

HIV Community Services Program

**HIV Medical Case Management Program
2014 Chart Review Summary Report
*County-Based Programs***



Introduction

The HIV Community Services Program implements ongoing comprehensive quality management activities that includes multiple source data collection and analysis, clinical outcomes measurement and trending, targeted evaluation of programmatic components, program monitoring site visits/chart reviews, local contractor-performed chart reviews and other quality improvement activities and initiatives.

As part of the program's quality management activities, the HIV Community Services program participates in the Oregon Health Authority (OHA) Triennial Review process. All local health department contractors receive a site visit every three years as part of the overall OHA program review process.

In order to continue developing contractor capacity to improve the quality of HIV/AIDS services funded by the HIV Community Services Program, contractors conduct a client chart review locally and report their results to OHA. This process provides an opportunity for local programs to monitor their own performance and make improvements based on their findings. Annual chart reviews are required, but it is an activity that benefits program quality when used consistently and regularly. Local programs are encouraged to integrate this process into their agency quality improvement plan.

This report and the program chart review follow the HIV Medical Case Management Standards of Service for the following areas: Intake and Eligibility, Assessment and Reassessment, and Care Planning. Data management and health outcome results are also reviewed and listed at the end of this report. This report shows the results of the chart reviews and provides comparative data over a three year period of time.

A minimum of 10 client files or 25% of the total HIV Case Management program client files were reviewed by each contractor. For contractors with less than 10 total clients, all client files were reviewed. Twenty-one criteria were measured.

Technical assistance will be offered to those counties who did not meet a minimum of 80% compliance in any of the 21 criteria reviewed, as well as those whose overall client files did not have current lab results in the chart or in CAREWare.

Chart Review Summary

Overall, the County HIV Case Management Programs are 97% compliant with the criteria measured:

- Of the 21 criteria reviewed, two were markedly lower than all other items reviewed: the accuracy of data entry related to primary insurance provider was 78%, and files with current lab results were at 84%, the lowest level in three years.
- Data quality has significantly improved from 91% in 2009 to 98% in 2014.
- Sixty-five percent (65%) of people with HIV/AIDS living in the service area as of 12/31/14, as provided by the State of Oregon Data and Analysis Program (surveillance),

are in active HIV case management, which has been a consistent trend in the last two years since the peak of 71% of clients in HIV case management in 2012.

- Care planning continues to improve from 87% of the client files in 2009 having a care plan that included goals, assigned activities and outcomes documented to 98% in 2014.

Number/Percent of Files Reviewed and Total HIV/AIDS Living in Service Area

County	Number of Files Reviewed (2014)	Number of Active Clients Reported in CAREWare (9/30/14)	Total HIV/AIDS Living in Service Area (As of 9/30/14) ¹	% of total living with HIV/AIDS in Case Management
Crook	8	8	6	133%
Deschutes	12	48	79	61%
Hood River	10	10	17	59%
Jefferson	9	9	18	50%
Linn/Benton	18	71	97	73%
Polk	10	26	41	63%
Tillamook	5	5	15	33%
TOTAL	72	177	273	65%

Health Outcomes

In 2010, the White House released the first National HIV/AIDS Strategy. The strategy focuses on a number of goals which aim to reduce new HIV infections, increase access to care and improve health outcomes for people living with HIV and reduce HIV-related health disparities.

The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) stated in their recent newsletter that : *“...failure to engage PLWH along the HIV Care Continuum threatens the ability to meet critical NHAS targets. As such, on the third anniversary of the release of the NHAS, President Obama announced a national effort—the federal HIV Care Continuum Initiative—to increase the proportion of individuals engaged in each step along the continuum. In an executive order, President Obama called for a coordinated, multidisciplinary approach, led by the White House Office of National AIDS Policy, to prioritize and intensify efforts to improve rates of HIV testing, linkage to and retention in care, access to ART, and viral suppression, as they continue to implement the NHAS. Applying HIV best practices as well as targeting initiatives and*

¹ [Oregon HIV cases currently living in Oregon, by HIV/AIDS status, living as of 9/30/2014](http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/HIVData/Pages/epiprofile.aspx) provided by State of Oregon Surveillance.
<http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/HIVData/Pages/epiprofile.aspx>.

interventions along the HIV Care Continuum will remain critical to meeting the goals of the NHAS...²

According to the Center for Disease Control and Prevention (CDC), “the ultimate goal of HIV treatment is to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable. This is important for people with HIV to stay healthy, live longer and reduce their chances of passing HIV to others.”

The HIV care continuum consists of several steps required to achieve viral suppression. These steps include:

- Diagnosed with HIV infection
- Linked to care, meaning they visited a health care provider within three months after learning they were HIV positive
- Engaged or retained in care, meaning they received medical care for HIV infection
- Prescribed antiretroviral therapy to control their HIV infection
- Virally suppressed, meaning that their HIV viral load – the amount of HIV in the blood – is at a very low level

At the state and local levels, jurisdictions can use the HIV care continuum – compiled using local data – to determine where improvements are most needed and target resources accordingly.³ Client participation in HIV/AIDS care falls along a [continuum](#), from not being involved in care to full participation, with periods of time inconsistent engagement in care. A wide range of interventions can be used to encourage, support and enhance engagement in care.⁴

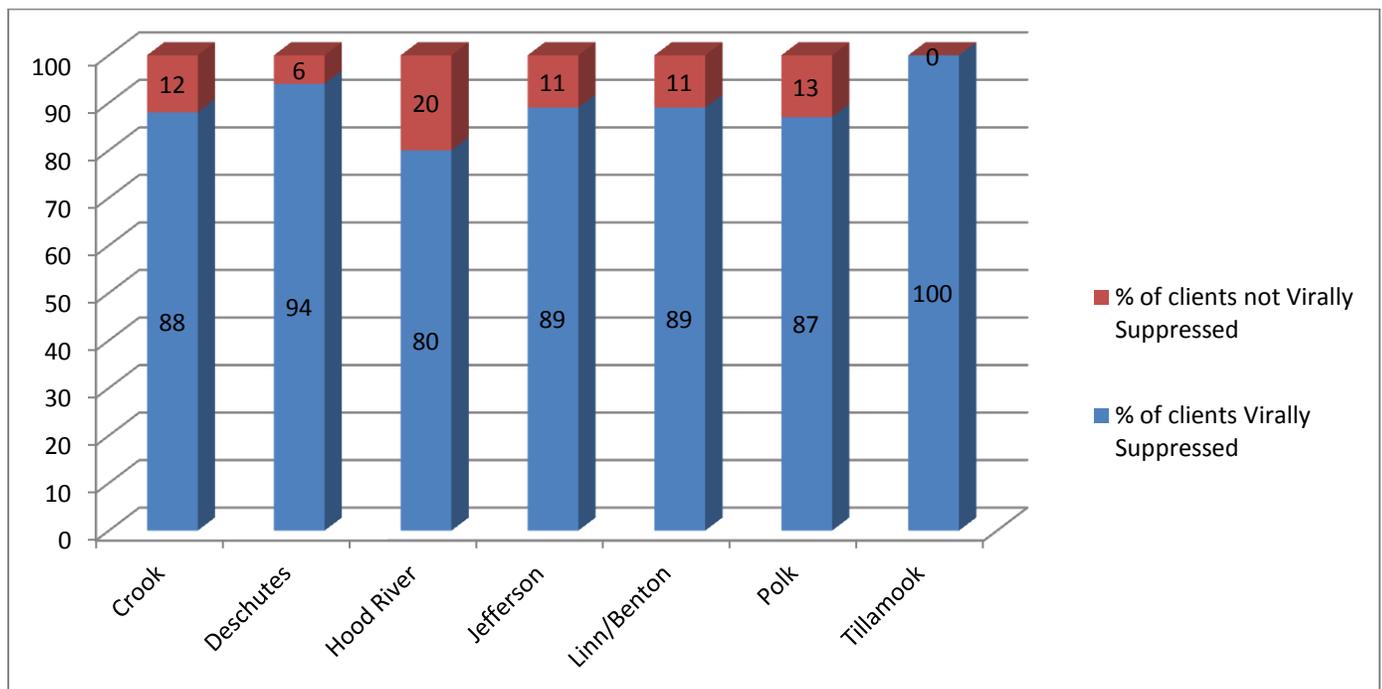
The Health Resources and Services Administration (HRSA), the federal administrative agency for the Ryan White Program, plays a critical role in achieving the goals identified in the strategy by engaging and retaining clients in care in order to achieve and sustain viral load suppression. Table 1 provides information by county on the total number of clients enrolled in local Ryan White services in the past year and the percentage whose last viral load indicated viral. Each County is encouraged to use the following data to identify opportunities for specific program and clinical interventions for increasing client engagement and retention in care. Outreach efforts should be considered for HIV positive individuals that are listed in the County’s service area (above table) that are not involved in their HIV Case Management program.

² U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). HRSA CARE Action. October 2014. Available at: <http://hab.hrsa.gov/deliverhivaidscarescarecontinuum.pdf>

³ CDC. Understanding the HIV Care Continuum. [Fact sheet] December 2014. Available at: http://www.cdc.gov/hiv/pdf/DHAP_Continuum.pdf#page=1&zoom=auto,-99,792. Accessed from HAB Information Email, Volume 18, Issue 1, January 8, 2015

⁴ Topic: Engagement in Care. HRSA/HAB Technical Assistance Resources, Guidance, Education & Training (TARGET).website. Accessed January 8, 2015 at: <https://careacttarget.org/category/topics/engagement-care>.

Table 1. Viral Suppression by Oregon Part B Case Management County, 2014



As of 12/3/14

Chart Review Data Results By County

Table 2. Viral Load and Laboratory reports documentation

County	% of files chart matches CAREWare for current CD4/Viral Load			% of files with current Lab Reports		
	2012	2013	2014	2012	2013	2014
Crook	100%	100%	100%	100%	100%	100%
Deschutes	100%	100%	100%	80%	100%	80%
Hood River	67%	100%	100%	67%	100%	90%
Jefferson	100%	86%	100%	75%	71%	89%
Linn/Benton	100%	83%	88%	88%	100%	100%
Polk	100%	100%	100%	100%	80%	30%
Tillamook	100%	100%	100%	100%	100%	100%
Mean	95%	96%	98%	87%	93%	84%

Intake/Eligibility

Standard: Each prospective client who is referred and desires or who requests Ryan White Program, Part B services will be properly screened and evaluated through a brief intake process designed to determine the client's eligibility for the program, gather information for future service delivery and assist in decision-making regarding immediate needs.

Table 3. Intake/Eligibility Criteria Met

County	Intake Completed			HIV Documentation Within 30 days of Intake			Income Verified		
	2012	2013	2014	2012	2013	2014	2012 ⁵	2013	2014
Crook	100%	100%	100%	100%	100%	100%	71%	100%	100%
Deschutes	80%	100%	100%	100%	100%	100%	0%	20%	100%
Hood River	100%	100%	100%	100%	100%	100%	100%	100%	100%
Jefferson	100%	100%	100%	100%	100%	100%	0%	100%	89%
Linn/Benton	100%	100%	100%	100%	100%	100%	93%	92%	100%
Polk	100%	90%	100%	100%	100%	100%	70%	90%	80%
Tillamook	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mean	97%	99%	100%	100%	100%	100%	62%	86%	96%

County	Release of Information Current			Client Rights & Responsibilities Signed			Informed Consent Obtained		
	2012	2013	2014	2012	2013	2014	2012	2013	2014
Crook	100%	88%	100%	100%	100%	100%	100%	100%	100%
Deschutes	90%	100%	92%	100%	100%	100%	100%	100%	100%
Hood River	78%	100%	100%	100%	100%	100%	100%	100%	100%
Jefferson	88%	71%	78%	100%	100%	100%	75%	100%	77%
Linn/Benton	100%	100%	100%	92%	100%	100%	85%	100%	100%
Polk	100%	90%	90%	100%	100%	100%	100%	100%	80%
Tillamook	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mean	94%	93%	94%	99%	100%	100%	94%	100%	94%

⁵ Six (6) month Eligibility Determination Process introduced.

Psychosocial & Nurse Assessment & Reassessment

Standard: Annually, each client of case management services will participate in at least one (1) face-to-face interview with a case manager for a psychosocial screening and at least one (1) face-to-face interview with a nurse for a nurse assessment. Annually, after the completion of the annual Psychosocial Screening and Nurse Assessment, each client of case management services will have an updated Acuity documented in their file.

Table 4. Assessment and Reassessment Criteria Met

County	Psychosocial Assessment/Reassessment completed					
	2012		2013		2014	
	Psycho-social	Nurse	Psycho-social	Nurse	Psycho-social	Nurse
Crook	100%	100%	100%	100%	100%	100%
Deschutes	80%	100%	100%	100%	92%	92%
Hood River	100%	100%	100%	100%	100%	100%
Jefferson	100%	100%	100%	100%	100%	100%
Linn/Benton	100%	100%	100%	100%	94%	100%
Polk	100%	90%	100%	100%	100%	100%
Tillamook	100%	100%	100%	100%	100%	100%
Mean	97%	99%	100%	100%	98%	99%

Table 5. Acuity Scale Completed

County	Acuity Scale Completion		
	2012	2013	2014
Crook	100%	100%	100%
Deschutes	80%	100%	92%
Hood River	78%	100%	100%
Jefferson	100%	100%	89%
Linn/Benton	94%	100%	100%
Polk	100%	100%	100%
Tillamook	100%	100%	100%
Mean	93%	100%	97%

Care Planning

Standard: Every client in HIV Medical Case Management will have a Care Plan documented in CAREWare that is reviewed and updated every 6 months. Every active client will identify at least one self-management goal to be included in their Care Plan. Documentation of the client's success in achieving all of their goal(s) must be included in the CAREWare case notes.

Table 6. Care Planning Criteria Met

County	Care Planning Includes required documentation*			Progress Notes records required documentation**		
	2012	2013	2014	2012	2013	2014
Crook	100%	100%	100%	100%	100%	100%
Deschutes	80%	100%	92%	97%	100%	92%
Hood River	100%	100%	100%	100%	100%	100%
Jefferson	100%	100%	86%	100%	100%	100%
Linn/Benton	99%	100%	100%	98%	100%	100%
Polk	100%	100%	100%	100%	100%	100%
Tillamook	100%	100%	100%	100%	100%	100%
Mean	97%	100%	97%	99%	100%	99%

*Care Planning Documentation Includes: Goals, Assigned Activities & Outcomes.

**Progress note Documentation includes: Date, Action & CM Signature for Every Contact

Data Management

The *HIV Case Management and Support Services Policies, Services Definitions and Guidance* require that any client served within the reporting year must have a corresponding electronic record with specific data elements accurately and completely entered. The RW CAREWare review included a comparison of what was reported in the hard chart versus what was entered into the electronic record in RW CAREWare. The federal agency responsible for administration of Ryan White Program funds, HRSA, determines the quality of Oregon's Part B funded services based on accurate reporting of client level data elements (HIV/AIDS status, medical funding source, medical provider, acuity level, adherence/acuity level and selected lab values).

Data Entry Policy: Users are required to enter all demographic, service and clinical data fields within 30 days of the date of service or receipt in the county-based service model.

Table 7. Data elements Criteria Met

County	HIV/AIDS Status			Primary Insurance Provider			Primary Medical Provider		
	2012	2013	2014	2012	2013	2014	2012	2013	2014
Crook	100%	100%	100%	100%	100%	100%	100%	100%	100%
Deschutes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hood River	100%	100%	100%	100%	100%	100%	100%	100%	100%
Jefferson	100%	100%	100%	100%	100%	89%	100%	100%	100%
Linn/Benton	100%	100%	100%	72%	94%	78%	72%	94%	89%
Polk	100%	100%	100%	100%	100%	90%	100%	100%	100%
Tillamook	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mean	100%	100%	100%	96%	99%	94%	96%	99%	98%

Table 8. Acuity Level/Points Documented

County	Acuity Level/Acuity Points					Adherence Acuity Stage				
	2012		2013		2014	2012		2013		2014
	Level	Pts.	Level	Pts.	Level	Level	Pts.	Level	Pts.	Level
Crook	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%
Deschutes	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hood River	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Jefferson	100%	100%	100%	100%	89%	100%	100%	100%	100%	100%
Linn/Benton	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Polk	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Tillamook	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mean	100%	100%	100%	98%	98%	100%	100%	100%	100%	100%

Client Identity

Standard: Verification of identity is required. Full legal name is used to establish client’s RW CAREWare record.

Table 9. Data Elements Criteria Met

County	% of clients entered into RW CAREWare by their full legal name		
	2012	2013	2014
Crook	100%	100%	100%
Deschutes	100%	100%	100%
Hood River	100%	100%	100%
Jefferson	100%	100%	100%
Linn/Benton	100%	100%	100%
Polk	100%	100%	100%
Tillamook	100%	100%	100%
Mean	100%	100%	100%

Service Documentation

Standard: Service entry in RW CAREWare matches the client file progress note in terms of accuracy of service date entered.

Table 10. Progress note documentation

County	% of electronic client records that match client file progress notes		
	2012	2013	2014
Crook	83%	100%	100%
Deschutes	100%	100%	100%
Hood River	90%	100%	100%
Jefferson	100%	100%	100%
Linn/Benton	99%	99%	99%
Polk	88%	100%	83%
Tillamook	100%	100%	100%
Mean	94%	100%	97%