

# **HIV COMMUNITY SERVICES PROGRAM**

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## **FY 2016-2017 REPORTING PACKAGE COUNTY AND REGIONAL SERVICES**





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## HIV COMMUNITY SERVICES PROGRAM FY 2016-2017 REQUIRED REPORTS

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

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

Contract agencies are expected to run RW CAREWare (CW) generated reports for their own internal data quality monitoring and clean-up, but are not required to submit these reports to the HIV Community Services Program. CW users are required to follow data entry requirements as outlined in 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.



**County and Regional Services Reporting Calendar FY 2016-2017**

REQUIRED REPORTS	DESCRIPTION	REPORTING TIMEFRAME	DUE DATE
1. Quarterly Progress Report Form	Quarterly Progress Report Form Sections:  Section I: Data <ul style="list-style-type: none"> <li>• Include a “Non-Client Specific Units of Service” summary form.</li> <li>• Include a “Home Test Kit” excel worksheet, if appropriate.</li> </ul> Section II: Performance Measures Narrative—a written evaluation of the agency’s performance.	1. 7/1/16 - 9/30/16 2. 10/1/16 - 12/31/16 3. 1/1/17 - 03/31/17 4. 4/1/17 - 06/30/17	1. October 31, 2016 2. January 31, 2017 3. April 30, 2017 4. July 31, 2017
	Section III: Program Narrative—a written summary of the agency’s performance at six and twelve months.	1. 7/1/16 – 12/31/16 2. 1/1/17 – 6/30/17	1. January 31, 2017 2. July 31, 2017
2. Administrative Fiscal Form	Administrative Fiscal Form includes:  Administrative and service expenditures.	1. 7/1/16 - 9/30/16 2. 10/1/16 - 12/31/16 3. 1/1/17 - 03/31/17 4. 4/1/17 - 06/30/17	1. October 31, 2016 2. January 31, 2017 3. April 30, 2017 4. July 31, 2017
County Based Programs <b>only</b> :  3. LPHA Chart Review Summary	LPHA Chart Review Summary includes: LPHA review of documentation in the client chart and data entry in CAREWare.	1. Chart and data entry review of services and documentation for the preceding 12 months.	1. October 31, 2016

*Submit reports by e-mail only to:*

**DeAnna P. Kreidler, M.S.**  
**HIV Care and Treatment Program**  
**Quality and Compliance Coordinator**  
[deanna.p.kreidler@state.or.us](mailto:deanna.p.kreidler@state.or.us)



## Quarterly Progress Report FY 2016-2017 **Reporting Forms Instructions**

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The Quarterly Progress Report consists of two forms:

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

Section I: Data

Section II: Performance Measures Narrative

Section III: Program Narrative (Quarter 2 and Quarter 4 only)

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

### **QUARTERLY PROGRESS REPORT FORM INSTRUCTIONS**

#### **SECTION 1: DATA**

##### QUESTION 1:

Email a “Non-Client Specific Units of Service” summary form detailing the specific activities for the units of service reported in 1a. and 1b. The form must include the month, date, number of units, activities and staff person separately for case management and supervision. An excel template is available upon request.

##### Question 2:

Only complete question 2.a and 2.b if your Agency ordered HIV Home Test Kits from HIV Community Services for the agency to distribute. Email a completed “Home Test Kit Inventory” excel worksheet if you answer “yes” to 2.a or 2.b.

#### **SECTION II: PERFORMANCE MEASURES NARRATIVE**

HIV Community Services will provide quarterly performance measure data (shaded grey) to your Agency by the 5<sup>th</sup> of the next month after the end of the quarter. Once you receive the data for each goal, please complete a narrative describing your current and future efforts at meeting the goal.



The HCS team reviews the data and the Agency's narrative, and the Quality and Compliance Coordinator identifies items requiring follow-up.

### **SECTION III: PROGRAM NARRATIVE (QUARTER 2 AND QUARTER 4 ONLY)**

This narrative section is only completed at the end of Quarter 2 and Quarter 4. Each of the five questions pertains to six months of the contract. The HCS team reviews the Agency's narrative, and the Quality and Compliance Coordinator identifies items requiring follow-up.



## Quarterly Progress Report Form FY 2016-2017

Agency:

Submitted by:

Date submitted:

- Quarter:**
- 1 July 1-Sept 30, 2016 (Due: Oct 31, 2016)
  - 2 Oct 1-Dec 31, 2016 (Due: Jan 31, 2017)
  - 3 Jan 1-Mar 31, 2017 (Due: Apr 30, 2017)
  - 4 Apr 1-June 30, 2017 (Due: July 31, 2017)

### Section I: Data (Quarterly)

**1. Non-client specific units of service not recorded in CAREWare (1 unit = 15 minutes)**

Email a “Non-Client Specific Units of Service” summary form detailing the specific activities for the units of service reported in 1a. and 1b. The form must include the month, date, number of units, activities and staff person separately for case management and supervision. An excel template is available upon request.

a.	Number of case management units conducting HIV case management related work not linked to a specific client(s) (such as trainings or administrative time):	
b.	Number of HIV case management program related supervision units:	

**2. HIV Home Test Kit Inventory (Quarterly)**

a.	Did your Agency have any Home Test Kits left over from last Quarter?	
b.	Did your Agency order any Test Kits this Quarter?	

If 2 a. or 2 b. are “yes”, please email your completed “Home Test Kit Inventory” excel worksheet.



## Section II: Performance measures narrative (Quarterly)

HIV Community Services will provide quarterly performance measure data (shaded grey) to your Agency by the 5<sup>th</sup> of the next month after the end of the quarter. Once you receive the data for each goal, please complete a narrative describing your current and future efforts at meeting the goal.

<b>Goal 1:</b>	90% of clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test.		
Your Agency Achieved:		Statewide Part B Agencies Achieved:	
	Numerator:		
	Denominator:		
<b>Agency Narrative:</b>			

<b>Goal 2:</b>	90% of clients have a medical visit in the last 6 months (no gap in medical visits).		
Your Agency Achieved:		Statewide Part B Agencies Achieved:	
	Numerator:		
	Denominator:		
<b>Agency Narrative:</b>			



<b>Goal 3:</b>	90% of Medical Case Management (MCM) clients have a MCM nurse Care Plan developed and/or updated 2 or more times a year.		
Your Agency Achieved:		Statewide Part B Agencies Achieved:	
	Numerator:		
	Denominator:		
<b>Agency Narrative:</b>			

<b>Goal 4:</b>	95% of clients have stable housing.		
Your Agency Achieved:		Statewide Part B Agencies Achieved:	
	Numerator:		
	Denominator:		
<b>Agency Narrative:</b>			

<b>Goal 5:</b>	90% of clients attend a medical visit within 3 months of diagnosis.		
Your Agency Achieved:		Statewide Part B Agencies Achieved:	
	Numerator:		
	Denominator:		
<b>Agency Narrative:</b>			



### **Section III: Program narrative (Quarter 2 and Quarter 4 only)**

1. Programmatic successes and issues with service delivery within the last 6 months:
  - a. Strengths/improvements in delivering services:
  
  - b. Problems/challenges in delivering services:
  
2. Client/Outcome specific successes and issues with service delivery within the last 6 months:
  - a. Strengths/improvements specific to clients and/or outcomes:
  
  - b. Problems/challenges specific to clients and/or outcomes during this quarter:
  
3. Outreach efforts within the last 6 months:
  - a. Ongoing outreach and/or client referral efforts to community resources:
  
  - b. Outreach activities related to informing eligible individuals and Agencies/providers working with HIV clients about the services available at your agency:
  
4. Quality Assurance (QA) and Quality Improvement (QI):
  - a. Describe QA and/or QI activities/projects within the last 6 months:
  
  - b. Describe QA and/or QI activities/projects that are being considered/planned:
  
5. Describe efforts made by your agency or case manager(s) within the last 6 months to provide trauma informed services:



## ADMINISTRATIVE FISCAL FORM INSTRUCTIONS

### I. Contact Information:

1. Enter the agency name
2. Enter the phone number of your agency
3. Enter the date this report was prepared
4. Enter the street Address, City, State and Zip Code of your agency
5. Enter the contact name, title and e-mail address of the person who can answer questions regarding this report.
6. Enter the report period and the quarter reporting.

### II. Case Management:

**\*Important: Only report those expenditures paid for with Ryan White Program, Part B funds.**

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

1. Direct Service Costs – Case Management Salary & Fringe: Enter the case management staff costs. This includes wages/salaries, fringe.
2. 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.
3. Direct Program Costs – Materials, Equipment and Supplies: This may include materials, equipment and supplies directly related to the provision of case management.
4. 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.
5. 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:
  - Rent, utilities and facility costs
  - 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.



6. Total of 1-5 (Case Management): Total columns 1-5 (Case Management).

Under the column titled “**Year to Date (beginning July 1, 2016)**” enter the expenses from the beginning of the fiscal year to current quarter you are reporting.

### **III. Support Services (all services excluding Case Management)**

**\*Important: Only report those expenditures paid for with Ryan White Program, Part B funds.**

1. 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.
2. 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.
3. 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.
4. Total of 1-3 (Support Services): Total columns 1-3 (Support Services)

Under the column titled “**Year to Date (beginning July 1, 2016)**” enter the expenses from the beginning of the fiscal year to current quarter you are reporting.

**IMPORTANT:** It is expected that total expenditures reported will match the data entered into RW CAREWare plus the units reported in Section 1, question 1 of the Quarterly Progress Report (includes both case management and support services). This also includes fiscal year end reporting of bulk purchases not utilized in this fiscal year. Although stored value cards and other items allowed per the Support Services Guidance may be purchased in bulk and dispersed to clients as needed, 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 explain the discrepancies between total expenditures reported and the data entered into RW CAREWare. Please explain any of these discrepancies in the area provided on the bottom of the Administrative Fiscal Form.



ADMINISTRATIVE FISCAL FORM FY 2016-2017

<b>I. Contact Information</b>		Page 1 of 1
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:  <input type="checkbox"/> <b>Quarter 1 (Jul-Sept)</b> <input type="checkbox"/> <b>Quarter 2 (Oct-Dec)</b> <input type="checkbox"/> <b>Quarter 3 (Jan-Mar)</b> <input type="checkbox"/> <b>Quarter 4 (Apr-Jun)</b>
<b>II. Case Management</b>		
	Current <u>Quarter</u> Expenses	Year To Date (beginning July 1, 2016)
1. Direct Service Costs <b>Case Management Salary &amp; Fringe</b>		
2. Direct Service Costs <b>Non-Case Management Salary &amp; Fringe</b>		
3. Direct Program Costs <b>Materials, Equipment and Supplies</b>		
4. Sub-Contracted Services		
5. Administrative Costs		
6. <b>Total of 1-5 (Case Management)</b>		
<b>III. Support Services</b>		
	Current <u>Quarter</u> Expenses	Year To Date (beginning July 1, 2016)
1. Direct Client Service Costs <b>Actual Support Services Expenditures</b>		
2. Sub-Contracted Services		
3. Administrative Costs		
4. <b>Total of 1-3 (Support Services)</b>		

**IMPORTANT:** It is expected that total expenditures reported will match the data entered into RW CAREWare plus the units reported in Section 1, question 1 of the Quarterly Progress Report (includes both case management and support services). This also includes reporting fiscal year end reporting of bulk purchases not utilized in this fiscal year. **Please explain any discrepancies:**



## LOCAL PUBLIC HEALTH AUTHORITY CHART REVIEW SUMMARY FY 2016-2017

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



## LOCAL PUBLIC HEALTH AUTHORITY CHART REVIEW SUMMARY

All Chart Review Summary forms are due by October 31, 2016 via e-mail submission to:

DeAnna Kreidler, MS  
Quality and Compliance Coordinator  
deanna.p.kreidler@state.or.us

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

### INSTRUCTIONS FOR COMPLETING CHART REVIEW

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



**LOCAL PUBLIC HEALTH AUTHORITY CHART REVIEW SUMMARY**

**AGENCY:**

**DATE OF REVIEW:**

**REVIEWER:**

(Name and Title)

**Client URN #**

(Do not use client name)

Note: Please see the abbreviation key on the last page

	Yes	No	N/A	Comments
<b>INITIAL INTAKE/ELIGIBILITY REVIEW</b>				
<b>New Clients only</b> (client has been in your program 11 months or less)				
Intake/Eligibility Review form completely filled out. (Intake/Eligibility Review Form # 8395)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV status verified within 30 days of initial Intake, and documentation is in the chart (see Intake/Eligibility Review Form # 8395)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Verification of Identity and supporting documentation match the Intake/Eligibility Review Form # 8395	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Verification of Residency and supporting documentation match the forms: <ul style="list-style-type: none"> <li>• Intake/Eligibility Review Form # 8395 <b>or</b></li> <li>• Residency Verification Form #8485</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Verification Income and supporting documentation match the Intake/Eligibility Review Form # 8395	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS Status and risk factor is completed in CW on demographic page.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Full legal name in CW matches identity documentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Demographic information (address/phone/email, mail preference, race(s)) is accurate in CW.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
“Intake/Eligibility Review” service date in CW matches form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The <b>Initial Intake/Eligibility Review</b> data in CW Annual Review tab (Annual sub-tab) matches the form (#8395) and the supporting documentation for: <ul style="list-style-type: none"> <li>○ Insurance (Primary &amp; Other)</li> <li>○ Household Income</li> <li>○ HIV Primary Care</li> <li>○ Housing Arrangement</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The “Intake/Eligibility Review” service in CW was used for the initial intake, there was a charted CW case note, and the service date matches the case note and form date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



	Yes	No	N/A	Comments
LPHA Client Rights & Responsibilities form is signed and dated by client and case manager. (Ensure Agency form complies with <a href="#">OAR</a> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LPHA Informed Consent form signed at the Initial Intake.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ANNUAL UPDATE/ELIGIBILITY REVIEW</b>				
<b>Established Clients only</b> (Client has been in your program 12 months or longer)				
<b>Annual Intake/Eligibility Review</b> form completely filled out for demographic data, residency, and insurance information, and supporting documentation is filed in the chart: <ul style="list-style-type: none"> <li>• Intake/Eligibility Review Form completed # 8395 and matches the supporting documentation</li> <li>• Residency Verification Form #8485, when needed.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Annual Intake/Eligibility Review</b> proof of Income: <ul style="list-style-type: none"> <li>○ If CA, CEV form is in chart as proof of income</li> <li>○ If not CA, income listed on Intake/Eligibility Review form #8395 matches supporting documentation</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Annual Update/Eligibility Review</b> data in CW Annual Review tab (Annual sub-tab) was updated at the annual update/eligibility review, and matches the form (#8395) and supporting documentation in the areas of: <ul style="list-style-type: none"> <li>○ Insurance (Primary &amp; Other)</li> <li>○ Household Income</li> <li>○ HIV Primary Care</li> <li>○ Housing Arrangement</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The <b>Annual Update/Eligibility Review</b> “Intake/Eligibility Review” service in CW was used for the annual update/eligibility review, there was a charted CW case note, and the service date matches the case note and form date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Semi-annual Eligibility Review:</b> <ul style="list-style-type: none"> <li>• Self-Attestation Form #8395a completed.               <ul style="list-style-type: none"> <li>○ If CA, CEV form attached.</li> <li>○ If not CA, supporting documentation is in the chart.</li> </ul> </li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



	Yes	No	N/A	Comments
<b>Semi-annual Eligibility Review</b> data in CW Annual Review tab (Annual sub-tab) was updated if there were changes on the form or on the CEV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The “Intake/Eligibility Review” service in CW was used for the semi-annual eligibility review, there was a charted CW case note, and the service date matches the case note and form date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Current LPHA ROI form signed and dated. (Current per agency written policy on frequency of updating the ROI.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>TRIAGE</b>				
<b>Acuity 1 clients only</b> (if a Triage was not completed, check N/A)				
The Triage was completed at the same time as the annual update/eligibility review.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If a Triage was completed, the client met all of the following criteria for a Triage based on documentation in CW: <ul style="list-style-type: none"> <li>VL lab test was within last 12 months</li> <li>VL lab test was unsuppressed (&gt;200 copies/ml)</li> <li>CW case note documentation indicates the client is stable and does not indicate a need for a Psychosocial Screening and/or an Assessment</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If the client answered “Yes” to one or more Triage question, follow-up with the client by telephone was completed w/in the timeline stated in the standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If there was a Triage, the CW Triage case note template was used and documented justification for use of Triage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>PSYCHOSOCIAL AND ASSESSMENT</b>				
Psychosocial Screening was completed within 12 months of last screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial Screening form completely filled out. (Psychosocial Screening Form #8401)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of the Psychosocial Screening process, findings, recommendations, and referrals were entered in the CW case note “Screening” template.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nurse Assessment was completed within 12 months of last assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nurse Assessment form completely filled out. (Nurse Assessment Form #8402)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



	Yes	No	N/A	Comments
Documentation of the Assessment process, findings, recommendations, and referrals were entered in the CW case note "Assessment" template.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The "Acuity Form-County" is completed in CW (under "Forms" tab) and the date matches the last Psychosocial Screening and Nurse Assessment forms. (Psychosocial Acuity-County Form #8496; Medical Acuity-County Form #8497)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acuity Level:
<b>CARE PLANNING &amp; REFERRAL</b>				
Care Plan is completed and documented as specified in LPHA policy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Care Plan is developed, monitored and updated according to Acuity contact timelines: <ul style="list-style-type: none"> <li>• Acuity 1/2: every 6 months</li> <li>• Acuity 3: every 30 days</li> <li>• Acuity 4: every 14 days</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The Care Plan referral and advocacy, follow-up, and final status was documented in CAREWare chart note.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any of the following referrals made are in the Referral Tab: <ul style="list-style-type: none"> <li>• 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.</li> <li>• Final status w/in 6 mo.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HEALTH OUTCOMES</b>				
Viral Load Suppression: <ul style="list-style-type: none"> <li>• VL lab completed within the past 12 months?</li> <li>• If VL lab over 12 months, is the client a minimum Acuity 3?</li> <li>• If client is not virally suppressed (see CW Performances Measure tab), is the client a minimum Acuity 3?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**ADDITIONAL COMMENTS:**

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

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

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