HIV COMMUNITY SERVICES PROGRAM

HIV Case Management: Standards of Services

Regional Based Model

Oregon Health Authority

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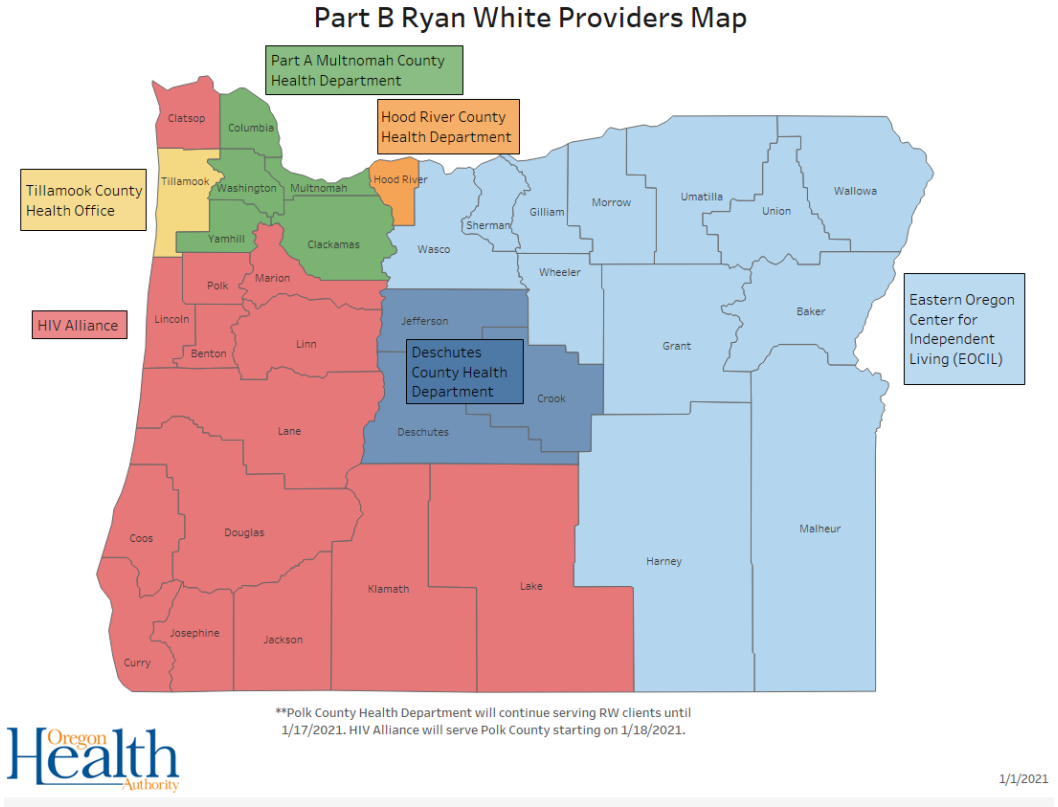
The Oregon Health Authority, HIV/STD/TB Program, HIV Community Services gratefully acknowledges the work of the Oregon HIV Case Management Task Force in providing recommendations for edits changes and improvements in this document.

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

INTRODUCTION Oregon HIV Case Management Program Overview

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



The HIV Case Management model addresses the needs of persons with HIV disease by funding regional based care coordination and support services that support access to and retention in medical care. The regional based model of HIV care coordination was implemented in 2009 as an alternative to county based services. Case management guiding principles, interventions and strategies are targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation. Special thanks to the HIV Case Management Task Force which convenes to review and modify these documents. The following Standards of Service are utilized by all regional based care coordination service providers and are required by contract and Oregon Administrative Rule.

Client Rights

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

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

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

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

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

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

Education Requirements & Training

The HIV Case Management model recognizes the need for three distinct areas of expertise: (1) eligibility determination/administrative; (2) psychosocial services coordination/helping clients access programs that will help pay for medical treatment and (3) medical care and treatment engagement. Under this model, the Intake

Coordinator (IC) is responsible for all enrollment and re-enrollment activities; the Care Coordinator (CC) is responsible for all psychosocial services such as insurance and benefits coordination and the Medical Case Manager (MCM) is responsible for assisting the client to successfully engage in medical care and treatment.

Role	Education/Licensure Requirements
Intake Coordinator (IC)	Administrative background, minimum high school graduate or equivalent and related office experience for a period of 2 years of full time (or equivalent), regardless of academic preparation.
Care Coordinator (CC)	Bachelor of Social Work, or other related health or human service degree from an accredited college or university, OR; related experience for a period of 2 years of full time (or equivalent), regardless of academic preparation.
Medical Case Manager (MCM)	Oregon licensed registered nurse (RN) with additional AIDS Certification (AIDS Certified RN) or ability to obtain certification within 12 months of employment. It is highly recommended that any RN hired without a current ACRN certification have at least 1 year experience providing clinical care to persons living with HIV/AIDS. The ACRN must work at least .5 FTE in HIV services or oversight must be provided by an ACRN working at least .5 FTE in HIV services.

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

Roles & Responsibilities

Intake Coordinator (IC)

The Intake Coordinator (IC) is the first contact for new clients and plays an important role in educating the client about the HIV Case Management Model, and how a client most successfully navigates the process. Additionally, the IC begins to establish trust and rapport with the client. The intake is a screening process, which serves as the primary source of demographic and client eligibility documentation. For new clients, the IC orients the client to the agency, conducts the initial intake, and schedules both the Psychosocial Screening and the Nursing Assessment. For existing clients, the IC conducts the eligibility update process every 6 months, completes the intake update and conducts the phone triage depending on client acuity, referring to the CCs and MCMs as needed. The majority of the intake, update and triage are conducted by phone.

The Intake Coordinator will:

- Conduct the initial intake for all new clients.
- Provide client orientation for all new clients.
- Conduct 6 month eligibility review or self-attestation process.
- Coordinate annual update and triage according to the standards
- Refer client to the RN or CC based on need indicated during the triage.
- Schedule (or alert the appropriate staff to the need for) an annual Nursing Reassessment, and/or annual Psychosocial Rescreening for RN and/or CC Acuity 3 or 4 clients.
- Offer language assistance services including access to translation and interpretation services, at no cost, if the client has limited English proficiency, in order for the client to access HIV case management services.

Care Coordinator (CC)

Care Coordination services assist clients to access private and public services to meet basic needs such as housing, transportation, food, health insurance, medical care, alcohol and drug treatment, mental health services, vocational programs and SSI/SSDI. The CC facilitates this access through the provision of complete referrals, and additional coordination and advocacy as needed. CCs are part of a multi-disciplinary team of providers who work with the client to coordinate and provide seamless access to the full continuum of HIV services and resources necessary to assist successful management of HIV disease.

Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) provision of services required to implement the plan; (4) monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of care coordination including face-to-face, phone contact, and any other form of communication either directly with or on behalf of a client

The first and highest priority of the CC must be to ensure that persons living with HIV/AIDS are enrolled and sustained in coordinated health care for HIV disease that optimizes their health and well-being.

The CC will:

- Conduct a Psychosocial Screening for all new clients.
- Conduct an annual Psychosocial Screening for all clients assigned CC Acuity 3 or 4.
- Follow up on the CC triage when appropriate. The CC will determine the seriousness of the encounter and decide on a plan of action.
- Develop and update, as appropriate, a comprehensive individualized care plan for clients assigned CC Acuity 3 or 4. Coordinate services and activities required in implementing the care plan
- Refer to appropriate agencies required to assist the client in achieving the goals and objectives identified in their care plan and provide client-specific advocacy

- Monitor clients to assess the efficacy of the care plan
- Evaluate care plan goals and conduct follow-up
- Provide health education and advocacy
- Participate in case conferencing with the MCM and other members of the care coordination team.
- Include OHOP Housing Coordinators in case conferences for clients who are enrolled in OHOP.
- Transfer and inactivate clients as appropriate.
- Document in case notes, on the required forms and in CAREWare.
- Provide Emergency Financial Assistance in compliance with program standards and guidance
- Offer language assistance services including access to translation and interpretation services, at no cost, if the client has limited English proficiency, in order for the client to access HIV case management services.

Medical Case Manager (MCM)

The MCM participates in a multidisciplinary team that works in partnership with the client's medical provider to assess the medical needs of the clients. The MCM conducts a Nurse Assessment to determine the client's medical need and access to medical services, develops a nursing plan, performs nursing interventions (treatment adherence, nutritional health, oral health, and liver health), advocates on behalf of the client and participates in the care coordination team to improve client health outcomes.

The MCM will:

- Conduct a face-to-face nursing assessment for all new clients.
- Conduct a face-to-face annual assessment for clients assessed as an RN Acuity 3 or 4 and for any clients who have been triaged at the Agency as requiring a Nurse Reassessment.

- Perform a physical examination to include (at a minimum): Weight, height, vitals (blood pressure, temperature, pulse/heart rate) and inspection of the mouth.
- Determine the need for ongoing Medical Case Management as defined in Nurse Assessment Standards.
- Develop an individualized Nurse Plan for clients assigned an RN Acuity 3 or 4.
- Refer for medical evaluation and treatment.
- Provide education and counseling about HIV transmission, disease management, risk reduction and harm education.
- Provide HIV medication therapy to include client education concerning risks and side effects, monitoring disease process to include lab values, monitoring client adherence and tolerance of medications.
- Provide counseling, education and referral specifically associated with the nursing areas of treatment adherence, nutrition, liver health, and oral health.
- Provide nursing interventions and education about a variety of issues, as appropriate to both client assessed need for intervention and the nurse's trained skills. Interventions (education and/or counseling) may include (but are not limited to):
    - Healthful living habits and holistic approaches to good nutrition, adequate sleep, regular exercise, stress management, appropriate immunizations, age appropriate health screenings etc.
    - Safer sex practices, sexually transmitted diseases and partner notification services
    - Prevention of exposure to opportunistic pathogens
- Provide information about available resources and services for clients and their support system.
- Follow up on the nurse triage when appropriate. The nurse will need to determine the seriousness of the encounter and decide on a plan of action.
- Communicate regularly with the client's medical providers and other health and human service providers and provide client advocacy services when appropriate.

- Case conference with the client's medical provider and the care coordination team.
- Conduct home visits and accompanying the client to medical visits as needed.
- Document in CAREWare case notes, on the required forms and in the CAREWare database.
- Offer language assistance services including access to translation and interpretation services, at no cost, if the client has limited English proficiency, in order for the client to access HIV case management services.

HIV Case Management Activities

Activity	IC	CC	MCM
Intake	X		
Semi-annual eligibility review	X		
Annual update	X	X*	
Triage (CC and RN)	X		
Psychosocial Screening		X	
CC Acuity		X	
CC Care plan		X	
Nursing Assessment			X
RN Acuity			X
Nurse Plan			X
Case Conference		X	X
Referral & Advocacy		X	X
Transfer & Discharge		X	

*Some agencies may have the CC complete the annual updates at the time of rescreening/reassessment.

Client-Centered Approach to HIV Case Management

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

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

It is the care coordination team's responsibility to:

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

Chronic Disease Management

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

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

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

Improving the health of people with chronic illness requires not only determining what care is needed, but spelling out roles and tasks to ensure that everyone involved as part of the client's care team understands their role. It also requires coordinated follow-up so clients aren't on their own once they leave the doctor's or case manager's office. More complex clients need more intensive case management for a period of time to optimize the clinic care, the effectiveness of their treatment regimen and their self-management behavioral skills.

Effective self-management support means acknowledging the clients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. But self-management can't begin and end with a class. Using a collaborative approach, case managers and clients work together to define problems, set priorities, establish goals, create care plans and solve problems along the way.

Key principles of chronic disease management & client self-management:

- Emphasis on the client's role
- Standardized assessment
- Effective, evidence based interventions
- Care planning (goal-setting) and problem solving
- Active, sustained follow-up

Self-Management Guidelines

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

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

Stages of Change

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

Trauma Informed Care

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

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, which emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. Traditional approaches see problems or symptoms as discrete and separate, client behavior as "working the system" and clients as broken and vulnerable. Instead, trauma informed care sees problems or symptoms as coping mechanisms that are dealing with trauma and client behavior as a way to get needs met. The HIV Community Services Program encourages both you, in your position, and your agency, to embrace a trauma informed care approach, and to apply a Universal Precautions approach in work with clients. In the context of trauma informed care, universal precautions means assuming that all individuals presenting for services have experienced or been exposed to trauma and may have symptoms from this exposure that are not immediately obvious. Briefly, the 8 principles of a trauma informed system believe that:

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

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

General Program Policies

1. All individuals accessing HIV Case Management services must participate in an Intake & eligibility review process, a Psychosocial Screening or triage and a Nursing Assessment or triage depending on the client's acuity.
2. All clients, no matter what acuity, must have their income, residence, and insurance status verified every 6 months.
3. New clients cannot receive financial assistance before they have completed the Intake/Eligibility Determination. Exceptions may be made if a client is in need of medical transportation assistance in order to meet with the MCM and/or medical provider.
4. All active clients will be assigned to a CC. Only clients assigned an RN Acuity 3 or 4 will be assigned to the caseload of a MCM. All newly diagnosed clients will be assigned to the MCM for a minimum of three months; the MCM may also assign clients to their caseload based on professional assessment regardless of Acuity.
5. All clients must have an identified medical insurance provider documented in their client record or clear documentation in the CAREWare case notes about why this program expectation was not met and what is being done to accomplish this priority.
6. Clients residing in the HIV Alliance or EOCIL regions are required to receive services by the HIV Case Management. Clients are not allowed to be co-managed across multiple case management jurisdictions without prior approval from the Oregon Health Authority.

Quality Management

The HIV Care and Treatment (HCT) Program is committed to developing, evaluating and continually improving a statewide, quality continuum of HIV care, ensuring equitable access and decreasing health disparities. The HCT Program supports this mission by gathering data and information about the services delivered by HCT 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. The Quality Management Plan, Performance Measures, and Site Visit Tools used in sub-recipient monitoring can be found on the program website.

Case Management for Reentry to Community

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

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

INTAKE COORDINATION SERVICES

Initial Intake & Eligibility Determination

Purpose
Each prospective client who requests Ryan White services will be screened and evaluated for eligibility through a comprehensive intake process. The Intake is intended to determine eligibility, gather required information, introduce the client to the agency, and assist in determining immediate needs. For more information on eligibility determination, see Support Services: Policies, Definitions and Guidance.
Forms
• Intake/Eligibility Review Form (8395) • Residency Verification (8485) (If needed) • HIV Care and Treatment Program Information Sheet (8405) • Informed Consent (agency provided) • Grievance Policy (agency provided) • Authorization For Use And Disclosure Of Information (agency provided) • Client Rights & Responsibilities (agency provided, and in accordance with ORS 431.250, and 431A.625)
Process

Schedule the Update and/or mail client required forms.	The IC schedules the intake either during the first contact with the client or within 7 days of the first contact. The IC will mail, email, and/or complete, with the client, all required forms.
Screen for basic eligibility	The IC will screen every potential client for eligibility criteria. Clients who are transferring to an agency within the Part B network or are returning to the same agency within 6 months are not required to complete a new Intake.

Conduct client orientation	The IC will describe the available services, and the intake, screening and assessment process.
Documentation & ROIs	The Intake is documented on the Intake/Eligibility Review Form. The IC will obtain Authorization for Release of Information for every client at a minimum: • Between the RN and the CC if outside the Agency • Between Agency and medical providers • Between Agency and mental health and/or addictions providers • Between Agency and any other providers currently working with the client • Between Agency and emergency contacts provided by the client • A Release of Information form provided by the agency (as required under ORS 192.553 to 192.581) in which a client authorizes in writing (ink or electronically) the disclosure of certain information about their case to another party (including family members). Included in the form are: the purpose of the disclosure, the types of information to be disclosed, entities to disclose to and the expiration date of client authorization. Because this program requires an annual assessment, it is expected that a Release of Information will be obtained annually. Part of the discussion should include information about the intent of the Release of Information, its components, and ways the client can nullify it. Clients should be informed of their right to **Confidentiality**. It is important not to assume that anyone - even a client's partner or family member - knows that the client is HIV positive.

	Part of this discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone, etc.) Case managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual has HIV or receiving social services.
Conduct crisis assessment & referral	The IC will assess the need, and make complete referrals for crisis intervention, if necessary. For clients who are newly diagnosed, homeless or otherwise in crisis, the intake process should begin within 24 hours of initial client contact.
Schedule Screening & Assessment.	The IC will alert appropriate staff, or schedule all new clients for a Nurse Assessment and Psychosocial Screening.
CAREWare Data Entry	
Create CAREWare Record	The IC will create the CAREWare record at the time of Intake. The official enrollment date will be the date informed consent was received.
Demographics	The IC will complete the Demographics tab.
Annual Review	The IC will complete the Annual Review tabs. IC may also upload intake form under the Annual Custom Fields Tab.
Services	The IC will enter staff time under 'Intake/Eligibility Review - Annual'" to indicate date of eligibility determination and intake completion. "Intake Coordination General" should be used to document time used prior to determination of eligibility. When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	The IC will enter a case note for every client contact.
Referrals	If referral was made, it should be documented in referral tab.

Contacts/ROI	Any Contacts collected must be entered under the Contacts/ROI tab, and ROIs uploaded as appropriate.

Six Month Eligibility Review/Self-Attestation

Purpose	
All clients must have their eligibility reviewed every 6 months or self-attest that nothing has changed.	
Forms	
• Self-attestation (8395a)	
Process	
For clients on CAREAssist	Print out the CAREAssist Eligibility Report & complete the Self-Attestation form.
For clients not on CAREAssist	Client must submit necessary documentation and complete the Self-Attestation form.
CAREWare Data Entry	
Demographics	Update the Demographics tab as needed.
Annual Review	Update the Annual Review tab as needed. IC may also upload six-month eligibility form under the Annual Custom Fields Tab.
Services	The IC will enter staff time under "Eligibility Review (Semi-Annual)" using 15-minute unit. When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	The IC will enter case note and any other relevant data.

Annual Update & Triage

Purpose

The purpose of the Annual Update is to gather updated documentation for a full eligibility review. The triage is a process used for low acuity clients to determine if there are existing or emerging needs and identify clients who need a referral to the CC or RN.

RN Acuity	CC Acuity	Annual update/triage requirements
1	1	Annual update, MCM & CC Triage by mail
2	2	Annual update, MCM & CC Triage by telephone.
2	3 or 4	Annual update, MCM Triage (In some circumstances, a CC may complete the update at time of rescreening)
3 or 4	2	Annual update, CC Triage

Forms

- Intake/Eligibility Review Form (8395)
- Residency Verification (8485)
- Care Coordination (8471) and/or Medical Case Management (8472) Triage Tool
- Release of Information

Process

Confirm Suppressed Viral Load	Prior to completing the RN triage, the IC will confirm evidence of a suppressed viral load within the encounters tab. If viral load is >200 copies/mL or it has been more than 12 months since last recorded viral load, the MCM should be notified to follow-up with complete assessment and the RN triage form will not be used.
Schedule the Update and/or mail client update forms	The IC will contact clients for annual update. The IC will mail or phone the client to complete all required forms. If mailing forms, the client should be asked to return the form within 7 – 10 business days. If the client has not responded within 7 – 10

	business days, phone based follow-up should occur to ensure client received and understood form.
Complete the Intake/Eligibility Review Form	The information gathered during the update will be documented on the Intake/Eligibility Review Form. Complete all of the sections except for HIV & Identity verification which are only required once at original Intake.
For clients on CAREAssist	For CAREAssist clients, Check the "Current CAREAssist Client" box and attach a copy of the CAREAssist Eligibility Report.
For clients not on CAREAssist	For clients not on CAREAssist, complete all of the sections of the form except for HIV and Identity verification. Attach current income and residency documentation.
Referral to MCM or CC.	Clients who answer "yes" to one or more questions asked in the triage must be referred to the appropriate MCM or CC by email, within 24 hours. For clients referred to the CC or MCM, the client will be contacted within 7 days of completing the Triage Tool.
CAREWare Data Entry	
Demographics	The Annual Update will reassess information previously collected, which may include changes to the client name, address, phone number, income, insurance or HIV status (client may have transitioned to AIDS from and HIV diagnosis). This information must be entered and updated under the Demographics tab.
Annual Review	Update Annual Review Tab as appropriate. IC may also upload annual update forms under the Annual Custom Fields Tab.
Services	When conducting an annual triage for clients the IC will enter staff time under "RN Triage" or "CC Triage" using a 15-minute unit. Time spent on the "annual update" will be recorded as "Eligibility Review (IC)- Annual". General IC work will be captured by entering "Intake Coordination General" using a 15-minute unit, which includes time spent attempting to contact clients, or in preparation for the triage. When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".

Case Notes	The IC will enter a case note for every client contact, and document the triage results using the Triage Templates.
Contacts/ROI	The Update process will include the collection of some of the client's Contacts and must be entered under the Contacts/ROI tab.

CARE COORDINATION SERVICES

Psychosocial Screening

Purpose
The Psychosocial Screening is an information gathering process that includes a telephone or face-to-face interview between a client and a CC. The screening is a cooperative and interactive process during which a client and CC collect, analyze, synthesize and prioritize information which identifies client needs, resources, and strengths, for purposes of developing a care plan to address the needs identified. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination.
Forms
• Psychosocial Screening (8401) • Benefits Planning Tool (8486) (optional)
Process

Complete initial Psychosocial Screening	The Psychosocial Screening must be conducted by a CC within 30 days of intake completion. There may be factors which require a longer period of time to complete the Screening and these should be documented in the client record.
Verify insurance payer	An insurance payer must be documented in CAREWare, and a copy of the card (s) will be in the client chart.
Obtain Authorization to Release Information	ROIs must be in place for coordination activities identified in the screening
CC Triage	For clients referred to the CC via triage, the CC will contact the client within 7 days. The CC may determine to conduct a screening based on need.

Complete annual update	CC may also complete the annual update for CC 3 and 4 at time of rescreening.
Rescreening	For CC Acuity 3 and 4, the Psychosocial Screening must be conducted annually. There may be factors which require a longer period of time to complete the Screening and these should be documented in the client record.
CAREWare Data Entry	
Annual Review	The Screening will reassess information previously collected, which may include changes to the client's housing arrangement, health insurance or income. This information must be entered and updated under the Annual Review tab. The screening form may be uploaded into the Annual Custom Fields Tab. Mental health and substance use fields should now be updated based on outcome of screening. o Mental Health Yes – Mental health need identified at last screening or triage. No – Mental health need not identified at last screening or triage. Not medically indicated – Do not use. o Substance Use Yes – Substance use need identified at last screening or triage. No – Substance use need not identified at last screening or triage. Not medically indicated – Do not use.
Services	Time associated with the completion of the Psychosocial Screening Form must be entered as a "Screening (CC)". This includes time associated with documentation and the collection of information from the client of other sources. When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	Documentation of the screening process, findings, recommendations, and referrals must be entered in the case notes using the "Psychosocial Screening" template.
Contacts/ROI	If the screening process includes the collection of any client Contacts they must be entered under the Contacts/ROI tab.

Referrals	Referrals provided during the screening process must be documented under the Referrals tab.

CC Acuity Assignment

Purpose	
The Acuity Scale assists the care coordinator by translating the screening process into a level of programmatic support designed to provide assistance appropriate to the client's assessed need and functioning. Additionally, the Acuity Scale assists in program planning and case-load administration.	
Forms	
• Acuity Worksheet (8496r)	
Process	
Complete Acuity Worksheet	Information gathered during a Screening will be used to assign every client an acuity level. The guidelines direct the case management activities and timeframes required (see the Acuity Level Guidelines below.) The Acuity will be completed using the following instructions: • Check the applicable box in each life area. • The highest level with a checked box is the level that is assigned points. • Using the points listed at the top of the form, total the points for each life area and then for the overall acuity. • The guidelines direct the case management activities and timeframes required (see the Acuity Level Guidelines below).
Change in acuity without a screening	The CC may change the client's acuity without a Screening <u>unless</u> it has been longer than a year since the last Screening, or the client's annual Screening is due within 30 days. All life area acuities should be evaluated for accuracy, and attempts to communicate acuity change to the client must be documented.
Exceptions to acuity assignment	The psychosocial acuity level is automatically assigned to Acuity 4 and the acuity must be reassessed in 60 days if: (a) the client has been incarcerated within the last 90 days; (b) the client was diagnosed with HIV in the last 180 days; and/or (c) the client is currently homeless.

CAREWare Data Entry	
Forms	Acuity data will be entered in the "Psychosocial Acuity" form.
Services	When the acuity is updated in connection with completing a full Screening, the service will be entered using the "Screening" service. When the acuity is not updated in connection with a full Screening the service will be entered using the "CC Acuity Change" service. When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	If an acuity change is made without a full screening, the "Psychosocial Acuity Change" case notes template must be completed documenting the reasons for the change.

CC Acuity Stage Guidelines

Level	Guidelines
Level 1: 0 – 8 points	• Initial Psychosocial Screening. • Annual CC Triage and update via mail. • Eligibility verified every 6 months. • Optional Care Plan
Level 2: 9 – 16 points	• Initial Psychosocial Screening. • Eligibility verified every 6 months. • Annual CC Triage and update (telephone or face-to-face). • Optional Care Plan.
Level 3: 17 – 24 points	• Initial Psychosocial Screening and annually thereafter. • Eligibility verified every 6 months. • Annual update • Care Plan developed and monitored, with minimum contact by CC (telephone or face-to-face), every **30 days**. • A case conference with internal staff or external providers is recommended every **30 days**.
Level 4: 25 - 32 points	• Initial Psychosocial Screening and annually thereafter. • Eligibility verified every 6 months • Annual update • Care Plan developed and monitored, with minimum contact by CC (telephone or face-to-face) every **2 weeks**. • A case conference with internal staff or external providers is recommended every **2 weeks**.

CC Care Plan

Purpose	
The CC will work with the client to develop a care plan that is client centered and includes self-management goals. The care plan must include both goals and specific tasks or activities. While a goal is the future state that a client would like to achieve, tasks or activities are the actions necessary to complete the goal. Tasks are in the present, specific, active, have deadlines and involve specific people. Monitoring is an ongoing process that involves collection and analysis of data and information that results in evaluation of client satisfaction, client progress and need for care plan revision. The CC, along with the client, will reassess the goals and activities identified in the care plan to assess for progress and the need for appropriate changes and follow-up on any referrals made. Follow up and monitoring should comply with the requirements under "Acuity Scale". Follow-up and monitoring goals include ensuring that changes in client condition or circumstance are communicated, ensuring that goals and activities are meeting client need, building and maintaining rapport, and reducing service duplication.	
Process	
Care Plan development and follow-up	**Acuity 3 or 4** clients will have a current CC care plan that is monitored in accordance with their acuity. **Acuity 1 and 2 clients** will not receive additional formal care planning unless need is determined. If a care plans is developed, it should be reviewed at least once every 6 months. N**ew clients** will have a care plan at intake. CC will follow up with all clients on the care plan within 6 months.
Acuity reassignment	If a client is reassigned from CC2 to CC3 or CC4, a care plan must be developed with the client and the CC3 or CC4 standards for follow-up will be applied.
Copy to client	A copy of the Care plan should be offered to the client when updated.

Care Plan Documentation	Documentation of care plan should be consistent with agency policy and procedure. At a minimum, the care plan should include the client's name, goals, the specific activities for completing the goal, the person responsible for completing the activity, proposed deadline, any required referrals, status of both the activities and overall goal, and date of most recent update. If the client is referred to OHOP, the Care Plan should address housing stability. If the client is most comfortable communicating in another language, indicate in the Care Plan how staff will communicate with the client (interpreter, translation services.) Although recommended, the care plan does not need to live in CAREWare.
CAREWare Data Entry	
Services	Time associated with care planning should be recorded as "Care Plan (CC)". Time associated with follow up and monitoring that does not directly impact the Care Plan must be entered as "Case Management". When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	Care Planning activity should be documented in the case notes. A Care Plan template is available in the case notes feature.

CC Referral and Advocacy Standards

Purpose	
Each client will receive assistance to facilitate access to those services critical to achieving optimal health and well-being; and will receive advocacy assistance to help problem solve as necessary when barriers impede access. The purpose of this service is to assess the client needs and direct them to one or more organizations/programs capable of meeting those needs. This process includes providing enough information about each organization to help the client make an informed choice. Advocacy is the act of assisting someone in obtaining needed goods, services or benefits. This may be necessary when a client has been denied services or benefits, when they are unable to communicate their needs or challenges, or when they have a complaint about services. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration. Advocacy does not involve coordination and follow-up on medical treatments (this should not be confused with appropriate nursing activities).	
Form	
• Authorization For Use And Disclosure Of Information (Agency provided)	
Process	
Identify resources	The CC will maintain a working knowledge of community resources, and when necessary will conduct outreach to identify needed services.
Assess readiness	Referrals are only provided when the client is ready to receive and accept the referral. When a need has been identified but the client is not ready or refuses the referral, the CC should document this and reference the appropriate stage of change/readiness for behavior change/referral in the case notes.
Provide referral information	Clients will be provided complete referral information that is relevant to their needs, is up-to-date, and in a format/language that they understand.

Identify follow-up plan	The CC and the client will identify how and when follow-up will occur. The initial follow-up should occur within 2 weeks after the initial referral.
Assess for and provide advocacy	Initially and throughout the process, the CC will assess the client's progress. Their need for advocacy will be monitored through follow-up with the client and referral agency. Advocacy may include communication with the referral agency staff, by phone, email or letter. All communication with the referral agency must be authorized by the client using the Authorization For Use and Disclosure of Information.
CAREWare Data Entry	
Services	Time associated with referrals and/or advocacy must be entered as "Care Coordination (CC)". When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	Documentation of client contact or contacts made on the client's behalf must be documented in the case notes.
Referrals	Referrals required to be documented include: outpatient/ambulatory care, CAREAssist, oral health care, mental health services, medical nutritional therapy, substance abuse services outpatient, housing (including complete OHOP referrals), employment, tobacco cessation, and food banks. Ongoing referrals or referrals where no follow-up or tracking is required do not have to be entered into the Referral Tab. See Referral Section in the CAREWare User Guide for more information. All referrals entered require a final status within 6 months from initial date of referral. • Pending – Status of all new referrals. If referral is pending, follow up with the client every two weeks with regards to the status of the referral. • Completed – When you have evidence that client has made initial contact with the agency to which you referred the client. • Lost to Follow up – After a reasonable amount of time, or a maximum of 3 months, during which time you have been usable to verify the outcome of the referral.

	• Rejected – If at any point in the referral process, the client informs you that they no longer need or desire the referral you provided.

CC Case Conferencing Standards

Purpose
Ongoing communication and case conferencing happens as part of coordinating client care. Case conferencing differs from care coordination in that it is a formal, planned, structured activity; separate from routine contact, that brings together individuals providing specific services to a client for the purpose of assuring unduplicated, integrated and well-coordinated services. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication of services. Case conferences can be used to identify or clarify issues regarding a client's status, needs and goals; review activities including progress and barriers towards meeting the goals; map roles and responsibilities of the participants; resolve conflicts or strategize solutions; and create an integrated Care Coordination Plan. Regular case conferences are strongly encouraged for clients who are virally unsuppressed, newly diagnosed, or have high overall acuity or in life areas of housing, mental health and substance use.
Forms
• Case Conferencing Form (8470)
Process

Case conference	Case conferences can be internal to your organization (ICs, pharmacist, Patient Navigator), external to your organization (OHOP, CAREAssist, parole officers, mental health providers, caregivers, etc.) or a combination of both. The frequency of case conferencing is dependent upon the client's acuity. A case conference (either internal or external) is recommended at least once every 30 days for acuity 3s and once every 2 weeks for acuity 4s. For high acuity clients who are NOT also in Medical Case Management, it is the CC's responsibility to facilitate and document the Case Conference, and update the Care Plan as necessary. If a client is also receiving Medical Case Management, responsibility for facilitating the case conference is left to the RN.

	When appropriate, the client should be involved in the case conference.
CAREWare Data Entry	
Services	Time associated with the case conferencing must be entered as "Case Conference (CC)".
Case Notes	Documentation of the case conference must be entered in the case notes. The case conference template may be used.

Transfer & Termination Standards

Purpose
The purpose of the transfer or termination process is to close a client out from your case management agency. The transfer process should be used when a client is requesting services from a case management provider outside of the agency's jurisdiction. The transfer process should minimize disruption and assist a client moving between programs. This Standard requires that the care coordination team work with the client and the new case manager; to forward copies of appropriate chart documentation; to assist the new case manager in understanding the client's needs; and to reduce barriers and "red tape" to the client's ongoing access to care. Termination can only occur if a client's circumstances meet specific criteria, limited to the following: • Client fails to meet eligibility requirements • Client is lost to follow up or is unresponsive for more than 60 days • Client moves into a system of care which provides institutional case management • Client submits false, fraudulent or misleading information in order to retain benefits • Client uses supportive services fraudulently • Client consistently violates program responsibilities outlined in OAR 333-022-2070. Termination requires clear documentation of the reason(s) for termination, and notifying the client of termination and the grievance and hearings process.
Forms
• Authorization For Use And Disclosure Of Information (Agency provided) • Grievance Form (Agency provided) • Request for Hearing (MSC 0443)
Transfer Process (to another case management provider)

Client notification of transfer	The CC will discuss transfer with client. The CC will provide the client with appropriate referrals.
Obtain appropriate releases of information	The CC will obtain permission to share information with referral agency by updating the Authorization For Use and Disclosure of Information.
Case Conference between referring agencies	The CC will communicate the clients transfer plan to the referral agency.
Information Sharing	The CC will fax the current Intake/Update Form, Screening Form, Nursing Assessment Form and HIV verification documentation.
Transfers within the Part B network	Clients who are transferring to an agency within the Part B network or are returning to the same agency within 6 months are not required to complete a new Intake, Psychosocial Screening or Nurse Assessment.
Notification to CAREAssist	The CC will notify CAREAssist of the change.
Close file	The CC will follow the agency protocol for closing charts.
Termination Process	
Documentation	Termination requires clear documentation of the reason(s) for termination noted in the CAREWare case notes.
Conference with supervisor	The agency supervisor should be consulted prior to terminating any client.

Verbal consult with client	When possible, clients will be informed of reasons for termination verbally (via phone or face to face), and provide referral and information regarding other available services as needed. A certified letter should then be sent indicating that the case is being closed. The letter should inform the client of the grievance and hearing options, as well as requirements for their return to case management services. In circumstances where despite attempts, you have been unable to have a conversation with client regarding termination, a certified letter can be sent without verbal consult.
Lost to follow up process	If the case is being closed because the client has been unresponsive for more than 60 days, the CC will make a minimum of 6 attempts to contact the client. A minimum of 4 different communication methods must be used. These methods may include, but are not limited to: phone calls, text messages, letters, home visits, and/or information provided by medical providers, emergency contacts, social media sites, jail rosters, CAREAssist, and OHOP. Communication methods utilized must be consistent with local case management agency policy and procedure. If no response is received, the CC will send a certified letter indicating that the case will be closed in two weeks unless the client makes contact. The letter should inform the client of the grievance and hearing options, as well as requirements for their return to case management services.
Notification to CAREAssist	The CC will notify other providers within the agency of change in client status, as well as, CAREAssist and OHOP as necessary.
Close client file	The CC will follow the agency protocol for closing charts.
CAREWare Data Entry	

Demographics	Information on demographics tab should be up to date prior to closing client. Ensure enrollment status is documented appropriately with a case closed date.
	
	• Referred or discharged indicates that you have
	  o Referred the client to another Part B funded provider.
	  o Closed the client because they requested closure

	from case management. o Lost contact with a client and they are considered to be "lost to follow up". o Been notified that client is deceased. • Removed indicates that the client was removed from your agency due to violation of rules. • Incarcerated indicates that the client is serving a criminal sentence in a correctional institution (prison or jail) • Relocated indicates that the client has moved out of the Part B Service area (to the Part A service area/Portland metro area or out of state or country).
Annual Review	Ensure information on annual review tab is as up to date as possible.
Services	Time associated with Transfer and Discharge must be must be entered as "Transfer/Discharge (CC)", and "Transfer/Discharge (RN) for high nursing acuity clients. You must also check the "Lost to follow-up" box within this service. When you leave a voicemail for a client, use "Non-RN Attempt Clt. Contact".
Case Notes	Documentation of the service includes a case note summarizing the effort made to contact the client through use of the Lost to Follow up template, and a note that CAREAssist has been notified of the change in the client's status.
Referrals	All Pending referrals should be closed accordingly.

Nursing Assessment Standards

Purpose	
The Nursing Assessment is intended to assist the MCM to collect, analyze, synthesize and prioritize HIV disease management information, which identifies client needs, resources and strengths, for the purpose of developing a Nurse Plan to address HIV medical needs. At a minimum, nursing activities must include assessment, education and counseling on: (a) treatment adherence/disease progression, (b) nutrition health, (c) oral health, (d) liver health (Hepatitis in general and Hepatitis C in particular) and (e) HIV transmission risk reduction. All interventions delivered must adhere to the "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIVA" and the "Clinical Manual for Management of HIV-Infected Adults".	
Forms	
• Nursing Assessment (8402) • Medication Profile (8417)	
Process	
Nurse Assessment is conducted	Each new client of the Agency will participate in a face-to-face Nurse Assessment within 30 days after completion of the Intake. Ongoing clients with RN acuity of 3 or 4 will receive an annual face-to-face Nurse Reassessment. There may be factors which require a longer period of time to complete the Assessment and these should be documented in the client record.
Acuity 1 or 2	Clients who have been referred to the MCM for any reason will be contacted with 7 days to determine the need for short-term health information, a medical referral, medical crisis or an in-depth Nurse Assessment. The MCM is responsible for monitoring medical visits and labs completed by all clients in their region, whether or not they are currently on the MCM case

	load. Outreach and follow-up should be made with any client if there has been a significant decline in CD4 and/or a significant increase in viral load since the last lab. If it has been more than 12 months since last reported viral load and/or the client was virally unsuppressed at last measure (>200 copies/mL), the client is an automatic RN Acuity 3.
Schedule Case Conference	Upon completion of the Nurse Assessment, if the client has been assessed as needing ongoing Medical Case Management, the MCM must contact the care coordination team within 1 week to schedule a case conference with the CC.
Compose Nurse Assessment Summary Letter	A Nurse Assessment Summary Letter or email must be completed and sent to the client's primary HIV medical provider (and other providers as necessary) within 2 weeks after completion of the Nurse Assessment. A copy of the Nurse Assessment or case notes may be sent in lieu of a summary letter per medical provider request. Regular case conferencing between the MCM and the client's HIV medical provider is a recommended best practice.
CAREWare Data Entry	
Demographics	HIV Status and Risk Factor must be indicated on demographics tab.
Services	Time associated with the completion of the Nurse Assessment must be entered as an 'Assessment (RN)'. This includes time associated with documentation and the collection of information from other sources. If the Summary Letter was sent, the checkbox indicating this must be checked. When you leave a voicemail for a client, use "RN Attempt Clt. Contact".
Case Notes	Documentation of the assessment and assessment process, findings, recommendations, referrals and goals must be entered in the case notes using the Nurse Assessment template.
Encounters	Any updated lab (CD4/Viral Load) results collected during the assessment process must be entered unless labs have been automatically imported.
Contacts/ROI	If the assessment process includes the collection of any client Contacts they must be entered under the Contacts/ROI tab.
Referrals	Complete Referrals provided during the assessment process

	must be documented in the Referrals tab.

MCM Acuity Standards

Purpose	
The Acuity Scale is a tool which complements the Nurse Assessment. The Acuity Scale translates the Nurse Assessment into a level of support designed to provide the client assistance appropriate to their assessed need.	
Forms	
• Medical Acuity (8497r)	
Process	
Complete Acuity Form	The Medical Acuity should be calculated using the following instructions: • Check the applicable box in each life area. • The highest level with a checked box is the level that is assigned points. • The points are listed at the top of the form. • Total the points for each life area and then for the overall acuity.
Assign Acuity	The MCM will determine if the client requires ongoing Medical Case Management by determining the acuity level of the client. The guidelines direct the case management activities and timeframes required (see the Acuity Stage Guidelines below.)
Change in acuity without an assessment	The MCM may change the client's acuity without an Assessment unless it has been longer than a year since the last Assessment or the client's annual Assessment is due within 30 days. Acuities in all MCM life areas should be evaluated for accuracy, and attempts to communicate acuity change to the client must be documented.
Exceptions to Acuity Assignment	The MCM will assign the client to ongoing Medical Case Management regardless of acuity if 1) the client is newly diagnosed (they will receive a minimum of 3 months of Medical Case Management;) 2) the client was virally unsuppressed (>200 copies/mL at last lab), 3) it has been longer than 12 months since

	last reported lab, and/or 4) the client shows evidence of significant physical decline. Acuity should be reassessed in 60 days. The MCM may assign the client ongoing Medical Case Management, regardless of acuity, if 1) the client has been recently released from a hospital or jail; 2) client is under the age of 18 2) the client has multiple medical diagnoses; 3) the client is non-compliant with medical care; 4) the client is having problems adhering to medication; 5) the client is symptomatic and/or 6) client has been released from a correctional facility within the past 90 days. Clients referred to the Pharmacist-Led Adherence Program must receive on-going Medical Case Management during the time they are receiving adherence services from the pharmacist and for at least 3 months following the end of pharmacy services. While enrolled in Pharmacy services, minimum contact expectation may be met by Pharmacist in lieu of MCM contact, although MCM should continue to follow-up on areas not being addressed by pharmacy as needed.
CAREWare Data Entry	
Forms	Acuity data will be entered in the "Medical Acuity" form.
Services	When the acuity is updated in connection with completing a full Nurse Assessment the service will be entered using the "Assessment" service. When the acuity is not updated in connection with a full Nurse Assessment the service will be entered using the "RN Acuity Change" service. When you leave a voicemail for a client, use "RN Attempt Clt. Contact".

Case Notes	The "Medical Acuity Change" case notes template must be completed documenting the reasons for an acuity change outside of an assessment.

MCM Acuity Level Guidelines

Level/Points	Guidelines
Level 1: 0-5 points	• Initial face-to-face Nursing Assessment. • Based on results of annual Medical Case Management Triage Tool clients may also receive a Nursing Assessment.
Level 2: 6 – 10 points	• Initial face-to-face nurse assessment. • Based on results of annual Medical Case Management Triage Tool clients may also receive a Nursing Assessment.
Level 3: 11- 15 points	• Initial face-to-face Nursing Assessment. • Minimum annual face-to-face Nursing Assessment. • Nurse Plan developed and monitored with minimum contact by MCM **every 30 days**. • A case conference with internal staff and/or external providers is recommended every 30 days.
Level 4: 16 – 20 points	• Initial face-to-face Nursing Assessment. • Minimum annual face-to-face Nursing Assessment • Nurse Plan developed and monitored with minimum contact by MCM **every 2 weeks.** • A case conference with internal staff and/or external providers is recommended every 2 weeks.

Nursing Plan

Purpose
The nurse plan includes both goals and specific tasks or activities. While a goal is the future state that a client would like to achieve and must be linked to identify need, tasks or activities are the actions necessary to complete the goal. Follow-up and monitoring are inseparable. It is through systematic follow-up that the MCM, care coordination team and client discover whether their planning effort is working and when they need to make revisions. The goals and activities developed during in the nurse plan should be regularly reviewed to determine whether any changes in the client's situation warrant a change in the plan and also to determine whether the goals and activities are being completed in a timely manner. Monitoring is an ongoing process that involves collection and analysis of data and information that results in: •Evaluation of the effectiveness and relevance of the planning process; •Evaluation of the level of client satisfaction; •Measurement of client progress toward stated goals and activities; and •Determination of the need for revisions. The overall goals of follow-up and monitoring are to ensure the goals and activities identified during the planning process are adequate to meet client service needs; ensure the care and treatment the client receives from different providers are being coordinated to avoid needless duplication and/or gaps in services, ensure any changes that have emerged in the client's condition or circumstances are being adequately addressed in order to avoid crisis situations; and maintain client contact on a regular basis to build trust, communication and rapport.

Process	
Nurse plan requirements	Anyone receiving ongoing MCM will have a current Nurse Plan which will be developed and updated according to the client's acuity. Nurse Planning must include: • Identification of the client needs through the Nurse Assessment Process • Prioritization of client needs

	• Develop Goals in the Nurse Plan • Assign Tasks/activities • Assign Roles (who does what)
Nurse Plan Documentation	Documentation of the nurse plan should be consistent with agency policy and procedure. At a minimum, the Nurse Plan should include the client's name, goals, the specific activities for completing the goal, the person responsible for completing the activity, proposed deadline, required referrals, status of both the activities and overall goal, and date of most recent update. Although recommended, the Nurse plan does not need to live in CAREWare.
Care Plan Monitoring Follow-up	Either the MCM or the client can initiate follow-up, but at a minimum should happen in accordance with the standards. Clients should also be encouraged to contact their MCM when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems. Follow-up and monitoring activities can occur through direct contact with the client, the client and their caregiver, parents or guardian (i.e. face-to-face meetings, telephone communication.)
Track medical visits and labs	The MCM is responsible for monitoring medical visits and labs completed by all clients in their region, whether or not they are currently on the MCM case load. Outreach and follow-up should be made with any client if there has been a significant decline in CD4 and/or a significant increase in viral load since the last lab. If it has been more than 12 months since last reported viral load and/or the client was virally unsuppressed at last lab (>200 copies/mL), the client is automatic RN Acuity 3.
CAREWare Data Entry	
Services	Time spent on development or update of the nurse plan should be recorded as "RN Care Plan (RN.)" Time associated with follow up and monitoring that does not directly impact the Care Plan must be entered as "Medical Case Management (RN.)"

	When you leave a voicemail for a client, use "RN Attempt Clt. Contact."
Case Notes	Nurse Planning activity should be documented in the case notes. A nurse plan template is available in the case notes.

MCM Case Conferencing Standards

Purpose
Ongoing communication and case conferencing happens as part of coordinating client care by the CC and the MCM. Case conferencing differs from care coordination in that it is a formal, planned, structured activity; separate from routine contact, that brings together individuals providing specific services to a client for the purpose of assuring unduplicated, integrated and well-coordinated services. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication of services. Case conferences can be used to identify or clarify issues regarding a client's status, needs and goals; review activities including progress and barriers towards meeting the goals; map roles and responsibilities of the participants; resolve conflicts or strategize solutions; and create an integrated Care Coordination Plan. Regular case conferences are strongly encouraged for clients who are virally unsuppressed, newly diagnosed, or have high overall acuity or in life areas of housing, mental health and substance use.
Forms
• Case Conferencing Form (8470)
Process

Case conference	Case conferences can be internal to your organization (CCs, ICs, pharmacist, Patient Navigator), external to your organization (OHOP, CAREAssist, Insurance Assister, MDs, parole officers, mental health providers, caregivers, etc.) or a combination of both. The frequency of case conferencing is dependent upon the client's acuity. A case conference (either internal or external) is recommended at least once every 30 days for acuity 3s and once every 2 weeks for acuity 4s. It is the MCM's responsibility to facilitate and document the Case Conference, and update the Nurse Plan as necessary. If appropriate, CC's will update the CC Plan after the case conference.

	MCM's and CC's are responsible for ensuring clients enroll in insurance directly through the whole process or with assistance from CAREAssist or the Insurance Assister. When appropriate, the client should be involved in the case conference.
CAREWare Data Entry	
Services	Time associated with the case conferencing must be entered as "RN Case Conference (RN)"
Case Notes	Documentation of the case conference must be entered in the case notes. The case conference template may be used.

MCM Referral & Advocacy Standards

Purpose	
Each client will receive assistance to facilitate access to those services critical to achieving optimal health and well-being; and will receive advocacy assistance to help problem solve as necessary when barriers impede access. The purpose of this service is to assess the client for medical needs and direct them to one or more organizations/programs capable of meeting those needs. This process includes providing enough information about each organization to help the client make an informed choice. Advocacy is the act of assisting someone in obtaining needed goods, services or benefits. This may be necessary when a client has been denied services or benefits, when they are unable to communicate their needs or challenges, or when they have a complaint about services. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration. Advocacy involves coordination and follow-up on medical treatments.	
Forms	
• Authorization For Use And Disclosure Of Information (Agency provided)	
Process	
Identify resources	The MCM will maintain a working knowledge of community resources, and when necessary will conduct outreach to identify needed services.
Assess readiness	Referrals are only provided when the client is ready to receive and accept the referral. When a need has been identified but the client is not ready or refuses the referral, the MCM must document this and reference the appropriate stage of change/readiness for behavior change/referral in the case notes.
Provide referral information	Clients will be provided referral information that is relevant to their needs, is up-to-date, and in a format/language that they understand.

Identify follow-up plan	The MCM and the client will identify how and when follow-up will occur. The initial follow-up must occur within 2 weeks after the initial referral.
Assess and provide advocacy	Initially and throughout the process, the MCM will assess the client's progress. Their need for advocacy will be monitored through follow-up with the client and referral agency. Advocacy may include communication with the referral agency staff, by phone, email or letter. All communication with the referral agency must be authorized by the client using the Authorization For Use And Disclosure Of Information
CAREWare Data Entry	
Services	Time associated with referrals and/or advocacy must be entered as "Medical Case Management (MCM.)" When you leave a voicemail for a client, use "RN Attempt Clt. Contact"."
Case Notes	Documentation of client contact or contacts made on the client's behalf must be documented in the case notes
Referrals	Referrals required to be documented include: outpatient/ambulatory care, CAREAssist, oral health care, mental health services, medical nutritional therapy, substance abuse services outpatient, housing (including complete OHOP referrals), employment, tobacco cessation, and food banks. Ongoing referrals or referrals where no follow-up or tracking is required do not have to be entered. See CAREWare User Guide or Referral Quick Guide for more information. All referrals entered require a final status within 6 months from initial date of referral. • Pending – Status of all new referrals. If referral is pending, follow up with the client every two weeks with regards to the status of the referral. • Completed – When you have evidence that client has made initial contact with the agency to which you referred the client. • Lost to Follow up – After a reasonable amount of time, or a maximum of 3 months, during which time you have been usable to verify the outcome of the referral.

	• Rejected – If at any point in the referral process, the client informs you that they no longer need or desire the referral you provided.

Tuberculosis (TB) Policy for Licensed Health Care Workers

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

1. TB testing requirement for staff and volunteers

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

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

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

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

2. Clients with symptoms of tuberculosis

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

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

1. If available, put on a surgical mask while discussing situation with patient. Do not visit patient again at home until they are medically cleared of tuberculosis.
2. Contact the patient's medical provider and make them aware of your concern for TB. Ideally the medical provider will at

minimum assess the resident's status by obtaining a chest x-ray.
3. If additional assistance is needed, contact the local health department where the client lives.

3. Exposure to tuberculosis

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

4. Client TB testing

a. Newly diagnosed HIV clients should be tested for TB at diagnosis. If this test is negative, the client should be tested again when their CD4 is above 200. (Below 200, the immune system is compromised and makes the TB test unreliable.)
b. For all clients (regardless of CD4), annual testing should occur if there is an ongoing risk of exposure to TB disease such as homelessness or ongoing travel to a TB endemic country.
c. If a client is not experiencing ongoing risk to TB exposure, there is no need to test annually.

Helping Clients Get to Work

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

- Assess their clients' readiness for employment (as part of the annual Psychosocial Screening);
- Complete a Risk-Benefits Analysis (use the Benefits Calculator Tool provided by HIV Community Services) to help the client determine the impact of employment;
- Help clients to evaluate the impact of HIV-related and other medical symptoms, as well as medication side effects, on their physical capacity to work.
- Help clients assess their prospects for sustained good health, including review of current and historical medical indicators such as CD4 count, viral load measures, and other serologic markers;
- Help the client to identify barriers and incorporate activities to overcome these barriers into their care plan;
- Refer the client who is assessed as ready for employment assistance programs. See the Employment Resource Guide for HIV Community Services
- Refer the client to the Positive Self-Management Program or other skills building programs;
- Read and be familiar with provided training materials.

Appendix A: HIV CASE MANAGEMENT SERVICE MATRIX

	RN 1			RN 2			RN 3			RN 4		
	Services	**Frequency**	**Staff**	**Services**	**Frequency**	**Staff**	**Services**	**Frequency**	**Staff**	**Services**	**Frequency**	**Staff**
CC 1	Update	Annual	IC	Update	Annual	IC	Update	Annual	IC	Update	Annual	IC
	CC Triage	Annual	IC	CC Triage	Annual	IC	CC Triage	Annual	IC	CC Triage	Annual	IC
	RN Triage	Annual	IC	RN Triage	Annual	IC	RN Assessment	Annual	RN	RN Assessment	Annual	RN
	Update and triage forms are mailed						Contact/Plan/ Conference	30 days	RN	Contact/Plan/ Conference	2 weeks	RN
CC 2	Update	Annual	IC	Update	Annual	IC	Update	Annual	IC	Update	Annual	IC
	CC Triage	Annual	IC	CC Triage	Annual	IC	CC Triage	Annual	IC	CC Triage	Annual	IC
	RN Triage	Annual	IC	RN Triage	Annual	IC	RN Assessment	Annual	RN	RN Assessment	Annual	RN
	Contact			Contact			Contact/Plan/ Conference	30 days	RN	Contact/Plan /Conference	2 weeks	RN
CC 3	Update	Annual	CC	Update	Annual	CC	Update	Annual	CC	Update	Annual	CC
	RN Triage	Annual	IC	RN Triage	Annual	IC	RN Assessment	Annual	RN	RN Assessment	Annual	RN
	CC Screening	Annual	CC	CC Screening	Annual	CC	CC Screening	Annual	CC	CC Screening	Annual	RN
	Contact	30 days	CC	Contact	30 days	CC	Contact/Plan/ Conference	30 days	CC/R N	Contact/Plan /Conference	2 weeks/ 30 days	RN/C C
CC 4	Update	Annual	CC	Update	Annual	CC	Update	Annual	CC	Update	Annual	CC
	RN Triage	Annual	IC	RN Triage	Annual	IC	RN Assessment	Annual	RN	RN Assessment	Annual	RN
	CC Screening	Annual	CC	CC Screening	Annual	CC	CC Screening	Annual	CC	CC Screening	Annual	CC
	Contact	2 weeks	CC	Contact	2 weeks	CC	Contact/Plan/ Conference	2 weeks/ 30 days	CC/R N	Contact/Plan /Conference	2 weeks	RN/ CC

Appendix B: COVID-19

- Visit the OHA website for the most current COVID-19 guidance. For **COVID EFA**, see the Ryan White Part B COVID-19 Temporary Guidance. Current COVID EFA funds are only available through 3/14/21. The funding period is March 15, 2020-March 14, 2021.