

HIV COMMUNITY SERVICES PROGRAM

**HIV Medical Care Coordination:
Standards of Services**

**Regional
Based Model**

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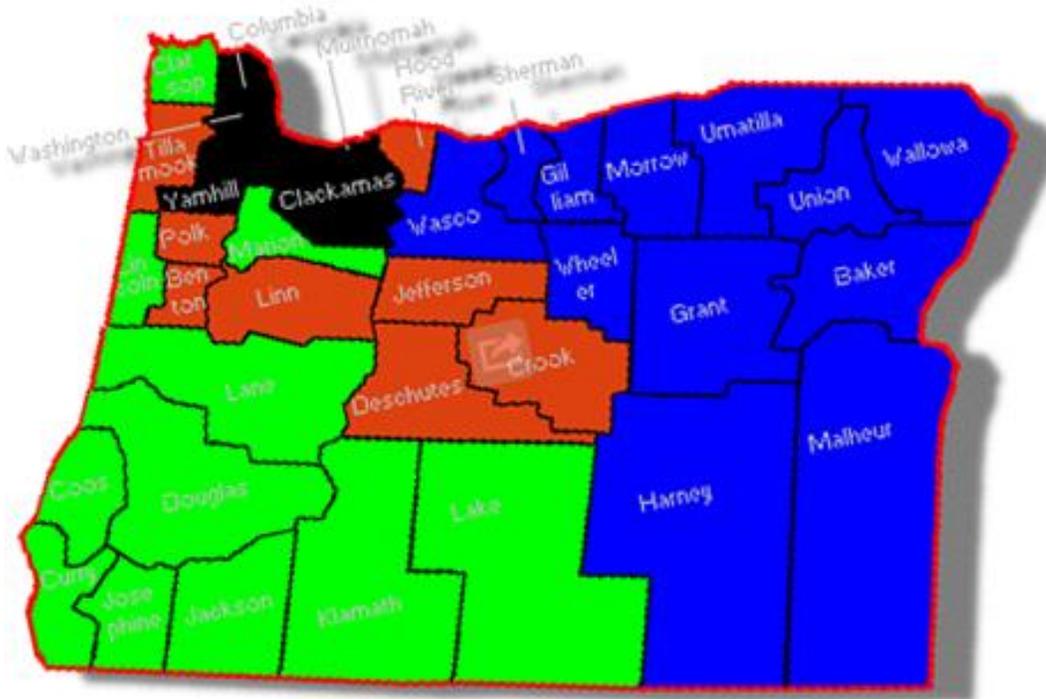
The Oregon Health Authority, HIV/STD/TB Program, HIV Community Services gratefully acknowledges the work of the Oregon HIV Case Management Task Force in providing the recommendations for edits changes and improvements in this document.

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

INTRODUCTION

Oregon Medical Care Coordination (MCC) 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 green, EOCIL serves counties in blue, and county health departments serve counties in red. Counties in black are served by providers funded by the Ryan White Part A grantee, Multnomah county.



The HIV Medical Care Coordination (MCC) 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 MCC 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 medical care coordination services to clients will be qualified and properly trained in the individual agency policies and procedures, the Oregon HIV Medical Care Coordination Standards of Service, all required forms, CAREWare, confidentiality policies and procedures and basic case management/care coordination skills. Each agency is responsible for ensuring that new Ryan White Part B funded staff providing services under the HIV Medical Care Coordination 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 MCC 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.

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 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.
- 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

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, liver health, HIV transmission/risk reduction), 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 treatment adherence, nutrition, liver health, HIV transmission risk reduction 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.

Medical Care Coordination Activities

Activity	IC	CC	MCM
Intake	X		
Six month eligibility review	X		
Annual Update	X	X*	
Low Acuity 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 with MD			X
Referral & Advocacy (related to care plans)		X	X
Follow-up & Monitoring (related to care plans)		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 Medical Care Coordination

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
- 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

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- Active, sustained follow-up

Self-Management Guidelines

Step	Actions
<p>STEP #1: Define the problem <i>(the assessment and screening process)</i></p>	<ul style="list-style-type: none"> ✓ Impact of the illness ✓ Symptoms of the illness ✓ Medication side-effects ✓ Lifestyle factors ✓ Strengths and barriers ✓ With the client, determine factors that will affect his or her capacity for self-management
<p>STEP #2: Planning <i>(care planning)</i></p>	<ul style="list-style-type: none"> ✓ Determine stage of change ✓ Determine specific goals ✓ Prioritize goals ✓ Identify outcomes ✓ Determine realistic timeframes ✓ Select interventions ✓ Document the care plan
<p>STEP #3: Management <i>(referral and follow-up)</i></p>	<ul style="list-style-type: none"> ✓ Achievement of goals ✓ Availability of resources ✓ Quality of resources ✓ Personal capacity

“People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others”

Stages of Change

Stage	Goals	Strategies	Example Language
<p>Pre-contemplation: Not thinking of change</p>	<p>Keep the door open for future discussions</p> <ol style="list-style-type: none"> 1) Build rapport by joining with client 2) Bring awareness to the surface 3) Keep client engaged in process 	<ol style="list-style-type: none"> 1) Listen to concerns (reflective listening) 2) Elicit information (past and current strengths) 3) Communicate caring (empathy and non-judgment) 	<p>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.</p>
<p>Contemplation: Thinking about change</p>	<p>Keep the client thinking about change</p> <ol style="list-style-type: none"> 1) Increase perceived benefits of change 2) Boost awareness of options for change 3) Keep client talking 	<ol style="list-style-type: none"> 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 	<p>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?</p>
<p>Preparation: Preparing for change</p>	<p>Help client prepare for change</p>	<ol style="list-style-type: none"> 1) Clarify goals 2) Negotiate change plan 3) Encouragement, and with permission, advice offering 	<p>What are you willing to do now? What is a good first step? What have you seen work for others?</p>
<p>Action: Changing behavior</p>	<p>Decrease barriers to change</p> <ol style="list-style-type: none"> 1) Increase confidence 2) Helping to problem solve 	<ol style="list-style-type: none"> 1) Coach on process of change 2) Reduce barriers 3) Restrain excessive change 	<p>How are things going? What's working/not working? Is there anything I can help you with?</p>
<p>Maintenance: Maintaining change and preventing relapse</p>	<p>Sustain gains made</p> <ol style="list-style-type: none"> 1) Help client stay focused 2) Reduce chance of relapse 3) When relapse occurs, normalize 	<ol style="list-style-type: none"> 1) Predict ups and downs 2) Enlist support 3) Plan for relapse prevention 4) When relapse occurs, reassess 	<p>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....?</p>

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. 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 Medical Care Coordination (MCC) 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 in the agency's jurisdiction 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 within 30 days of Intake 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 MCC region are required to receive services by the MCC. Clients are not allowed to be co-managed across multiple case management jurisdictions without prior approval from the Oregon Health Authority.
7. HIV CCs may provide transitional case management services to facilitate an HIV positive inmate's transition from a correctional facility to the community under the following circumstances:
 - i. The incarcerated person will be released within 180 days; and
 - ii. There are no other transitional case management or discharge planning services provided by the correctional facility, though it is expected that the CC will coordinate the transition with the correctional staff.

Transitional case management includes an Intake, a Psychosocial Screening, and the development of a transition plan which may include referrals to CAREAssist and OHOP, if needed. 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. Additionally, if it is determined that the incarcerated individual will be released to another case management jurisdiction, the HIV CCs will facilitate the transition and referral. HIV CCs are expected to communicate with

local correctional facilities, and maintain a referral relationship in order to facilitate the transition of PWLH/A from jail/prison to the community.

INTAKE COORDINATION SERVICES

Initial Intake & Eligibility Determination

Purpose	
<p>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.</p>	
Forms	
<ul style="list-style-type: none"> • Intake/Eligibility Review Form (8395) • Residency Verification (8485) (If needed) • HIV Care and Treatment Program Information Sheet (8405) • Client Rights & Responsibilities (8392) • Grievance Policy (agency provided) • Informed Consent (agency provided) • Authorization For Use And Disclosure Of Information (agency provided) 	
Process	
<p>Schedule the Update and/or mail client required forms.</p>	<p>✓ 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 and/or complete, with the client, all required forms.</p>
<p>Screen for basic eligibility</p>	<p>✓ The IC will screen every potential client for the eligibility criteria. For more information on eligibility determination, see Support Services: Policies, Definitions and Guidance.</p> <p>✓ Clients who are transferring to an agency within the Part B network or are returning to the same agency within 6</p>

	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	<p>✓ The Intake is documented on the Intake/Eligibility Review Form</p> <p>✓ The IC will obtain Authorization for Release of Information for every client at a minimum:</p> <ul style="list-style-type: none"> • 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 <p>✓ Between Agency and emergency contacts provided by the client</p>
Conduct crisis assessment & referral	✓ The IC will assess the need, and make referral for crisis intervention, if necessary. The Intake process will be expedited for clients who are newly diagnosed, homeless or otherwise in crisis.
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 the Intake process was begun.
Demographics & Annual Review	The IC will complete the Demographics and Annual Review tabs.
Service & case notes	The IC will enter staff time under 'Intake/Eligibility Review (Annual)' using a 15 minute unit when completing the Intake/Eligibility form/process. The IC will enter a case note for every client contact.
Key Contacts	Any key contacts collected must be entered under the 'Key Contacts' tab.
Referrals	If referral was made, it should be documented in referral tab.

Six Month Eligibility Review/Self-Attestation

Purpose	
All clients must have their eligibility reviewed every 6 months or self-attest that nothing has changed. For more information on eligibility determination, see Support Services: Policies, Definitions and Guidance.	
Forms	
<ul style="list-style-type: none"> Self-attestation (8395a) 	
Process	
For clients on CAREAssist	Enter the client's CAREAssist number on the Self-Attestation form, sign, and attach a printed copy of the CAREAssist Eligibility Verification report.
For clients not on CAREAssist	Client must complete Six Month Self-Attestation and submit necessary documentation.
Documentation	
Demographics & Annual Review	Update the Demographics and Annual Review tab as needed.
Service & Case Notes	The IC will enter staff time under "Eligibility Review (Mid-Year)" using 15 minute unit. The IC will enter case note and any other relevant data.

Annual Update & Triage

Purpose		
<p>The purpose of the Annual Update is to discuss any life changes with the client and 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.</p>		
RN Acuity	CC Acuity	Annual update/triage requirements
1	1	Annual update, RN & CC Low Acuity Triage by mail
2	2	Annual update, RN & CC Low Acuity Triage by telephone.
2	3 or 4	Annual update, RN Low Acuity Triage (In some circumstances, a CC may complete the update at time of rescreening)
3 or 4	2	Annual update, CC Low Acuity Triage
Forms		
<ul style="list-style-type: none"> • Intake/Eligibility Review Form (8395) • Residency Verification (8485) • Care Coordination (8471) and/or Medical Case Management (8472) Triage Tool • Release of Information 		
Process		
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.	
Complete the Intake/Eligibility Review Form	<ul style="list-style-type: none"> ✓ 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 Verification 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.
Complete the triage form	✓ 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.
CAREWare Data Entry	
Demographics & Annual Review	Update the Demographics and Annual Review tab as needed.
Service & Case notes	<p>When conducting an annual triage for clients the IC will enter staff time under “RN Triage” or “CC Triage” using a 15 minute unit. 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.</p> <p>The IC will enter a case note for every client contact, and document the triage results.</p>
Key Contacts	The Update process will include the collection of some of the client’s key contacts and must be entered under the ‘Key Contacts’ tab.

CARE COORDINATION SERVICES

Psychosocial Screening

Purpose	
<p>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.</p>	
Forms	
<ul style="list-style-type: none"> • Psychosocial Screening (8401) • Benefits Planning Tool (8486) (optional) 	
Process	
Complete initial Psychosocial Screening	✓ The Psychosocial Screening is conducted by a CC within 30 days of initial intake
Verify insurance payer within 30 days	✓ An insurance payer must be documented in CAREWare, and a copy of the card (s) will be in the client chart within 30 days of Intake.
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 of receiving the Triage Tool. 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 is conducted annually from the date of enrollment

CAREWare Data Entry	
Demographics & Annual Review	The Screening will reassess information previously collected, which may include changes to the client name, address, phone number, income, HIV status (client may have transitioned to AIDS from and HIV diagnosis) and housing status. This information must be entered and updated under the Demographics and Annual Review tabs.
Services & Case notes	<p>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.</p> <p>Documentation of the screening and assessment process, findings, recommendations, and referrals must be entered in the case notes using the "CC Screening" template.</p>
Key Contacts	If the screening process includes the collection of any client key contacts they must be entered under the 'Key Contacts' tab.
Referrals	Referrals provided during the screening process must be documented under the Referrals tab.

CC Acuity Assignment

Purpose	
<p>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.</p>	
Forms	
<ul style="list-style-type: none"> • Acuity Worksheet (8496r) 	
Process	
Complete Acuity Worksheet	<ul style="list-style-type: none"> ✓ 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 Stage Guidelines below.) ✓ The Acuity worksheet will be completed using the following instructions: <ul style="list-style-type: none"> • 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 Stage Guidelines below).
Change in acuity without a screening	<ul style="list-style-type: none"> ✓ The CC may change the client's acuity either up or down without a Screening <u>unless</u> (a) the client has been a CC3 or CC4 for 12 months; and/or (b) if the client's annual CC Screening is due within 30 days. The acuity cannot be changed without a Screening if there has been no communication with the client.
Exceptions to acuity assignment	<ul style="list-style-type: none"> ✓ 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	

Acuity Form	Acuity data will be entered in the “CC Client Acuity Scale” form.
Service & Case Note	<p>When the acuity is updated in connection with completing a full Screening, the service will be entered using the “Screening” service.</p> <p>When the acuity is not updated in connection with a full Screening the service will be entered using the “CC Acuity Change” service. In addition, the “CC Acuity Change Interview Documentation” case notes template must be completed documenting the reasons for the change.</p>

CC Acuity Stage Guidelines

Level	Guidelines
Level 1: 0 – 8 points	<ul style="list-style-type: none"> ● Initial Psychosocial Screening. ● Annual CC Triage and update via mail. ● Eligibility verified every 6 months. ● Optional Care Plan
Level 2: 9 – 16 points	<ul style="list-style-type: none"> ● Initial Psychosocial Screening. ● Eligibility verified every 6 months. ● Annual CC Triage and update (telephone or face-to-face). ● Nurse consultation as needed. ● Optional Care Plan.
Level 3: 17 – 24 points	<ul style="list-style-type: none"> ● Initial Psychosocial Screening and annually thereafter. ● Eligibility verified every 6 months. ● Annual update ● Care Plan developed and monitored. ● Minimum contact by CC (telephone or face-to-face) every 30 days. ● Minimum evaluation of goals, activities and outcomes by CC every 30 days
Level 4: 25-32 points	<ul style="list-style-type: none"> ● Initial Psychosocial Screening and annually thereafter. ● Eligibility verified every 6 months. ● Annual update ● Care Plan developed and monitored. ● Minimum contact by CC (telephone or face-to-face) every 2 weeks. ● Minimum evaluation of goals, activities and outcomes by CC every 2 weeks

CC Care Plan

Purpose	
<p>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 and must be linked to an identified need, tasks or activities are the actions necessary to complete the goal. Tasks are in the present, specific, active, have deadlines and involve specific people.</p>	
Forms	
<ul style="list-style-type: none"> • CAREWare Form 	
Process	
Develop CC care plan	<ul style="list-style-type: none"> ✓ Acuity 3 or 4 clients will have a current CC care plan that, at a minimum, is updated annually at the time of Screening. ✓ Acuity 1 and 2 clients will not receive additional formal care planning unless the CC determines the need. If the CC chooses to develop a care plan, it should be reviewed periodically. ✓ New clients will have a care plan at intake. CC will follow up with all clients on the care plan within 6 months.
Acuity reassignment	<ul style="list-style-type: none"> ✓ 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	<ul style="list-style-type: none"> ✓ A copy of the Care plan must be mailed or given to the client when updated.
CAREWare Data Entry	
Care Plan Form	<ul style="list-style-type: none"> ✓ Document the care plan goals in the CAREWare form and provide a copy of the care plan for the client.
Service and case notes	<ul style="list-style-type: none"> ✓ Time associated with care planning should be entered as “Care Coordination (CC)”, and a relevant case note should be made.

CC Referral and Advocacy Standards

Purpose	
<p>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).</p>	
Form	
<ul style="list-style-type: none"> • 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 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	✓ Initially and throughout the process, the CC will assess the client's progress. Their need for advocacy will be monitored

advocacy	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 & Case note	Time associated with referrals and/or advocacy must be entered as "Care Coordination (CC)". 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 OHOP), 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 each time the referral is made, just the initial referral needs to be entered. See CAREWare Handbook for more information. All referrals entered have a final status within 6 months from initial date of referral.

Follow-up and Monitoring Standards

Purpose	
<p>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.</p>	
Process	
Identify a follow-up Plan	✓ The CC will work with the client to identify when and how follow up will occur, in accordance with the standards.
Review care plan	✓ The CC will review the care plan as indicated by the client acuity assignment.
Provide referral information	✓ Additional referral information will be provided to the client as determined necessary during follow up and monitoring.
CAREWare Data Entry	
Demographic & annual review tabs	Any data collected during follow up and monitoring (change in phone number, address, HIV status, contacts, income, household size, medical provider, housing or insurance status) should be entered on demographic and annual review tabs.
Service & case notes	Time associated with follow up and monitoring must be must be entered as a service under: “Care Coordination (CC)”. Documentation of the service must be entered in the case notes.
Referrals	Referral updates must be documented under the Referrals tab. Pending referrals that have been completed must be indicated by editing the ‘Referral Status’ and entering the ‘Referral Complete Date’ under the ‘Referrals’ tab.

Transfer & Termination Standards

Purpose	
<p>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:</p> <ul style="list-style-type: none"> • 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. <p>Termination requires clear documentation of the reason(s) for termination, and notifying the client of termination and the grievance and hearings process.</p>	
Forms	
<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> ✓ The CC will discuss transfer with client. ✓ The CC will provide the client with appropriate referrals.
Obtain appropriate releases of information	<ul style="list-style-type: none"> ✓ 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	<ul style="list-style-type: none"> ✓ 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	<ul style="list-style-type: none"> ✓ If the case is being closed because the client has been unresponsive for more than 60 days, the CC will make a minimum of two attempts to contact the client, by phone, letter, home visit, etc. ✓ 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 CAREAssist and OHOP of the change in client status if necessary.
Close client file	✓ The CC will follow the agency protocol for closing charts.
CAREWare Data Entry	
Demographic and annual review data	Information on demographic and annual review tabs should be up to date prior to closing client.
Services and Case notes	Time associated with Transfer and Discharge must be must be entered as "Transfer/Discharge (CC)". Documentation of the service must be entered in the case notes, including a note that CAREAssist has been notified of the change in the client's status
Update Client Referrals	Referral updates must be documented under the Referrals tab.

MEDICAL CASE MANAGEMENT

Nursing Assessment Standards

Purpose	
<p>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 <u>“Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents”</u> and the <u>“Clinical Manual for Management of HIV-Infected Adults”</u>.</p>	
Forms	
<ul style="list-style-type: none"> • Nursing Assessment (8402) • Medication Profile (8417) 	
Process	
<p>Nurse Assessment is conducted</p>	<ul style="list-style-type: none"> ✓ 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 within 30 days of the anniversary of their Intake. The Nurse Assessment is conducted in accordance with the Standards of Service and any written policies and procedures established by the Agency, especially those related to confidentiality requirements.
<p>Acuity 1 or 2</p>	<ul style="list-style-type: none"> ✓ Nurse Acuity and/or Care Coordination 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 the need for an in-depth Nurse Assessment.

Schedule Case Conference	<ul style="list-style-type: none"> ✓ 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	<ul style="list-style-type: none"> ✓ 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	
Services & case notes	<ul style="list-style-type: none"> ✓ 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. ✓ Time associated with RN interventions must be entered by checking the checkbox that indicates the type of intervention provided: 'Adherence Activity', 'Nutritional Activity', 'Liver Health', 'Oral Health'. ✓ Documentation of the assessment and assessment process, findings, recommendations, referrals and goals must be entered in the case notes using the Nurse Assessment template.
Demographics Data	<ul style="list-style-type: none"> ✓ HIV Risk Factor must be indicated on demographics tab.
Lab Data	<ul style="list-style-type: none"> ✓ Any updated lab (CD4/Viral Load) results collected during the assessment process must be entered unless the client is an active client of CAREAssist.
Key Contacts	<ul style="list-style-type: none"> ✓ If the assessment process includes the collection of any client key contacts they must be entered under the 'Key Contacts' tab.
Referrals	<ul style="list-style-type: none"> ✓ Referrals provided during the assessment process must be documented in the Referrals tab.

MCM Acuity Standards

Purpose	
<p>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.</p>	
Forms	
<ul style="list-style-type: none"> • RN Acuity (8497r) 	
Process	
<p>Complete Acuity Worksheet</p>	<p>The Acuity Worksheet should be completed using the following instructions:</p> <ul style="list-style-type: none"> ✓ 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.
<p>Assign Acuity</p>	<ul style="list-style-type: none"> ✓ 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.)
<p>Exceptions to Acuity Assignment</p>	<ul style="list-style-type: none"> ✓ The MCM may change the client's acuity either up or down without an Nurse Reassessment <u>unless</u> (a) it has been longer than a year since the last assessment; and/or (b) the client's annual RN Reassessment is due within 30 days ✓ 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) there has been a significant decline in CD4 and/or a significant increase in viral load since the last lab; 3) and/or the client shows evidence of significant physical decline. ✓ The MCM <u>may</u> assign the client ongoing Medical Case Management 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

	<p>medication; 5) the client is symptomatic and/or 6) client has been released from a correctional facility within the past 90 days.</p> <p>✓ 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 3 months following the end of pharmacy services.</p>
CAREWare Data Entry	
Acuity Form	Acuity data will be entered in the “RN Client Acuity Scale” form.
Services & Case Note	<p>When the acuity is updated in connection with completing a full Nurse Assessment the service will be entered using the “Assessment” service. In addition, the “Nurse Assessment” template will be completed capturing the results of the assessment and case notes.</p> <p>When the acuity is not updated in connection with a full Nurse Assessment the service will be entered using the “RN Acuity Change” service. In addition, the “RN Acuity Change Interview Documentation” case notes template must be completed documenting the reasons for the change.</p>

MCM Acuity Stage Guidelines

Level/Points	Guidelines
Level 1: 0-5 points	<ul style="list-style-type: none"> ● Initial face-to-face Nursing Assessment. ● Based on results of annual Medical Case Management Triage Tool clients may also receive a Nursing Assessment.
Level 6 – 10 points	<ul style="list-style-type: none"> ● 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	<ul style="list-style-type: none"> ● Initial face-to-face Nursing Assessment. ● Minimum annual face-to-face Nursing Assessment. ● Nurse Plan developed, including appropriate intervention identified and ongoing follow-up provided ● Minimum contact with the client by MCM every 30 days. ● At the discretion of the MCM, a case conference with the CC may be requested and is required after every Nursing Assessment.
Level 4: 16 – 20 points	<ul style="list-style-type: none"> ● Initial face-to-face Nursing Assessment. ● Minimum annual face-to-face Nursing Assessment ● Nurse Plan developed, including appropriate intervention identified and ongoing follow-up provided ● Minimum contact with the client by MCM every 2 weeks. ● A case conference with the CC is required after every Nursing Assessment

Nursing Plan

Purpose	
<p>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.</p>	
Process	
Nurse plan requirements	<ul style="list-style-type: none"> ✓ Anyone receiving MCM will have a current Nurse Plan which will be reviewed and updated every 6 months at a minimum. ✓ Nurse Planning must include: <ol style="list-style-type: none"> a) Identification of the client needs through the Nurse Assessment Process b) Prioritization of client needs c) Develop Goals in the Nurse Plan d) Assign Tasks/activities e) Assign Roles (who does what)
Nutritional food vouchers	<ul style="list-style-type: none"> ✓ Any client receiving a Nutritional Food Voucher under Medical Nutritional Therapy must have a Nurse Plan that includes nutrition goals, be monitored and must be on an MCM case load
CAREWare Data Entry	
Service & case notes	<ul style="list-style-type: none"> ✓ Time associated with the development of the RN Plan must be entered by checking the 'Care Plan' checkbox as a component of the 'Medical Case Management (RN)' service. ✓ Documentation that a Nurse Plan has been updated must be noted in the case notes
Care Plan	<ul style="list-style-type: none"> ✓ Care plan should be entered into the Care Plan template in the case notes. A copy should be printed and provided for the client.

MCM Case Conferencing Standards

<i>Purpose</i>	
<p>Ongoing communication and case conferencing happens as part of coordinating client care by the CC and the MCM. Case conferencing differs from case management and 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.</p>	
Forms	
<ul style="list-style-type: none"> • Case Conferencing Form (8470) 	
Process	
Case conference with the medical provider	<ul style="list-style-type: none"> ✓ Case conferencing between the MCM and the client’s HIV medical provider office is not proscribed at this time, but it is strongly recommended to happen every 4 months for clients with an Acuity 3 and 4 clients with those medical providers who will participate, and may include the Pharmacist, a mental health counselor, staff from the client’s medical home, parole officer etc.
Case conference with the client's CC	<ul style="list-style-type: none"> ✓ Case conferencing between the MCM and the client's CC is required after every Nurse Assessment and at any other time that the MCM feels that a case conference with the CC is warranted and would be beneficial.
CAREWare Data Entry	
Service & Case notes	<p>Time associated with the case conferencing must be entered as “Case Conferencing (RN w/CC)” or as “Case Conferencing (RN w/MD)”.</p> <p>Documentation of the case conference must be entered in the case notes.</p>

MCM Referral & Advocacy Standards

Purpose	
<p>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.</p>	
Forms	
<ul style="list-style-type: none"> • 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	✓ Initially and throughout the process, the MCM will assess the client's progress. Their need for advocacy will be monitored

advocacy	<p>through follow-up with the client and referral agency.</p> <p>✓ 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</p>
CAREWare Data Entry	
Service & case notes	<p>Time associated with referrals and/or advocacy must be entered as “Medical Case Management (MCM)”.</p> <p>Documentation of client contact or contacts made on the client’s behalf must be documented in the case notes.</p>
Referrals	<p>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 OHOP), 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 each time the referral is made, just the initial referral needs to be entered. All referrals entered must have a final status entered within 6 months from initial date of referral. See CAREWare guide for more information.</p>

MCM Follow-up & Monitoring Standards

Purpose	
<p>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 the planning process 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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	
Process	
Initiate follow-up	<ul style="list-style-type: none"> ✓ The MCM should initiate follow-up when it is needed. ✓ 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.
Determine contact level	<ul style="list-style-type: none"> ✓ Careful planning by the client and the MCM can determine how often contact is needed to minimize crisis situations and to best meet the client’s anticipated needs. The client and MCM will regularly reassess the goals and activities identified with the client during the planning process and documented in the Nurse Plan to comply with the requirements under “Acuity Scale” to assess for progress and the need for appropriate changes.
Follow-up and monitor activities	<ul style="list-style-type: none"> ✓ 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.)
Acuity 3 and 4	✓ The Nurse Plan is updated and documented for all clients with a Nurse Acuity 3 or 4.
Track medical visits and labs	✓ The MCM is responsible for monitoring medical visits and labs completed by 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.
CAREWare Data Entry	
Service & Case note	Time associated with follow up and monitoring must be entered as "Medical Case Management (RN)". Documentation of the service must be entered in the case notes.
Referrals	Referral updates must be documented under the Referrals tab. Pending referrals must have a final status within 6 months.
Update Nurse Plan	When appropriate, the Nurse Plan must be updated to reflect the results of the follow-up and monitoring.

Other Program Policies

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 he/she is 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: MEDICAL CARE COORDINATION 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 Reass/Plan	Annual	RN	RN Reass/Plan	Annual	RN
	Update and triage forms are mailed						Contact	30 days	RN	Contact	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 Reass/Plan	Annual	RN	RN Reass/Plan	Annual	RN
	Contact			Contact			Contact	30 days	RN	Contact	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 Reass/Plan	Annual	RN	RN Reass/Plan	Annual	RN
	CC Screening	Annual	CC	CC Screening	Annual	CC	CC Screen/Plan	Annual	CC	CC Screen/Plan	Annual	RN
	Contact	30 days	CC	Contact	30 days	CC	Contact	30 days	CC/RN	Contact	2 weeks/ 30 days	RN/CC
CC 4	Update	Annual	CC	Update	Annual	CC	Update	Annual	CC	Update	Annual	CC
	RN Triage	Annual	IC	RN Triage	Annual	IC	RN Reass/Plan	Annual	RN	RN Reass/Plan	Annual	RN
	CC Screening	Annual	CC	CC Screening	Annual	CC	CC Screen/Plan	Annual	CC	CC Screen/Plan	Annual	CC
	Contact	2 weeks	CC	Contact	2 weeks	CC	Contact	2 weeks/ 30 days	CC/RN	Contact	2 weeks	RN/ CC

July 16, 2015

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Regional Based Model: Standards of Service

Oregon Health Authority