**HIV Community Services Program**

**FY 2018-2019**

**Reporting Package**

**County and Regional Services**



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HIV Community Services Program

## FY 2017-2018 Required Reports

The Oregon HIV Community Services Program (HCS) is committed to developing, evaluating and continually improving a statewide, quality continuum of HIV care, treatment and supportive services that meets the identified needs of persons living with HIV and their families, ensures equitable access and decreases health disparities.  The HCS Program supports this mission by gathering data and information about the services delivered by HCS and its contractors, analyzing this information to measure outcomes and quality of services, reporting this analysis in order to identify areas requiring needed planning, and implementing improvement activities in order to meet program goals.

As a part of the HCS’s quality management plan, HIV case management provider agencies submit program reports which provide a written evaluation of the services delivered, and includes partnership and referral activities, and targeted quality improvement activities the agency has undertaken. The HCS team reviews required reports and the HCS Quality and Compliance Coordinator identifies items requiring follow-up. Technical assistance is provided to the contractor as requested.

Contract agencies are expected to run RW CAREWare (CW) generated reports for their own internal data quality monitoring and clean-up, but are not required to submit these reports to the HIV Community Services Program. CW users are required to follow service and data entry requirements as outlined in the [Support Services Guide](https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/ServicesandDefinitions.aspx) and the [CAREWare User Guide](http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Documents/care/UserGuide.pdf). All demographic, service and clinical data fields will be entered in to CW within the following timelines from the date of service: Regional based data entry within 72 hours, and County based data entry within 30 days.

**County and Regional Services Reporting Calendar FY 2018-2019**

|  |  |  |  |
| --- | --- | --- | --- |
| **Required Reports** | **Description** | **Reporting Timeframe** | **Due Date** |
|
| 1. Progress  Report Form |  | 1. 7/1/18 - 12/31/18  2. 1/1/19 - 06/30/19 | 1. January 31, 2019  2. July 31, 2019 |
| 2. Administrative  Fiscal Form | Administrative Fiscal Form includes:  Administrative and service expenditures. | 1. 7/1/18 - 9/30/18  2. 10/1/18 - 12/31/18  3. 1/1/19 - 03/31/19  4. 4/1/19 - 06/30/19 | 1. October 31, 2018  2. January 31, 2019  3. April 30, 2019  4. July 31, 2019 |
| County Based Programs **only**:  3. LPHA Chart Review Summary | LPHA Chart Review Summary includes:  LPHA review of documentation in the client chart and data entry in CAREWare. | 1. Chart and data entry review of services and documentation for the preceding 12 months. | 1. October 31, 2018 |

***Submit reports by e-mail only to:***

**DeAnna P. Kreidler, M.S., LMFT**

**HIV Care and Treatment Program**

**Quality and Compliance Coordinator**

[**deanna.p.kreidler@state.or.us**](mailto:deanna.p.kreidler@state.or.us)

# Reporting Forms Instructions

The Progress Report consists of two forms:

1. **Progress Report Form** includes the following sections:

Section I: HIV Home Test Kit Inventory

Section II: Performance Measures Narrative

Section III: Program Narrative

2. **Administrative Fiscal Form** -- completed by your fiscal/business department and can be submitted separately from the Progress Report Form.

Progress Report form Instructions

**Data provided to your Agency**

The HIV Community Services program provides Agency quarterly data for the HIV Care Continuum, the current program Quality Improvement project, and Performance Measures, in an excel worksheet. Your Agency is encouraged to analyze this data and run additional CAREWare reports, as needed, in order to identify health disparities across different demographics, client outreach/referral, service delivery evaluations and/or changes, assessment of barriers, quality improvement projects, and/or request for program TA/training.

Instructions for completing the form is listed in each section.

**Progress Report Form** FY 2018-2019

Agency:       Submitted by:

Date submitted:

**Reporting period:  Quarter 1 and 2 (July 1-Dec 31, 2018)**

**Due: Jan 31, 2019**

**Quarter 3 and 4 (Jan 1-June 30, 2019)**

**Due: July 31, 2019**

HIV case management providers are required to submit progress reports to the HIV Community Services Program in order to provide a written evaluation of their Agency service delivery system, including strengths, challenges, and Quality Management efforts. The HIV Community Services team reviews these reports and follows up with providers on identified items and offers technical assistance and training. Report information is used for program planning and evaluation purposes.

**Section I: HIV Home Test Kit Inventory**

|  |  |  |
| --- | --- | --- |
| a. | Did your Agency have any Home Test Kits left over from last reporting period? |  |
| b. | Did your Agency order any Test Kits this reporting period? |  |

If a. or b. are “yes”, please email your completed “Home Test Kit Inventory” excel worksheet.

**Section II: Performance measures narrative**

HIV Community Services will provide 6 months of performance measure data to your Agency by the 10th of the next month after the end of the reporting period. Once you receive your performance measure data[[1]](#footnote-1), **complete an Agency narrative below** describing your current and/or future plan at reaching or exceeding the identified goal for each performance measures that did not meet the goal as listed in “Your Agency Outcome” section[[2]](#footnote-2).

You are encouraged to include the following information in your plan: data analysis for health disparities across different demographics; client outreach/referral, service delivery evaluations and/or changes, assessment of barriers, quality improvement project, and/or request for program TA/training.

|  |  |  |  |
| --- | --- | --- | --- |
| Performance Measure: | **Viral Suppression** | | |
| Goal | 90% of clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test. | | |
| CAREWare Performance Measures Worksheet: SC or SR - 01 | | | |
| **Your Agency Outcome**: |  | Part B Agencies Outcome: |  |
| Your Agency *N:* | *Numerator (N)* description:  Clients VL lab entry in CW in the last 12 months was under 200 copies/mL. | | |
| Your Agency *D:* | *Denominator (D)* description:  Clients who received a service this reporting period and had a VL lab entry in CW in the last 12 months. | | |
| **Agency Narrative:** describe your current and/or future plan for reaching or exceeding the goal (if you met the goal, leave this section blank or write N/A). | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Performance Measure: | **No Gap in medical visits in 12 months** | | |
| Goal | 90% of clients have a medical visit in the last 12 months | | |
| CAREWare Performance Measures Worksheet: SC or SR - 05 | | | |
| **Your Agency Outcome**: |  | Part B Agencies Outcome: |  |
| Your Agency *N:* | *Numerator (N)* description:  Clients who had a CD4 or Viral load lab entry in the last 12 months | | |
| Your Agency *D:* | *Denominator (D)* description:  Clients who received a service this reporting period | | |
| **Agency Narrative:** describe your current and/or future plan for reaching or exceeding the goal (if you met the goal, leave this section blank or write N/A). | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Performance Measure: | **RN Care Plan** | | | | | |
| Goal | 90% of Medical Case Management (MCM) clients have a RN Care Plan developed and/or updated 2 or more times a year. | | | | | |
| CAREWare Performance Measures Worksheet: SC or SR - 12 | | | | | | |
| **Your Agency Outcome**: |  | | Part B Agencies Outcome: | |  | |
| Your Agency *N:* | *Numerator (N)* description:  Clients with at least one of the following service entries in CW this reporting period:  Regional=RN Care Plan County=RCP-RN Care Plan | | | | | |
| Your Agency *D:* | *Denominator (D)* description:  Clients who received a Medical Case Management service this reporting period and the client’s most recent Acuity was one of the following:  Regional=Acuity RN 3 or RN 4 County=Acuity 2-4 | | | | | |
| **Agency Narrative:** describe your current and/or future plan for reaching or exceeding the goal (if you met the goal, leave this section blank or write N/A). | | | | | | |
| Performance Measure: | | **Stable Housing** | | | | |
| Goal | | 95% of clients have stable housing. | | | | |
| CAREWare Performance Measures Worksheet: SC or SR – 12 | | | | | | |
| **Your Agency Outcome**: | |  | | Part B Agencies Outcome: | |  |
| Your Agency *N:* | | *Numerator (N)* description:  Clients CW Annual Tab “Housing Arrangement” entry is listed as “*stable/permanent*” | | | | |
| Your Agency *D:* | | *Denominator (D)* description:  Clients who received a case management or housing this reporting period | | | | |
| **Agency Narrative:** describe your current and/or future plan for reaching or exceeding the goal (if you met the goal, leave this section blank or write N/A). | | | | | | |

**Section III: Program narrative**

**Please answer the following eight sections for this reporting period:**

1. Service delivery

a. Describe the strengths and/or improvements in delivering services:

b. Describe the problems and/or challenges in delivering services:

2. Community Resources and Referrals

Describe efforts undertaken by your Agency and/or case manager(s) to build and/or maintain relationships with community resources and ensure Ryan White funds are payer of last resort:

3. Closed Cases

a. Provide the number of clients you have closed from case management during the reporting period for each enrollment status at closing.

|  |  |
| --- | --- |
| **Enrollment Status at closing (Reason)** | **# of closed cases** |
| Referred or discharged |  |
| Removed |  |
| Incarcerated |  |
| Relocated |  |
| Deceased |  |

b. Describe efforts, both successes and challenges, to provide follow up and engagement with persons who were at risk of following out of care or were lost to follow-up.

4. Case Conferencing

a. The goal of case conferencing 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.

a. 1. Describe your monitoring process to ensure case conferencing occurs with other providers.

b. Regular case conferences are strongly encouraged for clients who are virally unsuppressed, newly diagnosed, have a high acuity, or a high acuity life area in housing, mental health and/or substance use.

b. 1. Provide a specific example of a client (no client names) who meets one of the issues listed in 4.b. above, and describe your efforts at using case conferencing to address one or more of the following: 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/or create an integrated Care Coordination Plan.

b. 2. How was this client informed and/or involved in the case conferencing?

5. Quality Management

a. Quality Assurance (QA) activities are a retrospective review of measuring **compliance with service delivery and standards of care.** QA is not the same as QI, although the results of QA activities can be used to develop QI activities.

a. 1. Describe your QA activities or projects[[3]](#footnote-3) and include changes made or planned to improve QA compliance based:

a. 2. Describe how you used or plan to use the QA results to make changes in your program to ensure improvement in client care, health outcomes, and/or client satisfaction:

b. Quality Improvement (QI) entails the development and implementation of activities to make changes to your program **in response to your performance measure and outcomes data.**

b. 1. Describe your current or upcoming Quality Improvement (QI) activities or projects[[4]](#footnote-4) planned at your agency or program to improve client care, health outcomes and/or client satisfaction. If your agency or program does not currently have a specific QI project, describe how you are ensuring you are using performance measure data to identify needed changes to improve client care or health outcomes.

b. 2. If your QI project or activities ended, describe how changes or improvements (as a result of your QI activity) had a positive impact on your agency or program’s client care, health outcomes, and/or client satisfaction. If there were no changes/improvements, state what additional changes and QI activities are planned in the future:

b. 3. Describe what type of formal client complaints/grievances agency leadership received and if it was resolved (no client name or specifics). What program changes or QI activities are planned to address client satisfaction for this type of complaint/grievance received:

6. Trauma Informed Care

Describe efforts made by your agency or case manager(s) to implement the principles of trauma informed services: safety, trust, empowerment, choice, and collaboration.

7. Training or technical assistance

a. Describe training received/attended by your agency or case manager(s):

b. Are there any training or technical assistance needs you have at this time.

8. Recommendations or improvements

Please provide any recommendations or improvement ideas (related to case management standards, policies, forms, technical assistance, CAREWare, Reporting, communication, etc.) you have for the HIV Community Services Program.

**Administrative Fiscal Form instructions**

**I. Contact Information:**

1. Enter the agency name

2. Enter the phone number of your agency

3. Enter the date this report was prepared

4. Enter the street Address, City, State and Zip Code of your agency

5. Enter the contact name, title and e-mail address of the person who can answer questions regarding this report.

6. Enter the report period and the quarter reporting.

**II. Case Management:**

***Only report those expenditures paid for with Ryan White Part B funds or other OHA Awarded HIV Care & Treatment Funding.***

Under the column titled “**Current Quarter Expenses**” enter the expenses for the quarter you are reporting for the following:

1. Direct Service Costs – *Case Management Core Medical Salary & Fringe*: Enter the case management staff costs. This includes wages/salaries, fringe.

2. Direct Service Costs – *Case Management Non-Medical Salary & Fringe*: Enter the case management staff costs. This includes wages/salaries, fringe.

3. Direct Service Costs – *Non-Case Management Salary & Fringe*: This may include staff salaries and fringe benefits for receptionist, file clerk, direct service supervisory staff, etc.

4. Direct Program Costs – *Materials, Equipment and Supplies*: This may include materials, equipment and supplies directly related to the provision of case management.

5. Sub-Contracted Services: Includes the total for contracts covering provision of an approved service such as a community based organization (CBO) providing case management services.

6. Administrative Costs: *Indirect and Overhead costs are identified under Administrative costs in the Part B guidance from HRSA.* Administrative costs include usual and recognized overhead activities, including:

* + Costs of management oversight including program coordination, clerical, financial and management staff not directly related to client services
  + Program evaluation
  + Liability insurance
  + Audits
  + Computer hardware/software not directly related to client services

Administrative costs may also include training (not sponsored by the HIV Case Management and Support Services Program) and routine agency charges for IS and other automatic agency required charge-backs. This category also includes any Indirect Charges which are defined as: any costs incurred for common or joint purposes that benefit more than one project, service, program or other distinct activity of an organization and cannot be readily identified with any one of them.

7. Total Case Management Services: Sum Line 1 through Line 6.

Under the column titled “**Year to Date (beginning July 1, 20XX)**” enter the expenses from the beginning of the fiscal year to current quarter you are reporting.

**III. Support Services**

***Only report those expenditures paid for with Ryan White Part B funds or other OHA Awarded HIV Care & Treatment Funding.***

8. Direct Client Service Costs – *Actual Support Services Expenditures*: This includes any service provided to a client, such as transportation, food, utilities etc. It is not necessary to include detail of purchased service provided in this part of the fiscal report.

9. Sub-Contracted Services: Includes the total for contracts covering provision of an approved service such as a fiscal agent paying for services provided outside the host agency, and other services which are provided on an ongoing basis.

10. Administrative Costs: *Indirect and Overhead costs are identified under Administrative costs in the Part B guidance from HRSA.* Administrative costs include usual and recognized overhead activities as defined in question 5 of the Case Management section above.

11. Total Support Services: Sum Line 8 through Line 10.

Under the column titled “**Year to Date (beginning July 1, 20XX)**” enter the expenses from the beginning of the fiscal year to current quarter you are reporting.

**IV. Oral Health Care Services**

***Only report those expenditures paid for with Ryan White Part B funds or other OHA Awarded HIV Care & Treatment Funding.***

12a. Direct Service Costs – *Dental/Oral Health Care Services and Supplies*.

12b.-d. HIV Alliance only: Dental contract Direct Service Costs – *Dental/Oral Health Care Services and Supplies*.

13. Administrative Costs: *Indirect and Overhead costs are identified under Administrative costs in the Part B guidance from HRSA.* Administrative costs include usual and recognized overhead activities,

14. Total Dental/Oral Health Care Services: Sum Line 12 and Line 13.

15. **TOTAL CASE MANAGEMENT, SUPPORT SERVICES AND ORAL HEALTHCARE SERVICES THIS PERIOD:** Sum Line7, Line 11, and Line 14

Under the column titled “**Year to Date (beginning July 1, 20XX)**” enter the expenses from the beginning of the fiscal year to current quarter you are reporting.

**V. Inventory Reconciliation of Payment Cards**

V1. Enter total value of all store/gas “gift” cards, cards, vouchers, coupons at beginning of the reporting period.

V2. List total new inventory purchases for the reporting period.

V3. Sub-Total Inventory Value: Sum of Line 1 and Line 2.

V4. Subtract value of Inventory items distributed to Clients, also listed in CAREWare for the reporting period.

V5. Adjust value of Payment Cards entered in to clients’ CAREWare record but were later added or reduced outside of previous reporting periods.

Examples of adjustments:

Previously-issued cards given to the client but were lost, destroyed, or never used and have been deleted as costs in the expenditures/FFR report, or timing difference between CAREWare entry and card vendor charges to the recipient.

V6. Final Total, Inventory on Hand, Sum of Line 3, Line 4 and Line 5.

**IMPORTANT:**

**Reconciliation:** It is expected that total Support Services and Oral Health Care Services expenditures reported on the Administrative Fiscal Form will match the data entered in to the CAREWare database. Further, totals reported should also match the amounts paid to your organization for the reporting periods.

**Store/Gas “Gift” Cards:** Store/Gas value cards and other vouchers, coupons, or such items allowed per the Support Services Guidance may be purchased in bulk and dispersed to clients as needed, however, bulk purchases are intended to be utilized in the same fiscal year they are purchased. Any remaining items left over at the end of the fiscal year must be reported on the Quarter 4 Administrative Fiscal Form to reconcile the discrepancies between total expenditures reported and the data entered in to the CAREWare database. Please explain any Reconciliation discrepancies in the area provided on the bottom of the Administrative Fiscal Form.

**Administrative Fiscal Form FY 2018-2019**

|  |  |  |  |
| --- | --- | --- | --- |
| **I. Contact Information** | |  | **Page 1 of 2** |
| **1. Agency Name:** | | **2. Phone Number:** | **3. Date Prepared:** |
| **4. Street Address, City, State and Zip Code** | | **5. Contact Person:**    **Title:**    **E-mail:** | **6. Reporting Period:**  Quarter 1 (Jul-Sept)  Quarter 2 (Oct-Dec)  Quarter 3 (Jan-Mar)  Quarter 4 (Apr-Jun) |
|  | |  |  |
| **II. Case Management** | | **Current Quarter Exp.** | **Year to Date Exp. (beginning July 1, 2018)** |
| **1. Direct Service Costs**  Case Management-Core Medical Salary & Fringe | |  |  |
| **2. Direct Service Costs**  Case Management-Non Medical Salary & Fringe | |  |  |
| **3. Direct Service Costs**  Non-Case Management and/or Supervisory Salary & Fringe | |  |  |
| **4. Direct Program Costs-Case Management**  Materials, Equipment and Supplies | |  |  |
| **5. Sub-Contracted Services-Case Management**  As approved by OHA Program Manager | |  |  |
| **6. Administrative Costs** | |  |  |
| **7. TOTAL CASE MANAGEMENT SERVICES:**  Sum Line 1 through Line 6 | |  |  |
|  | |  |  |
| **III. Support Services** | | **Current Quarter Exp.** | **Year to Date Exp. (beginning July 1, 2018)** |
| **8. Direct Client Service Costs-Support Services**  Support Services Expenditures provided to clients and entered in to CAREWare | |  |  |
| **9. Sub-Contracted Services-Support Services**  As approved by OHA Program Manager | |  |  |
| **10. Administrative Costs** | |  |  |
| **11. TOTAL SUPPORT SERVICES:**  Sum Line 8 through Line 10 | |  |  |
| (Report Continued on Page 2) | |  |  |
|  |  | | **Page 2 of 3** |
| **IV. Oral Health Care Services** | **Current Quarter Exp.** | | **Year to Date Exp.**  **(beginning July 1, 2018)** |
| **12a. Direct Client Service Costs-**  **Oral Health Care Services - SMS**  Oral Health Care expenditures provided to clients and entered in to CAREWare |  | |  |
| **12b. HIV Alliance only:**  **Direct Client Service Costs-Dental Case Management**  Personnel and Travel expenditures. |  | |  |
| **12c. HIV Alliance only:**  **Direct Client Service Costs-Travel/Lodging**  **HIV Alliance Service Area**  Expenditures for clients entered in to CAREWare |  | |  |
| **12d. HIV Alliance only:**  **Direct Client Service Costs-Travel/Lodging Outside of HIV Alliance Service Area**  Expenditures for clients entered in to CAREWare |  | |  |
| **13. Administrative Costs** |  | |  |
| **14. TOTAL ORAL HEALTHCARE SERVICES:**  Sum Lines 12a. (HIV Alliance only include: 12b., 12c., 12d.) and 13 |  | |  |
|  |  | |  |
| **15. TOTAL CASE MANAGEMENT, SUPPORT SERVICES AND ORAL HEALTHCARE SERVICES THIS PERIOD**  Add Line 7, Line 11, and Line 14 |  | |  |

**Inventory of Payment Cards Reconciliation**

**(Store/Gas “Gift” Cards, Vouchers, Tickets, Coupons[[5]](#footnote-5))**

|  |  |  |
| --- | --- | --- |
| **V. Inventory of Purchased Store/Gas Cards, Vouchers, Tickets, Coupons, etc.** | **Current Quarter Activity** | **Year to Date**  **(beginning July 1, 2018)** |
| **V1. Beginning Value of Inventory on Hand**  (Carried over from prior Quarter) |  |  |
| **V2. Add: New Inventory Purchased this Period** |  |  |
| **V3. Total Inventory IN:**  Add Lines 1 and 2 |  |  |
| **V4. Less: Inventory OUT, Items Distributed to Clients this Period[[6]](#footnote-6)** |  |  |
| **V5. Adjustment: Replacement Cards or Unused Items reversed from or added to Client Records** |  |  |
| **V6. END VALUE INVENTORY BALANCE on hand[[7]](#footnote-7):**  Sum Line 3, Line 4, and Line 5. |  |  |
| (Report Continued on Page 3) |  |  |

**Page 3 of 3**

**Reconciliation:** It is expected that total Support Services and Oral Health Care Services expenditures reported on the Administrative Fiscal Form will match the data entered in to the CAREWare database. Further, totals reported should also match the amounts paid to your organization for the reporting periods.

**Store/Gas “Gift” Cards:** Store/Gas value cards and other vouchers, coupons, or such items allowed per the Support Services Guidance may be purchased in bulk and dispersed to clients as needed, however, bulk purchases are intended to be utilized in the same fiscal year they are purchased. Any remaining items left over at the end of the fiscal year must be reported on the Quarter 4 Administrative Fiscal Form to reconcile the discrepancies between total expenditures reported and the data entered in to the CAREWare database. Please explain any Reconciliation discrepancies in the area provided on the bottom of the Administrative Fiscal Form.

**Please explain Reconciliation discrepancies here:**

Local Public health Authority (LPHA)

Chart Review summary

# FY 2018-2019

A Local Public Health Authority (LPHA) Chart Review is conducted annually by each county based contract agency delivering medical case management services using a tool developed by HIV Community Services (HCS) as a condition of contract. Quality indicators are reviewed by the HCS Quality Management Committee and the results are compiled and utilized for planning and quality improvement activities. Overall findings may result in the LPHA developing a plan of correction in partnership with HCS to rectify areas that did not meet the standard 80% compliance. HCS may also provide technical assistance to the LPHA and incorporate overall compliance issues in the case management training program curriculum to increase statewide compliance. Regional based programs have an annual chart review completed during the contractor’s annual site visit by the HCS Quality and Compliance Coordinator, therefore no annual chart review summary report is required from the Regional based services programs.

**Local Public Health Authority Chart Review**

All Chart Review Summary forms are due by October 31, 2018 via e-mail submission to:

DeAnna Kreidler, MS, LMFT

Quality and Compliance Coordinator

deanna.p.kreidler@state.or.us

This chart review provides an opportunity for the local Public Health Departments to monitor their own performance and to make improvements based on their findings. While the review is required, at a minimum, annually, it is a process that benefits program quality when used consistently and regularly. Local programs are encouraged to integrate quality review activities into their agency quality improvement plan and to report these outcomes in their HIV Community Services Program Progress Report Form.

**INSTRUCTIONS FOR COMPLETING CHART REVIEW**

* **Select a reviewer(s) who is not the HIV Case Manager(s)**. A reviewer could be the program supervisor or anyone who does not document regularly in the client files. In the case of subcontractors, the reviewer must be from the contracting agency.
* **The reviewer will randomly select active client files to be reviewed.** Agencies must review a minimum of 10 HIV case management program client files or 25% of the total HIV Case Management program client files, whichever is more. Agencies with 10 or fewer clients in the HIV case management program will review all of their client files.
* **Use one “Chart Review Summary” form** for each client file you review.
* Submit all of the “Chart Review Summary” forms you complete to the HIV Community Services Program, DeAnna Kreidler via email (see above contact information).
* “Current” refers to the past 365 days (12 months) unless otherwise stated.
* Check "N/A" when the client is excluded from the chart review item. Check "No" only to designate when the file does not meet the compliance requirement for that item. Check “Yes” when the file does meet the compliance requirement for that item.
* Hover over each section to identify if there is a link for a corresponding form related to the section.
* The following references have links that will access the documentation requirements:
  + HIV Case Management: [Standards of Service](http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Documents/care/CountyStandards%20Jan.2016.pdf) (County Based Model)
  + [CAREWare User Guide](https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/careware.aspx)
  + County [CAREWare Quick Guide](https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/careware.aspx)
  + [Support Services Guide](https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/ServicesandDefinitions.aspx)

**Agency:       Date of Review:**

**Reviewer:**       **Client URN #**

(Name and Title) (Do not use client name)

Note: Please see the abbreviation key on the last page

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **N/A** | **Comments** |
| **INITIAL INTAKE/ELIGIBILITY REVIEW**  **New Clients only** (client has been in your program less than 12 months) | | | | |
| Intake/Eligibility Review form completely filled out.  (Intake/Eligibility Review Form # 8395) |  |  |  |  |
| HIV status verified within 30 days of initial Intake, and documentation is in the chart (see Intake/Eligibility Review Form # 8395) |  |  |  |  |
| Verification of Identity and supporting documentation match the Intake/Eligibility Review Form # 8395 |  |  |  |  |
| Verification of Residency and supporting documentation match the forms:   * Intake/Eligibility Review Form # 8395 **or** * Residency Verification From #8485 If CA, CEV form is in the chart—address on CEV is used as proof of residency |  |  |  |  |
| Verification Income and supporting documentation match the Intake/Eligibility Review Form # 8395 |  |  |  |  |
| HIV/AIDS Status and risk factor is completed in CW on demographic page. |  |  |  |  |
| Full legal name in CW matches identity documentation. |  |  |  |  |
| Demographic information (address/phone/email, mail preference, race(s)) is accurate in CW. |  |  |  |  |
| “Intake/Eligibility Review” service date in CW matches form. |  |  |  |  |
| The **Initial Intake/Eligibility Review** data in CW Annual Review tab (Annual sub-tab) matches the form (#8395) and the supporting documentation for:   * + Insurance (Primary & Other)   + Household Income   + HIV Primary Care   + Housing Arrangement |  |  |  |  |
|  | **Yes** | **No** | **N/A** | **Comments** |
| The “Intake/Eligibility Review” service 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. |  |  |  |  |
| LPHA Client Rights & Responsibilities form is signed and dated by client and case manager. (Ensure Agency form complies with [OAR](http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Documents/333-022%20HIV%20Case%20Mgmt_FINAL%20text%20SOS.pdf)) |  |  |  |  |
| LPHA Informed Consent form signed at the Initial Intake. |  |  |  |  |
| [**ANNUAL UPDATE/ELIGIBILITY**](http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/forms.aspx) **REVIEW**  **Established Clients only** (Client has been in your program 12 months or longer) | | | | |
| **Annual Intake/Eligibility Review** form completely filled out for demographic data, residency, and insurance information, and supporting documentation is filed in the chart:   * Intake/Eligibility Review Form completed # 8395 and matches the supporting documentation * Residency Verification Form #8485, when needed. If CA, CEV form is in the chart—address on CEV is used as proof of residency |  |  |  |  |
| **Annual Intake/Eligibility Review** proof of Income:   * + If CA, CEV form is in chart as proof of income   + If not CA, income listed on Intake/Eligibility Review form #8395 matches supporting documentation |  |  |  |  |
| **Annual Update/Eligibility Review** data in CW Annual Review tab (Annual sub-tab) was updated at the annual update/eligibility review, and matches the form (#8395) and supporting documentation in the areas of:   * + Insurance (Primary & Other)   + Household Income   + HIV Primary Care   + Housing Arrangement |  |  |  |  |
| The **Annual Update/Eligibility Review** “Intake/Eligibility Review” service 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. |  |  |  |  |
| **Semi-annual Eligibility Review:**   * Self-Attestation Form #8395a completed.   + If CA, CEV form attached.   + If not CA, supporting documentation is in the chart. |  |  |  |  |
|  | **Yes** | **No** | **N/A** | **Comments** |
| **Semi-annual Eligibility Review** data in CW Annual Review tab (Annual sub-tab) was updated if there were changes on the form or on the CEV. |  |  |  |  |
| The “Intake/Eligibility Review” service in CW was used for the semi-annual eligibility review, there was a charted CW case note, and the service date matches the case note and form date. |  |  |  |  |
| Current LPHA ROI form signed and dated. (Current per agency written policy on frequency of updating the ROI.) |  |  |  |  |
| **TRIAGE**  **Acuity 1 and 2 clients only** (if a Triage was not completed, check N/A) | | | | |
| The Triage was completed at the same time as the annual update/eligibility review. |  |  |  |  |
| 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 12 months * VL lab test was unsuppressed (>200 copies/Ml) * CW case note documentation indicates the client is stable and does not indicate a need for a Psychosocial Screening and/or an Assessment |  |  |  |  |
| If the client answered “Yes” to one or more Triage question, follow-up with the client by telephone was completed w/in the timeline stated in the standards. |  |  |  |  |
| If there was a Triage, the CW Triage case note template was used and documented justification for use of Triage. |  |  |  |  |
| [**PSYCHOSOCIAL AND ASSESSMENT**](http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/forms.aspx) | | | | |
| 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. |  |  |  |  |
| Nurse Assessment was completed within 12 months of last assessment. |  |  |  |  |
| Nurse Assessment form completely filled out.  (Nurse Assessment Form #8402) |  |  |  |  |
|  | **Yes** | **No** | **N/A** | **Comments** |
| Documentation of the Assessment process, findings, recommendations, and referrals were entered in the CW case note “Assessment” template. |  |  |  |  |
| The “Acuity Form-County” is completed in CW (under “Forms” tab) and the date matches the last Psychosocial Screening and Nurse Assessment forms.  (Psychosocial Acuity-County Form #8496; Medical Acuity-County Form #8497) |  |  |  | Acuity Level: |
| [**CARE PLANNING**](http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/forms.aspx) **& REFERRAL** | | | | |
| Care Plan is completed and documented as specified in LPHA policy. |  |  |  |  |
| Care Plan is developed, monitored and updated according to Acuity contact timelines:   * Acuity 1/2: every 6 months * Acuity 3: every 30 days * Acuity 4: every 14 days |  |  |  |  |
| The Care Plan referral and advocacy, follow-up, and final status was documented in CAREWare chart note. |  |  |  |  |
| Any of the following referrals made are in the Referral Tab:   * 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. * Final status w/in 6 mo. |  |  |  |  |
| **HEALTH OUTCOMES** | | | | |
| Viral Load Suppression:   * VL lab completed within the past 12 months? * If VL lab over 12 months, is the client a minimum Acuity 3? * If client is not virally suppressed (see CW Performances Measure tab), is the client a minimum Acuity 3? |  |  |  |  |

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| **ADDITIONAL COMMENTS:** |

**Abbreviation code:** CW=CAREWare, CA= CAREAssist, CEV=CAREAssist Eligibility Verification report, MCM=Medical Case Management, RN=Registered Nurse (used interchangeably with MCM)

**Definition:** “New” refers to a client who began services within the last 12 months.

**Data Criterion**: Data entry compliance items are highlighted in blue.

1. Performance Measure data is preliminary and may not match final annual figures due to data entry delay, end of the year data clean-up, and exclusions. [↑](#footnote-ref-1)
2. If your Agency did not meet the PM goal, “Your Agency Outcome” percentage will be red [↑](#footnote-ref-2)
3. Examples of QA activities: site visits (compliance plan), data entry and chart reviews, service utilization reviews/committee, and other data quality evaluations. [↑](#footnote-ref-3)
4. QI activities are aimed at improving client care, health outcomes, and client satisfaction. [↑](#footnote-ref-4)
5. RWHAP recipients are advised to administer voucher and store “gift" card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for any purpose other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards. [↑](#footnote-ref-5)
6. V. 4. should match CAREWare and should be included in the County program PHD Expenditure & Revenue Report (aka FFR) or the Regional Programs’ Reconciliation worksheet. If allocated but not redeemed yet, please note reconciliation discrepancies below [↑](#footnote-ref-6)
7. This figure should match balances brought forward in the next quarter. It is expected that inventory balances would be reasonably depleted in the current fiscal year to avoid large carryover amounts from year to year. [↑](#footnote-ref-7)