HIV COMMUNITY SERVICES PROGRAM

FY 2020-2021
REPORTING PACKAGE
COUNTY AND REGIONAL SERVICES

Oregon Health Authority

Table of Contents

HIV COMMUNITY SERVICES PROGRAM
FY 2020-2021 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 support 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 HCS's quality management plan, HIV case management provider agencies submit program reports which provide a written evaluation of the services delivered, and include 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 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 and the CAREWare User Guide. 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.

Note: yellow highlights indicate new or revised items

County and Regional Services Reporting Calendar FY 2020-2021			
REQUIRED REPORTS	**DESCRIPTION**	**REPORTING TIMEFRAME**	**DUE DATE**
1. Biannual Progress Report Form	A Biannual program narrative of each Agency's service delivery system, including strengths, challenges, outcome performance measurement, and Quality Management efforts.	1. 7/1/20 - 12/31/20 2. 1/1/21 - 06/30/21	1. 1/31/21 2. 7/31/2021
2. Administrative Fiscal Form	Administrative Fiscal Form includes: Administrative and service expenditures.	1. 7/1/20 - 9/30/20 2. 10/1/20 - 12/31/20 3. 1/1/21 - 03/31/21 4. 4/1/21 - 06/30/21	1. 11/15/20 2. 2/15/21 3. 5/15/21 4. 9/15/21
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.	Chart and data entry review of services and documentation for the prior fiscal year: • 7/1/19 – 6/30/20	1. October 31, 2020
Submit reports by e-mail only to: **DeAnna P. Kreidler, M.S.** **HIV Care and Treatment Program** **Quality and Compliance Coordinator** **deanna.p.kreidler@dhsoha.state.or.us**			

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

Reporting Forms Instructions

Progress Reporting consists of two separate forms:

1. **Biannual Progress Report Form** includes the following sections:
   Section I: Performance Measures Narrative
   Section II: Program Narrative

2. **Administrative Fiscal Form** -- completed by your fiscal/business department and submitted quarterly.

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, including disaggregated data by race and ethnicity. 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 are listed in each section.

Oregon Health Authority

Progress Report Form FY 2020-2021

Agency: Submitted by:

Date submitted:

Reporting period: ☐   **Quarter 1 and 2 (July 1-Dec 31, 2020)**
Due: Jan 31, 2021

☐   **Quarter 3 and 4 (Jan 1-June 30, 2021)**
Due: July 31, 2021

HIV case management providers are required to submit progress reports to the HIV Community Services Program in order to provide a program narrative of each Agency's service delivery system, including strengths, challenges, outcome performance measurement, 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: Performance measures narrative

HIV Community Services will provide your Agency's performance measure data in the below tables by the 10th of the month following the end of the reporting period. Once you receive your performance measure data[1], **complete an Agency narrative below** describing your current and/or future plan at reaching, maintaining or exceeding the identified goal for each performance measure below. The program may not be able to provide specific disaggregated data by race and ethnicity on the reporting forms if the data meets the following: the Oregon Health Division HIV Surveillance Program does not publish counts of HIV cases by age, race, sex or transmission group if fewer than 10 people with HIV are believed to be living in this county, the county population is less than 10,000, or the estimated county population of any race group or age group typically used to group cases in its HIV reports is less than 50.

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

---

[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.

HIV Care Continuum[2] Performance Measure:	**Linked to Care**		
Goal	85% (by 2021) of newly diagnosed clients are in medical care within **30 days**, as defined as having CD4 or VL test after date of diagnosis.		
CAREWare Custom Report: New HIV Dx Linkage to Medical Care (Dk11162016)			
Your Agency Outcome:	%	Part B Agencies Outcome:	%
Your Agency *N:*	*Numerator (N) description:* Clients with 1 CD4 or VL test at least 1 day after their diagnosis date within **30 days** of the HIV+ date in CW		
Your Agency *D:*	*Denominator (D) description:* # of clients who received a service and had an enrollment date within **30 days** after the HIV+ date in CW		
Your Agency Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%

Agency Narrative

☐ Your clients **did** reach the 85% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of being linked to medical care within 30 days. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain a medical visit:

☐ Your agency's clients **did not** reach the 85% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges and/or barriers to reaching this goal and in linking clients to medical care within 30 days. Include your plan to address potential racial inequities based on the data.

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

HIV Care Continuum Performance Measure:	**Virally Suppressed**		
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[3]			
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**.		
Your Agency Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
All Clients who received a service (D) and <u>did not</u> have a VL lab in 12 mo. (N)	N= D= %		

Agency Narrative

☐ Your clients **<u>did</u>** reach the 90% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of viral suppression or did not have a viral load lab in the last 12 months. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain their viral load labs and viral suppression:

☐ Your clients **<u>did not</u>** reach the 90% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges and barriers to reaching this goal and for clients to obtain viral load labs and viral suppression. Include your plan to address potential racial inequities based on the data.

HIV Care Continuum Performance Measure:	**Retained In Care / In Care** **(previously:** 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 Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
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

☐ Your clients **did** reach the 90% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of being retained in medical care. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain a medical visit:

☐ Your clients **did not** reach the 90% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges and barriers to reaching this goal and for clients to assist these clients to obtain a medical visit. Include your plan to address potential racial inequities based on the data.

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 Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
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 1-4		
Agency Narrative			

☐ Your agency **did** reach the 90% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining MCM clients who did not reach this goal of having a RN Care Plan. Also describe any projects or changes you are planning in the next six months to ensure MCM clients have an RN Care Plan documented every six months:

☐ Your agency **did not** reach the 90% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or challenges and barriers to reaching this goal and ensure compliance with the Standards of Services. Include your plan to address potential racial inequities based on the data.

Performance Measure:	**Stable Housing**		
Goal	95% of clients have stable housing.		
CAREWare Performance Measures Worksheet: SC or SR – 10			
Your Agency Outcome:	%	Part B Agencies Outcome:	%
Your Agency Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
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 non-medical service this reporting period		

Agency Narrative

☐ Your clients **did** reach the 95% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of being stably housed. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain stable housing:

☐ Your clients **did not** reach the 95% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges and barriers to reaching this goal and for clients to become stably housed. Include your plan to address potential racial inequities based on the data.

Section II: Program narrative

Please answer the following eight sections for this reporting period:

1) **Community Resources and Referrals**
   a) 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:

   b) Describe how your agency has identified communities of color and what outreach efforts have been made to this community:

2) **Service delivery**
   a) Describe your agency and/or program's strengths and/or improvements in delivering services. Include examples of successes in how your agency prioritized clients from communities of color to receive services:

   b) Describe your agency and/or program problems and/or challenges in delivering services. Include a plan of how your agency will prioritize clients from communities of color to receive services if this has been identified as a challenge:

3) **Client Access to Services**

Enrolled Clients (in this reporting period)		**# of clients**
a)	# of Newly **Enrolled** clients (new in CAREWare)	
	• % of Newly Enrolled clients from CoC:	%
b)	# of Newly **Diagnosed** clients	
	• % of Newly HIV Diagnosed clients from CoC:	%
c)	Total # of All Clients who received a service (includes above newly enrolled and newly diagnosed clients)	
	• % of All clients who received a service from CoC:	%
Note: ""Enrolled Client" disaggregated data by Race and Ethnicity is included in the quarterly Excel data worksheet OHA secure emails to agency leadership.		

   a) Newly **Enrolled** Clients (not newly diagnosed) from table above: describe services provided to newly enrolled clients this reporting period in the following areas:

    i)   Newly enrolled—Successes and/or barriers:

    ii)   Were all newly enrolled clients given an Acuity 4 (CC 4) if they were incarcerated within 90 days of enrollment or homeless at the time of enrollment? How are you monitoring and tracking to ensure you are meeting this Standard of Service?

    iii)   Newly enrolled—Special client populations/emerging needs:

    iv)   Newly enrolled—any challenges/barriers with engagement/communication with non-English speaking clients?

    v)   Provide examples of how your agency prioritized new clients from communities of color in your Intake process to receive services:

b)   Newly **Diagnosed** Clients (from table above: describe services provided to newly diagnosed clients this reporting period in the following areas:

    i)   Newly diagnosed—Successes and/or barriers:

    ii)   Provide examples of how your agency prioritized newly HIV diagnosed clients from communities of color in your intake process to receive services:

    iii)   How did you monitor and track to ensure all newly HIV diagnosed clients are offered an expedited Intake process (less than 2 weeks), Psychosocial Screening and Nursing Assessment, and referral to CAREAssist?

    iv)   How did you monitor and track to ensure all the newly diagnosed clients listed in the table were given an automatic Acuity 4 (or CC 4) and then reassessed in 60 days to determine if they should continue to be an Acuity 4 (or CC 4)?

    v)   Regular case conferences are strongly encouraged for clients newly diagnosed, in particular to address viral suppression, homelessness, or having a high acuity life area in housing, mental health and substance use. How are you monitoring and tracking to ensure newly diagnosed clients are receiving case conferencing for these issues/needs?

c)   All Clients who received a service (not new) from table above: describe services provided to enrolled clients who received a service this reporting period in the following areas:

    i)   All Clients who received a service—Special client populations/emerging needs:

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

ii) All Clients who received a service—Communication with non-English speaking clients:

iii) Provide examples of how your agency prioritized current (not new) clients from communities of color when providing services:

Closed Clients Enrollment Status at closing (Reason)	# of closed cases
Referred or discharged	
Removed	
Incarcerated	
Relocated	
Deceased	
Total	
d) Of the Total above, # that were **Lost to Follow-up:**	
• % of clients Lost to Follow-up from CoC:	%

d.) Of the number of "Closed Clients" in above table d) who were **Lost to Follow-up** *(County based programs, enter the # in the table)*: describe efforts, successes and challenges, to providing follow up and engagement with clients who were at risk of following out of care or were lost to follow-up. Include your current QA and/or QI efforts to reduce the number of Lost to Follow-up, including specific efforts to address any potential racial inequities based on the data.

4) Quality Management

a) Describe your Quality Assurance (QA) activities or projects[4] to become or remain in compliance with the Support Services Guide, data requirements outlined in the CAREWare User Manual, and/or the Standards of Services. Include changes made or planned to improve QA compliance:

b) Describe your current or upcoming Quality Improvement (QI) activities or projects[5] 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

---

[4] Examples of QA activities: site visits (compliance plan), data entry and chart reviews, service utilization reviews/committee, and other data quality evaluations.
[5] QI activities are aimed at improving client care, health outcomes, and client satisfaction.

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

care or health outcomes, <mark>including efforts at addressing potential racial health and/or service inequities.</mark>

<mark>c)</mark> 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, <mark>including efforts at addressing potential racial health and/or service inequities:</mark>

5) **Trauma Informed Care**
   a) Describe efforts made by your agency or case manager(s) to implement the principles of trauma informed services: safety, trust, empowerment, choice, and collaboration. <mark>Include efforts at addressing racial health and/or service inequities.</mark>

6) **Training and technical assistance**
   a) Describe training received/attended by your agency or case manager(s):

   b) Provide information on changes to your training program. Include specific changes made to the onboarding training process for new staff:

   c) List any training or technical assistance needs you have at this time:

7) **Service Delivery: Staffing**:
   a) Has your staff supervision or agency program structure changed? If yes, <mark>briefly</mark> explain the changes <mark>below</mark> and attach a current Organizational chart showing the new structure.

   b) <mark>Briefly describe staff turnover/vacancies and retention efforts or improvements planned</mark> during this reporting period. <mark>Include how you addressed</mark> service delivery disruptions.

8) **Recommendations or improvements**
   a) 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.

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

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.
7. Enter your agency's Ryan White HIV Case Management Contract number (from your Award letter) or your Program Element number.
8. Enter your agency's Ryan White HIV Case Management Award Amount (from your Award letter).

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 <u>Quarter</u> 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.

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

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 Line 7, Line 11, and Line 14

16. Total Percentage of FY Award amount (listed in section I, 8) expended in #15 above.

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

1. Enter total value of all store/gas "gift" cards, cards, vouchers, coupons at beginning of the reporting period.
2. List total new inventory purchases for the reporting period.
3. Sub-Total Inventory Value: Sum of Line 1 and Line 2.
4. Subtract value of Inventory items distributed to Clients, also listed in CAREWare for the reporting period.

5. 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.

6. 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. Please explain Reconciliation discrepancies at the bottom of page 3 and explain your plan for reconciliation, including any changes to your process to ensure future reconciliation plan of correction.

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 page 3 of the Administrative Fiscal Form.

VI. 340B Program Income – HIV Alliance only

Definition of Program Income from Health Resources and Services Administration (HRSA's) HIV/AIDS Bureau (HAB) FAQ for Policy Clarification Notice 15-03 and 15-04[6]:

Program income is gross income earned by the non-Federal entity that is directly generated by a supported activity or earned as a result of the Federal award during the period of performance (or grant year) except as provided in 45 CFR §75.307(f). See 45 CFR §75.2.

---

[6] FAQ March 21, 2016 Policy Clarification Notices (PCNs) 15-03 and 15-04

All 340B generated revenue is considered program income. When the RWHAP grant is the sole Federal award that makes an organization eligible as a 340B Drug Pricing Program covered entity, and purchases pharmaceuticals via 340B pricing, all the program income should be attributed to the RWHAP grant.

Program income must be used for the purposes and under the conditions of the Federal award.
- For Parts A, B, and C, program income must be used for core medical and support services, clinical quality management (CQM), and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with HIV.

Instructions for completing 340B Program Income section:

340B Program Income and Expenditures: 340B Program Income must be spent on Ryan White eligible services and exclusively for Ryan White Program-eligible clients only before funds from Ryan White grant awards can be used.

1. Enter beginning balance (if any) of 340B Program Income earned in the period.
2. List total new 340B Program Income received during the period.
3. Sub-Total 340B Program Income Value: Sum of Line 1 and Line 2.
4. Subtract value of 340B Program Income expended for Ryan White Program-eligible clients, also listed in CAREWare for the reporting period.
5. Adjustments to 340B Program income received or spent. Please explain all adjustments in the 340B Program Income Narrative section 7.
6. Final Total, 340B Program Income, Sum of Line 3, Line 4 and Line 5.
7. The 340B Program Income narrative must be completed each quarter.
    7.2 The Program Income balance reported in 6. should be ZERO, as 340B Program Income is expected to be fully spent before using funds for OHA Ryan White Grant Awards received. If it is not zero, please provide an explanation.
    7.3 [7]: The source and use of program income and rebates must be tracked and reported separately. Subrecipients should adhere to their written accounting procedures that must be compliant with 45 CFR§ 75.302(b).

---

[7] FAQ March 21, 2016 Policy Clarification Notices (PCNs) 15-03 and 15-04

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

ADMINISTRATIVE FISCAL REPORT FY 2020-2021

I. Contact Information

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)
7. Contract/Program Element Number:	8. Award Amount: $	

II. Case Management	Current Quarter Exp.	Year to Date Exp. (beginning July 1, 2019)
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, 2019)
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		

IV. Oral Health Care Services	Current <u>Quarter</u> Exp.	Year to Date Exp. (beginning July 1, 2019)
12a. Direct Client Service Costs- Oral Health Care Services 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		
16. Percentage of FY Award amount (listed in section I, 8) expended	%	%

(REPORT CONTINUED ON PAGE 3)

INVENTORY OF PAYMENT CARDS RECONCILIATION
(STORE/GAS "GIFT" CARDS, VOUCHERS, TICKETS, COUPONS[8]) Page 2 of 3

V. Inventory of Purchased Store/Gas Cards, Vouchers, Tickets, Coupons, etc.	Current Quarter Activity	Year to Date (beginning July 1, 2019)
1. Beginning Value of Inventory on Hand (Carried over from prior Quarter)		
2. Add: New Inventory Purchased this Period		
3. Total Inventory IN Add Lines 1 and 2		
4. Less: Inventory OUT, Items Distributed to Clients this Period[9]		
5. Adjustment: Replacement Cards or Unused Items reversed from or added to Client Records		
6. END VALUE INVENTORY BALANCE on hand[10] Sum Line 3, Line 4, and Line 5.		

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 below.

Please explain Reconciliation discrepancies and your plan for reconciliation, including any changes to your process to ensure future reconciliation plan of correction:

---

[8] 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.

[9] 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

[10] 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.

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

340B PROGRAM INCOME – HIV ALLIANCE ONLY
(SEPARATELY ACCOUNTED FOR FROM OHA RYAN WHITE AWARD)

VI. 340B Program Income	Current Quarter Activity	Year to Date (beginning July 1, 2019)
1. Beginning Balance		
2. Add: 340B Program Income Received this period		
3. Subtotal - Total 340B Program Income Add Lines 1 and 2		
4. Less: Expenditures[11]		
5. Adjustment: (*provide narrative in item 7.1*)		
6. NET 340B Program Income BALANCE* *should be $0.00 (*if not, provide narrative in item 7.2*) Sum Line 3, Line 4, and Line 5.		
7. Program Income Narrative for the current Quarter Activity:		
7.1 Explain Adjustments to 340B Program Income (received or spent):		
7.2 Explain plan to resolve Item #6 Net 340B Program Income Balance if amount is not zero ($0.00):		
7.3 Describe how your organization tracks Program Income separately from RWHAP Part B awards grant income, and other funding sources. Include any discrepancies in tracking that were identified this quarter and plan for resolution.		
7.4 Describe fiscal procedures in place which prevent duplicate discounts with other agencies, providers or organizations, to include Medicaid and Medicare. Include any duplicate discounts that were identified this quarter and plan for resolution.		

---

[11] *See "Important" section in instructions about use of funds*

LOCAL PUBLIC HEALTH AUTHORITY (LPHA)
CHART REVIEW SUMMARY
FY 2020-2021

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.

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

LOCAL PUBLIC HEALTH AUTHORITY CHART REVIEW

All Chart Review Summary forms are due by October 31, 2020 via e-mail submission to:

DeAnna Kreidler, MS, LMFT
Quality and Compliance Coordinator
deanna.p.kreidler@dhsoha.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.

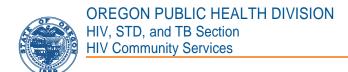## INSTRUCTIONS FOR COMPLETING CHART REVIEW

- **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 5 HIV case management program client files or 15% of the total HIV Case Management program client files, whichever is more. Agencies with 5 or fewer clients in the HIV case management program will review all of their client files.

- **Use one "HIV Care and Treatment Chart Review Tool"** 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 previous fiscal year (July 1-June 30) 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 (County Based Model)
    - CAREWare User Guide
    - County CAREWare Quick Guides for the chart review period
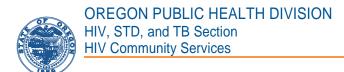   - Support Services Guide

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

LPHA 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

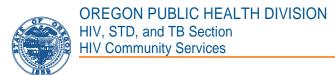| Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	**N**	**N/A**	
I. INITIAL INTAKE and SIX-MONTH ELIGIBILITY REVIEW New Clients only (*client was enrolled for the first time at this agency less than 12 months ago*) (*PE 08(4)(a: Eligibility)*)				
A. LPHA Informed Consent form signed at the Initial Intake and before the client was added to CAREWare.	☐	☐	☐	
B. LPHA Client Rights and Responsibilities form is signed and dated by client and case manager. (*Ensure Agency form complies with OAR*)	☐	☐	☐	
C. Current LPHA ROI form signed and dated. (*Current per agency written policy on frequency of updating the ROI.*)	☐	☐	☐	
D. 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*)	☐	☐	☐	
E. Intake/Eligibility Review form and documentation at Initial (*new*) is complete: Intake/Eligibility Review form # 8395	☐	☐	☐	

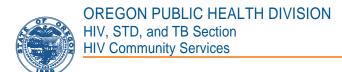| Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
F. Verification Income and supporting documentation match the forms: 1. *Intake/Eligibility Review Form # 8395* **or** if no income, the No Income Affidavit section/form is complete and signed: ☐ 2. If CAREAssist (CA) client, the CAREAssist Client Eligibility Verification (CEV) report form is in the chart and attached to the Intake/Eligibility Review form: ☐	☐	☐	☐	
G. 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: ☐	☐	☐	☐	
H. Initial first Intake/Eligibility Review Timeline met: intake eligibility review completed within 30 days of first contact (CW *enrollment date*).	☐	☐	☐	
I. Verification of Identity and supporting documentation match the Intake/Eligibility Review Form # 8395.	☐	☐	☐	
J. HIV/AIDS risk factor is entered in CAREWare (CW) on demographic page and matches documentation.	☐	☐	☐	
K. Full legal name entered in CW matches identity documentation.	☐	☐	☐	
L. Demographic information entered in CW (*address/phone/ email, mail preference, race(s)*) matches documentation.	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
M. 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*): ☐ 2. Household Income: ☐ 3. Household size: ☐ 4. HIV Primary Care: ☐ 5. Housing Arrangement: ☐ 6. HIV Status and date (***Initial***): ☐	☐	☐	☐	
N. 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.	☐	☐	☐	
O. **Six-month Eligibility Review Client** Self-Attestation Form #8395a completed. 1. If CA, CEV form attached: ☐ 2. If not CA, supporting documentation listed on form is in the chart: ☐	☐	☐	☐	
P. **Six-month Eligibility Review** was completed between 5 and 7 mo. after initial first Intake Eligibility Review.	☐	☐	☐	
Q. **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.	☐	☐	☐	
R. The **Six-month Eligibility Review** service entry in CW was entered for the initial Intake and Eligibility Review, there was a charted CW case note, and the service date matches the case note and form date.	☐	☐	☐	

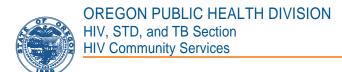| Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
II. ANNUAL UPDATE ELIGIBILITY REVIEW and SIX-MONTH ELIGIBILITY REVIEW **Established Clients only** (*client has been in your program 12 months or longer*): complete this section and check "N/A" for the "Initial Intake and Six-Month Eligibility Review" 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.*)	☐	☐	☐	
B. Annual update Intake/Eligibility Review form and documentation completed: *Intake/Eligibility Review Form # 8395*	☐	☐	☐	
C. Annual update Intake/Eligibility Review was completed between 5 and 7 mo. after the last Six-month Eligibility Review client Self-attestation.	☐	☐	☐	
D. **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: ☐ 2. If CA, CEV form is attached: ☐	☐	☐	☐	
E. **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: ☐ 2. If CA, CEV form is attached — address on CEV is used as proof of residency: ☐	☐	☐	☐	
F. **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:	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
1. Insurance (*Primary and Other*): ☐ 2. Household Income: ☐ 3. Household size: ☐ 4. HIV Primary Care: ☐ 5. Housing Arrangement: ☐ 6. HIV Status and date (*if changes occurred*): ☐				
G. 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.	☐	☐	☐	
H. **Six-month Eligibility Review Client Self-Attestation form and documentation completed:** 1. Self-Attestation Form #8395a completed: ☐ 2. If CA, CEV form attached: ☐ 3. If not CA, supporting documentation is in the chart: ☐	☐	☐	☐	
I. **Six-month Eligibility Review** was completed between 5 and 7 months after the last Annual Update/Eligibility Review.	☐	☐	☐	
J. **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.	☐	☐	☐	
K. **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.	☐	☐	☐	

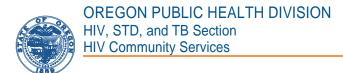| Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
III. LOW ACUITY TRIAGE **Acuity 1 and 2 clients only** (*if a Triage was not needed because a Psychosocial Screening or Medical Assessment was done, mark "N/A" for each item in this section*). [*PE 08(4)(d: Case Management and Supportive Services)(2)*]				
A. The Triage was completed annually within 11 to 13 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: 1. VL lab test was within last 12 months: ☐ 2. VL lab test was suppressed (*>200 copies/mL*): ☐ 3. CW case note documentation indicates the client is stable and does not indicate a need for a Psychosocial Screening and/or a Medical Assessment: ☐	☐	☐	☐	
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 CW case note template was used and documented.	☐	☐	☐	
E. Triage CW service entry and the date match case note and form.	☐	☐	☐	
IV. 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.	☐	☐	☐	
B. Psychosocial Screening form completely filled out. (*Psychosocial Screening Form #8401*)	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
C. Documentation of the Psychosocial Screening process, findings, recommendations, and referrals were entered in the CW case note "Screening" template.	☐	☐	☐	
D. Screening CW service entry and the date match case note and form.	☐	☐	☐	
E. Medical Assessment was completed within 12 months of last assessment.	☐	☐	☐	
F. Medical Assessment form completely filled out. (*Medical Assessment Form #8402*)	☐	☐	☐	
G. Documentation of the Assessment process, findings, recommendations, and referrals were entered in the CW case note "Medical Assessment" template	☐	☐	☐	
H. Assessment CW service entry and the date match case note and form.	☐	☐	☐	
V. 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.	☐	☐	☐	
B. Acuity 3/4 direct contact from Medical Case Manager met Standards for follow-up: Acuity 3=30 days; Acuity 4=14 days	☐	☐	☐	
C. Documented change in psychosocial and/or medical needs warranted a change in Acuity and Acuity was changed.	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	

F. If an Acuity was changed (*up or down*) without a Psychosocial Screening or Nursing Assessment, it met these criteria:
   a. Has not been an Acuity 3 or 4 for 12 months or longer: ☐
   b. **And** annual Nursing Assessment was not due within 30 days: ☐
   c. **And** there was communication with the client: ☐
	☐	☐	☐	

G. Acuity change CW case note documented the need for the change.	☐	☐	☐	

H. Acuity 4 is automatically assigned and reassessed in 60 days if meets one of these criteria:
   d. The client has been incarcerated within the last 90 days: ☐
   e. **And/or** the client was diagnosed with HIV in the last 180 days: ☐
   f. **And/or** the client is currently homeless: ☐
	☐	☐	☐	

I. Acuity form was completed in the CW Forms tab for an acuity change.	☐	☐	☐	
J. Psychosocial services provided per documented need: Case Manager contact made if need for psychosocial intervention identified and documented in case notes.	☐	☐	☐	
K. 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			Comments/documentation/explanation/timelines
	Y	N	N/A	
VI. 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: g. Acuity 1 or 2: every 6 months ☐ h. Acuity 3: every 30 days ☐ i. Acuity 4: every 14 days ☐	☐	☐	☐	
B. Care Plan is documented as specified in LPHA policy, in addition to being charted in a CW case note.	☐	☐	☐	
C. Care Plan CW service entry and the date matches case note.	☐	☐	☐	
D. **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")	☐	☐	☐	
E. Case Conferencing CW service entry and the date matches case note.	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
VII. 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.	☐	☐	☐	
B. Mandatory referrals are in the CW 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.	☐	☐	☐	
C. Mandatory referrals in the CW Referral Tab, Final status entered for all referrals within 6 months. (*CAREWare User Guide*)	☐	☐	☐	
VIII. HEALTH OUTCOMES (*PE 08(4)(d: Case Management and Supportive Services)(2)*; *Standards,* "*Acuity*")				
A. The client had no VL Lab within the past 12 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.	☐	☐	☐	

OREGON PUBLIC HEALTH DIVISION
HIV, STD, and TB Section
HIV Community Services

Oregon
Health
Authority

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	N	N/A	
IX. 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.	☐	☐	☐	
B. Transfer/Discharge data entry: CW service entry date matches the case note. If lost to follow-up, case note template used.	☐	☐	☐	
X. FINANCIAL SUPPORT SERVICES (*PE 08(4)(d)(2)*)				
A. Support Services only provided to eligible RW clients whose income is 300% FPL or under.	☐	☐	☐	
B. Support Services only provided to eligible RW clients whose eligibility was confirmed prior to financial support services being provided.	☐	☐	☐	
XI. 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.	☐	☐	☐	
B. Service #1 Case Note template was complete.	☐	☐	☐	
C. Service #2 recorded in the Services tab was correct and complete.	☐	☐	☐	
D. Service #2 Case Note template was complete.	☐	☐	☐	

Criteria for compliance	Compliant			Comments/documentation/explanation/timelines
	Y	**N**	**N/A**	
E. Service #3 recorded in the Services tab was correct and complete.	☐	☐	☐	
F. Service #3 Case Note template was complete.	☐	☐	☐	
Additional comments:				

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.