was suppressed (*>200 copies/mL*): ☐ CW case note documentation indicates the client is stable and does not indicate a need for a Psychosocial Screening and/or a Medical Assessment: ☐ Case note templates for triage required if not accompanied by paper form. If forms are uploaded, case note templates are not required.	☐	☐	☐	
C. If the client answered "Yes" to one or more Triage question, follow-up with the client by telephone or email was completed within 7 business days.	☐	☐	☐	
D. Triage: Case note templates for triage required if not accompanied by paper form. If forms are uploaded, case note templates are not required.	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
E. Triage CW service entry and the date match case note and/orform.	☐	☐	☐	
PSYCHOSOCIAL AND MEDICAL ASSESSMENT (*PE 08(4)(d: Case Management and Supportive Services)(2)*)				
A. Psychosocial Screening was completed within 12 months of last screening.	☐	☐	☐	
Psychosocial Screening form completely filled out. (*Psychosocial Screening Form #8401*)	☐	☐	☐	
Documentation of the Psychosocial Screening process, findings, recommendations, and referrals were entered in the CW case note "Screening" template. Case note templates for Psychosocial Screening required if not accompanied by paper form. If forms are uploaded, case note templates are not required.	☐	☐	☐	
Screening CW service entry and the date match case note and form.	☐	☐	☐	
Medical Assessment was completed within 12 months of last assessment.	☐	☐	☐	
Medical Assessment form completely filled out. (*Medical Assessment Form #8402*)	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Documentation of the Assessment process, findings, recommendations, and referrals were entered in the CW case note "Medical Assessment" template. Case note templates for Assessments required if not accompanied by paper form. If forms are uploaded, case note templates are not required.	☐	☐	☐	
Assessment CW service entry and the date match case note and/or form.	☐	☐	☐	
ACUITY AND CASE MANAGEMENT FOLLOW-UP (*PE 08(4)(d: Case Management and Supportive Services)(2)*)				
A. The "Acuity Form-County" is completed in CW (*under "Forms" tab*) and the date matches the last Psychosocial Screening and Nurse Assessment forms.	☐	☐	☐	
Acuity 3/4 direct contact from Medical Case Manager met Standards for follow-up: Acuity 3=30 days; Acuity 4=14 days	☐	☐	☐	
Documented change in psychosocial and/or medical needs warranted a change in Acuity and Acuity was changed.	☐	☐	☐	
B. If an Acuity was changed (*up or down*) without a Psychosocial Screening or Nursing Assessment, it met these criteria: Has not been an Acuity 3 or 4 for 12 months or longer: ☐	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
And annual Nursing Assessment was not due within 30 days: ☐ **And** there was communication with the client: ☐				
C. Acuity change CW case note documented the need for the change.	☐	☐	☐	
D. Acuity 4 is automatically assigned and reassessed in 60 days if meets one of these criteria: The client has been incarcerated within the last 90 days: ☐ **And/or** the client was diagnosed with HIV in the last 180 days: ☐ **And/or** the client is currently homeless: ☐	☐	☐	☐	
E. Acuity form was completed in the CW Forms tab for an acuity change.	☐	☐	☐	
F. Psychosocial services provided per documented need: Case Manager contact made if need for psychosocial intervention identified and documented in case notes.	☐	☐	☐	
G. Nursing services provided per documented need: Medical Case Manager Nurse contact made if need for nurse intervention identified and documented in case notes.	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
CARE PLAN and CASE CONFERENCING **Care Plan:** Every client in HIV Case Management will have a comprehensive, individualized Care Plan that is reviewed and regularly updated with the client in compliance with the acuity requirement. **Case Conferencing** goal is to provide holistic, coordinated, and integrated services across providers, to reduce duplication of services, and ensure Ryan White funds are payer of last resort. (*PE 08(4)(d: Case Management and Supportive Services)(2); Standards, "Care Plan" and "Case Conferencing"*)				
A. Care Plan is developed, monitored and updated according to the client's Acuity listed below: Acuity 3: every 30 days ☐ Acuity 4: every 14 days ☐	☐	☐	☐	
Care Plan is documented as specified in LPHA policy, in addition to being charted in a CW case note.	☐	☐	☐	
Care Plan CW service entry and the date matches case note.	☐	☐	☐	
Case Conferencing occurred, and documentation is present to address an identified need on the Care Plan, or when needed to address client needs related to viral suppression, new diagnosis, high Acuity 3 or 4, or have an overall high acuity in life areas of housing, mental health and substance use. Case Conferences can occur through staff meetings, telephone contact, written reports and letters, review of client records, and through client and/or agency staffing. (*Standards, "Case Conferencing"*)	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Case Conferencing CW service entry and the date matches case note.	☐	☐	☐	
REFERRAL AND ADVOCACY Advocacy and referral are key case management activities. Case managers are expected to maintain a working knowledge of community resources and when necessary, will conduct outreach to identify needed services. The client files show that the case management program is knowledgeable about community resources and is providing referral and advocacy services. (*PE 08(4)(d: Case Management and Supportive Services)(2); Standards, "Referral and Advocacy"*)				
A. Identified psychosocial and/or medical needs identified in the Psychosocial Screening, Medical Assessment, and/or case notes indicate a referral was necessary and the referral was made for the client or the client was provided information to contact the referral source directly and aided when necessary.	☐	☐	☐	
The following mandatory referrals and the follow-up/outcomes are required to be documented in a CW Care Plan case note: Outpatient/ambulatory care, CAREAssist, oral health care, mental health services, medical nutritional therapy, substance abuse services outpatient, housing (*including OHOP*), employment, tobacco cessation, and food banks.	☐	☐	☐	
Mandatory referrals The final status of the mandatory referrals are documented in a CW Care Plan case note within 6 months, Final status for all referrals within 6 months. (*CAREWare User Guide*)	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
HEALTH OUTCOMES (*PE 08(4)(d: Case Management and Supportive Services)(2); Standards, "Acuity"*)				
A. The client had no VL Lab within the past 15 months and is a high Acuity w/in 30 days of late/no lab.	☐	☐	☐	
B. The client was not virally suppressed at last VL lab within the last 12 months and is a high Acuity w/in 30 days of VL lab.	☐	☐	☐	
TRANSFER AND DISCHARGE (*PE 08(4)(d: Case Management and Supportive Services)(2); Standards, "Transfer and Termination"*)				
A. Transfer/Discharge and lost to follow-up: # of contacts followed identified Standards.	☐	☐	☐	
Transfer/Discharge data entry: CW service entry date matches the case note. If lost to follow-up, case note template used.	☐	☐	☐	
FINANCIAL SUPPORT SERVICES (*PE 08(4)(d)(2)*)				
A. Support Services only provided to eligible RW clients whose income is 300% FPL or under.	☐	☐	☐	
Support Services only provided to eligible RW clients whose eligibility was confirmed prior to financial support services being provided.	☐	☐	☐	

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
SERVICE DOCUMENTATION Services recorded were appropriate, the correct Case Note template was used and was complete, and all supporting documentation stated in the template was in the client record (*chart or CAREWare*) (*PE 08(7)(d)*)				
A. Service #1 recorded in the Services tab was correct and complete.	☐	☐	☐	
Service #1 Case Note template was complete.	☐	☐	☐	
Service #2 recorded in the Services tab was correct and complete.	☐	☐	☐	
Service #2 Case Note template was complete.	☐	☐	☐	
Service #3 recorded in the Services tab was correct and complete.	☐	☐	☐	
Service #3 Case Note template was complete.	☐	☐	☐	
Additional comments:				

Criteria for compliance	Compliant Y	N	N/A	Comments/documentation/explanation/timelines
Abbreviation code: CW=CAREWare, CA= CAREAssist, CEV=CAREAssist Eligibility Verification report, MCM=Medical Case Management, RN=Registered Nurse (*used interchangeably with MCM*), VL=Viral Load				
Definition: "New" refers to a client who began services within the last 12 months.				
Data Criterion: Data entry Quality assurance items are shaded.				