

HIV COMMUNITY SERVICES PROGRAM

**HIV Case Management:
Standards of Services**

**County
Based
Model**

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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.

HIV Case Management Program

The HIV Community Services Program addresses the needs of persons with HIV by funding case management and support services that enhance access to and retention in HIV medical care and treatment. The goals of case management are to help individuals living with HIV access primary medical care and medications, identify and remove barriers to medical care, and ensure adherence to a prescribed treatment plan.

HIV Case Management is a range of client-centered services that ensure timely and coordinated access to primary medical care, medications, and other support services, including treatment adherence. Core services link a person to primary medical care or services. Supportive services may be needed for HIV-positive individuals to achieve their medical outcomes and must have a direct relationship to an individual's HIV clinical outcomes.

Core services of HIV Case Management include assistance and support applying, accessing, and adhering to HIV medical services and treatment by providing:

- Assistance accessing health insurance/medical treatment payment programs such as the Oregon Health Plan (Medicaid), Medicare, and CAREAssist.
- Assistance accessing primary and HIV-specific medical care, including HIV medications.
- Screening, assessment, referral and appropriate intervention for oral health care, medical nutritional services, mental health services and outpatient substance abuse treatment.
- Nurse assessment, nurse plan and appropriate nurse intervention focusing on treatment adherence, nutrition, oral health, HIV transmission risk reduction and liver health.

Supportive services of HIV Case Management include assistance with applying for and accessing a variety of services, including but not limited to:

- Housing assistance
- Medical transportation
- Food and nutrition
- Linguistic/translation services

Roles and Responsibilities

Medical Case Managers

In the county based model of HIV Case Management, the majority of case managers are public health nurses who provide both the medical and psychosocial components of HIV case management. In a few health departments, the nurse is responsible only for the required nursing components in this program: nursing assessment/reassessment, RN consultation, developing nursing plans, performing nursing interventions and providing client advocacy with the medical care system. Some may use psychosocial case managers to assist the nurse with the intake/eligibility review process, psychosocial screenings, care planning and the referral and follow-up activities. Nurses are responsible for identifying the need for and facilitating access to appropriate interventions. The nurse will either directly provide the intervention in the form of counseling, education and training, or will refer the client to an appropriate resource to receive the intervention (for example, referral to a mental health counselor, a dietician, a substance abuse counselor, etc.)

Functional roles of the nurse:

- Face-to-face nursing assessment and reassessment to include history taking and an appraisal of the client's health status and needs.
- Development of an individualized Nursing Plan
- Referral for medical evaluation and treatment.
- Education and counseling about HIV transmission, disease management, risk reduction and harm education.
- Case management of 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.
- Evaluation of adherence, nutrition, liver health and oral health assessment and associated interventions to include counseling, education and referral, as appropriate.
- Nursing interventions and education about a variety of issues, including 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
- Providing information about available resources and services for clients and their support system.
- Follow up on the telephone triage when appropriate. The nurse will need to determine the seriousness of the encounter and decide on a plan of action.
- Regular communication and client advocacy with the client's medical providers and other health and human service providers as appropriate.
- Documentation in progress notes, on the required forms and in the CAREWare data base.

Psychosocial Case Managers

Some health departments may also use psychosocial case managers. Psychosocial case management is provided by social workers, mental health counselors, health educators or other professionals with related health and human service experience. The psychosocial case manager works in partnership with the nurse to assess the needs of the client, develop an individualized client care plan, and arrange, coordinate, advocate, monitor, and evaluate a comprehensive package of services to meet the specific client's complex needs.

Functional roles of the psychosocial case manager:

- Intake/Eligibility Review (Intake/Eligibility Review Form as well as informed consent, confidentiality, grievance, release of information, and rights & responsibilities forms are required.)
- Face-to-face psychosocial screening and rescreening. (Psychosocial Screening/Rescreening Form is required.)
- Development of a comprehensive individualized Care Plan (to include the Nursing Plan and the Housing Plan, if appropriate.)
- Coordination of the services and activities required in implementing the Care Plan.
- Referral to appropriate agencies required to assist the client in achieving the goals and objectives identified in their Care Plan.
- Client monitoring to assess the efficacy of the Care Plan.

- Periodic re-evaluation and revision of the Care Plan as necessary over the life of the client.
- Client-specific advocacy.
- Review of client utilization of services.
- Outreach and case finding activities.
- Health education and risk reduction education and counseling.
- Transfer and inactivation processes.
- Documentation in progress notes, on the required forms and in the CAREWare data base.

Education Requirements & Training

As the front line in providing service linkages for people living with HIV, case managers must be adequately and appropriately experienced and trained. Minimum education and/or training requirements for HIV case managers are:

Role	Requirements & Training
Medical Case Manager	Oregon licensed RN (BSN preferred)
Psychosocial Case Manager	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.

Staff who provide HIV case management services to clients will be qualified and properly trained in health department policies and procedures, the Oregon HIV Medical Case Management Standards of Service, all required forms, CAREWare, confidentiality policies and procedures and basic case management skills. Supervisors are responsible for ensuring that new Ryan White Part B funded staff 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.

Client-Centered Approach to HIV Case Management

The client-centered model 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 HIV case manager's professional judgment. The issue of valuing a client's right to personal choice is a relatively simple matter when the HIV case manager's and client's priorities are compatible. It is when there is a difference between the priorities that the HIV 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 an HIV case manager is to see their client making a choice that will probably result in negative outcomes. In these situations, the HIV case manager must be willing to let the client experience the consequences of their choices, and hope that the relationship with the HIV case manager will be a place to which the client can return to for support without being judged. The one exception is if the client is planning to harm themselves or others.

It is the HIV case manager'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 only 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 through effective management of chronic conditions that prevents deterioration, reduces risk of complications, prevents associated illnesses and enables 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 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, 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, by each client's desired outcomes. In order to meet these needs, it is essential for clients to have the following:

- Basic information about HIV 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 transforming a health care system from one that is reactive and only responsive when someone is sick, to one that is proactive and focused on keeping a person as healthy as possible. This requires not only determining what care is needed, but spelling out roles and tasks in a structured way to ensure that everyone involved as part of the client's care team understands their role. This requires making coordinated follow-up a part of standard procedure, so clients aren't left on their own once they leave the doctor's or case manager's office. Complex clients need more intensive case management to optimize the clinic care, the effectiveness of their treatment regimen and their self-management behavioral skills.

Effective self-management support means more than telling clients what to do. It means acknowledging the clients' central role in their care, and fostering 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. Using a collaborative approach, case managers and clients work together to define problems, set priorities, establish goals, create care plans and solve problems along the way.

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

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

Self-Management Guidelines

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

Trauma Informed Care

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

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, which emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. Traditional approaches see problems or symptoms as discrete and separate, client behavior as "working the system" and clients as broken and vulnerable. Instead, trauma informed care sees problems or symptoms as coping mechanisms for dealing with trauma and client behavior as a way to get needs met. The HIV Community Services Program encourages case managers and health departments 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](#).

HIV Case Management Program Policies

1. All people accessing HIV Medical Case Management must participate annually in an intake & eligibility review process, a Psychosocial Screening and a Nursing Assessment.
2. All clients 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 Medical Case Manager and/or medical provider.
3. 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.
4. Clients are required to receive HIV case management services in the county where they reside. Program approval must be received prior to providing any case management services to a client who does not live in the county.
5. HIV case managers may provide 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 HIV case manager will coordinate the transition with the correctional staff.

Transitional Case Management includes an Intake, Psychosocial Screening/Nurse Assessment 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 Case Manager will facilitate the transition and referral. HIV case managers are expected to

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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.

HIV Case Management Standards

These standards are intended to provide a direction to the practice of county based HIV Case Management in the State of Oregon. They are also intended to provide a framework for evaluating the practice of HIV Case Management and to define the professional case manager's accountability to the public and to the client to whom the profession is responsible.

The core standards of case management are addressed below:

- Intake/Eligibility Review
- Assessment/Screening
- Acuity Assignment
- Care Planning
- Referral and Advocacy
- Follow-up and Monitoring
- Reassessment/Rescreening
- Transfer and Termination

The following defines the purpose of each Standard, the process or main activities of the standard and what documentation is required.

Intake/Eligibility Review

Each prospective client who requests HIV Case Management Services will be screened and evaluated for eligibility through a comprehensive intake process. The intake is designed to determine eligibility, gather required information, introduce the client to the agency, and assist in determining immediate needs.

Purpose

The initial Intake serves as the primary source of demographic and eligibility information. It provides the case manager with important first impressions about the client and helps determine whether the client is in a crisis situation and requires immediate referral. Also, it allows the client to interact with agency staff and consider the ramifications of his or her participation in the program. The first contact between the client and the case manager also establishes the basis for rapport and trust, which are essential elements of successful case management. 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.

Forms

There are several forms that must be provided to and/or signed by the client during intake.

- The client's **Informed Consent** to participate in the case management program should be obtained at this time.
- Clients should understand the **Grievance Procedure** and Hearings Process as well as the right to refuse any and all services at any time during his or her participation in the case management program.
- Clients are informed of their right to **Confidentiality**. It is important not to assume that anyone - even a client's partner or family member - knows that the client is HIV positive. Part of this discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone, etc.) Case

managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual has HIV or receiving social services.

- A **Release of Information** form (as required under ORS 192.518-192.524) in which a client authorizes in writing the disclosure of certain information about his/her case to another party (including family members). Included in the form are the purpose of the disclosure, the types of information to be disclosed, entities to disclose to and the expiration date of client authorization. Because this program requires an annual reassessment, it is expected that a Release of Information will be obtained annually. Part of the discussion should include information about the intent of the Release of Information, its components, and ways the client can nullify it.
- **Client's Rights and Responsibilities** form. The case manager reviews all of the rights and discusses the responsibilities as part of the overall discussion of a client's participation in the case management system. A signed copy (by the client) of the Client's Rights and Responsibilities Form should remain in the client's file and a copy should be given to the client to keep.

Eligibility Determination

The Ryan White Program requires all service providers who receive Ryan White funds to screen clients and certify their eligibility for services based on (a) an HIV+ diagnosis; (b) proof of identity; (c) proof of residence in Oregon; and (d) proof of income. If documentation subsequently determines that a client is not eligible, the client is not considered a Ryan White client and may not receive any services funded by the Ryan White Program. For more information on eligibility determination, see [Supportive Services: Policies, Definitions and Guidance](#).

Process

1. The Intake is initiated by a prospective client, his or her representative, or by a third party referral (verified at least verbally by client) to the case management agency.
2. Prior to the Intake, the client should be provided a list of information/documentation they will need to bring to the Intake. Some level of crisis triage screening should be done with the client on the first contact. If the client is experiencing a medical crisis or is facing eminent interruption of HIV medication therapy, some level of case management intervention may need to happen prior to Intake.

3. The client should receive an Intake within 2 weeks of referral or initial client contact. Final eligibility is determined once all supporting documentation has been received and verified. The Intake process will be expedited for clients who are newly diagnosed or homeless. It will also be a local decision whether to allow drop-in Intake, whether to combine Intake, the Psychosocial Screening and the Nurse Assessment, and whether to have multiple sessions based on agency particulars and on client need.
4. Income eligibility for Ryan White funded services (except case management or medical case management) is 250% of federal poverty level or less. Except for case management services, the client cannot receive any other Ryan White funded supportive services until the final eligibility is verified
5. The client will be provided with an explanation of services offered by the case management program and of the role of the case manager. It is important for the case manager to make the client aware of the limitations of the program as well as its offerings. This information must be provided during the Intake in order to avoid problems that inappropriate expectations can cause the client and the agency later on.
6. Upon determining eligibility, a client will be referred to the Psychosocial Screening and the Nurse Assessment.

Documentation

Information collected during intake should be documented on the **Intake/Eligibility Review Form**. The demographic and annual review tab in CAREWare should be completed at this time, including any provided referrals. The "Enrollment Date" will be the date the Intake process was begun.

Six Month Eligibility Review/Self-Attestation

All clients must have their eligibility reviewed every 6 months or self-attest that nothing has changed.

Process

1. Eligibility is verified every 6 months while the client is actively engaged with Ryan White funded services.
2. For clients who are enrolled in CAREAssist, enter the client's CAREAssist number on the Self-Attestation form, sign, and attach a printed copy of the CAREAssist Eligibility Verification report.
3. For clients who are not enrolled in CAREAssist, clients may self-attest via telephone or in person and the Six Month Self-Attestation Form must be completed. For a telephone self-attestation, the person taking the information from the client signs the form. For in-person self-attestation, the client and case manager signs the form.
 - If there are no changes to residence, income or health insurance, nothing further is required.
 - If there are changes to residence, income or health insurance, required documentation must be submitted and attached to the self-attestation form.
4. Annually, clients are required to complete a full eligibility review. All sections of the intake/eligibility review form must be completed with the exception of HIV and Identity verification which are only required at intake. For clients on CAREAssist, the CAREAssist Eligibility Verification report can be submitted as verification of income. For clients not on CAREAssist, appropriate documentation for residency and income verification must be submitted. Other agency forms, such as ROIs, should be updated as appropriate.

Documentation

As appropriate, the CAREAssist Eligibility Verification report, Self-Attestation Form, and/or Intake Eligibility Review should be included in the client file. The demographic and annual review tab in CAREWare should be updated if there have been changes.

Psychosocial Screening and Nurse Assessment

Annually, each case management client will participate in at least one face-to-face interview with a case manager for a psychosocial screening and at least one face-to-face interview with a nurse for a nurse assessment.

Purpose

The Psychosocial Screening and Nurse Assessment provide an information gathering process through a face-to-face interview between a client and a case manager. It is a cooperative process during which a client and case manager collect, analyze, synthesize and prioritize information which identifies client needs, resources, and strengths. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination. In HIV case management programs where the nurse is the only case manager supporting the client, s/he is responsible for both the Screening and the Assessment. In programs with multidisciplinary teams of both nurses and psychosocial case managers, the appropriate professional completes their component of the Screening or Assessment.

Process

1. If the Screening and Assessment were not scheduled during the Intake process, the client is contacted to schedule an appointment. The Screening/Assessment should commence no later than seven (7) working days following Intake and should be completed within two (2) weeks. However, there may be factors which require a longer period of time to complete the Screening/ Assessment and these should be documented in the client record.
2. The Screening and Assessment are performed in accordance with the standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements.
3. The face-to-face interview is conducted at a site mutually acceptable to the client and case manager and does not necessarily have to take place in the case manager's office.

Documentation

The Screening and Assessment are completed and signed on the **Psychosocial Screening Form** and the **Nurse Assessment Form**. Documentation of the screening and assessment process, findings, recommendations, and referrals should be entered in CAREWare.

Acuity

Each case management client will have an updated Acuity documented in their file.

Purpose

The HIV Community Services Program strives to provide the greatest level of support to clients with the greatest need. The Acuity Scale translates the Screening and Assessment processes into a level of programmatic support designed to provide assistance appropriate to the client's assessed need. The Acuity Scale helps provide consistency from client to client and provides objective assessment, thereby minimizing inherent subjective bias.

Process

1. Upon completion of the Screening and Assessment, an acuity level should be assigned for each life area. Total points should be calculated according to the instructions to calculate the overall acuity level.
2. The Case Manager may change the client's acuity either up or down without a Reassessment or Rescreening, unless (a) the client has been an Acuity 3 or 4 for 12 months; and/or (b) the client's annual Nurse Reassessment is due within 30 days.
3. Release from a correctional facility may warrant an Acuity Level 3 or 4 during the first 90 days after release.
4. The Case Manager may assign an overall acuity of 3 or 4 if a client is assessed a level 3 or level 4 in the "Medical Needs" life area.
5. Follow up and monitoring guidelines are determined by the assigned acuity level. See table.

Acuity Level Guidelines

Level	Guidelines
Level 1: 13 – 22 points	<ul style="list-style-type: none"> ● Annual face-to-face nursing reassessment and psychosocial rescreening. ● Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 6 months with an updated copy printed for the client file. ● Eligibility verified every 6 months.
Level 2: 23 – 32 points	<ul style="list-style-type: none"> ● Annual face-to-face nursing reassessment and psychosocial screening. ● Minimum contact (telephone or face-to-face) every 6 months to check on client's current status. ● Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 6 months with an updated copy printed for the client file. ● Eligibility verified every 6 months.
Level 3: 43 – 63 points	<ul style="list-style-type: none"> ● Minimum annual face-to-face nursing reassessment and psychosocial re-screening. ● Minimum contact (telephone or face-to-face) every 30 days. ● Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 30 days with an updated copy printed for the client file. ● Eligibility verified every 6 months.
Level 4: 64 – 84 points	<ul style="list-style-type: none"> ● Minimum annual face-to-face nursing reassessment and psychosocial re-screening. ● Minimum contact (telephone or face-to-face) every 2 weeks. ● Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 2 weeks and an updated copy printed for the client file. ● Eligibility verified every 6 months.

Documentation

Completion of the **Oregon Acuity Scale Worksheet** in CAREWare or the paper "**Client Acuity Scale Worksheet**" with a copy placed in the client file.

Care Plan

Every client in HIV Case Management will have a Care Plan that is reviewed and updated every 6 months at a minimum. Documentation of the client's success in achieving all of their goal(s) must be included in the CAREWare Case Notes.

Purpose

Care planning provides the basis from which the case manager and the client work together to access the resources and services which will enhance the client's quality of life and his/her ability to cope with the complexity of living with HIV. The process supports client self-determination and empowers a client to actively participate in the planning and delivery of services. The client is assisted to create goals and objectives that are [SMART \(specific, measurable, attainable, realistic and time-based\)](#). With proper support, many clients are able to increase their coping skills and stabilize their life situation to avoid the cycle of moving from one crisis to another. Finally, the care plan also becomes the basis for evaluating whether the client achieved the desired outcomes.

Process

1. The Care Plan should be developed after the intake, screening and assessment process have been completed.
1. The client is assisted to prioritize their goals. Expecting a client to accomplish a large number of goals in a short period of time will only frustrate both the case manager and the client. Aim to accomplish one or two activities at a time while acknowledging the next tasks to be accomplished.
2. The case manager and client work together to decide what actions are necessary to accomplish their goals and *who* will take responsibility for each. The case manager encourages the client to act on their own behalf whenever possible.
4. The role of the case manager is primarily one of resource coordination. When, during care planning, specific knowledge or skills are needed beyond those of the case manager, consultation with other professionals should be sought after appropriate releases of information are obtained.

5. Case conferences can help ensure that all providers involved in a client's care treatment work together to achieve coordination of services and avoid duplication. Regular case conferencing about the care plan is especially important within a multi-disciplinary team where both a psychosocial case manager and a medical case manager are working with the client to accomplish the goals in a joint care plan. Clients who are receiving assistance through OHOP must also have a copy of their "Housing Stability Plan" in the client file.

6. If the care plan remains appropriate and no revisions need to be made at the 6 month review, the case manager should document that the care plan has been reviewed and no changes were indicated.

Documentation:

Completion of the **Care Plan** in CAREWare or the paper Care Plan form with a copy placed in the client file. Care planning includes documentation in the CAREWare Case Notes, including the status of goals and the outcomes of all referrals.

Referral & Advocacy

Each client receiving HIV Case Management services will receive referral to services critical to achieving optimal health and well-being, including advocacy assistance to help problem solve when barriers impede access.

Purpose

Referral and advocacy are often needed in order to meet planning goals. Referral is the act of directing the client to a service, in person or through telephone, written, or other type of communication. Referrals may be made: (1) from one clinical provider to another, (2) within the HIV case management system, (3) by other professional case managers, (4) by program staff or (5) as part of an outreach program.

Advocacy is the act of assisting a client to obtain necessary services, especially when the individual has had difficulty obtaining them on his/her own. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Process

1. The HIV case manager will maintain a working knowledge of community resources and, when necessary, will conduct outreach to identify needed services. Referral agencies should be assessed for appropriateness to the client situation, lifestyle and need. Agency eligibility requirements should be considered as a part of the referral process.
2. Clients will be provided referral information that is relevant to their needs, is up-to-date, and in a format/language that they understand.
3. Wherever possible, the client will be encouraged and supported to make their own appointments for referrals, to act on their own behalf and to report back to the HIV case manager about the status of the referral.
4. The referral process should include timely follow-up to ensure that services are being received. The HIV case manager and the client will identify how and when follow-up will occur. Clients who have difficulty with follow-up to referrals will be assisted to make appointments and to complete the referral recommendations.

Documentation

Referral and advocacy activities must be documented in the CAREWare Case Notes and in the CAREWare Referral Tab. Ongoing referrals (such as "go to the food bank each month") do not have to be entered into the CAREWare Referral Tab each time the referral is made, just the initial referral needs to be entered. 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. All referrals in the Referral tab must have a final status entered within 6 months of the original referral date. See CAREWare User Guide for more information about documenting Referrals.

Follow-up & Monitoring

The client and HIV case manager will reassess the goals and activities identified with the client during the planning process in compliance with the requirements under “Acuity Scale”

Purpose

Follow-up and monitoring are inseparable. It is through systematic follow-up that the case manager 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 and, if not, why not. Monitoring client satisfaction is an ongoing process throughout the delivery of case management services. It determines whether the mutually agreed upon goals of the care plan are truly meeting the needs of the client. Monitoring is an ongoing process that involves collection and analysis of data and information that results in:

- evaluation of the effectiveness and relevance of the planning process;
- evaluation of the level of client satisfaction;
- measurement of client progress toward stated goals and activities; and
- determination of the need for revisions.

The overall goals of follow-up and monitoring are to:

- ensure the goals and activities identified during the planning process are adequate to meet client service needs;
- ensure services received 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 and case manager contact on a regular basis to build trust, communication and rapport.

Process

1. Either the case manager or the client can initiate follow-up. Clients should be encouraged to contact the case manager when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems. Careful planning by the client and the case manager can determine how often contact is needed to minimize crisis situations and to best meet the client's anticipated needs.
2. Follow-up and monitoring activities can occur through direct contact with the client or the client's support system, either through face-to-face meetings or telephone or email communications. To build a client-centered relationship, it is important that at least some of the follow-up and monitoring happen as face-to-face meetings with the client. Client contact with the case manager can occur on regular, an ad hoc or a drop-in basis.
3. Follow-up can occur in the case manager's office, at the client's home or temporary residence, in the hospital or at other sites in the community.
4. The client and case manager will reassess the care planning goals and activities in compliance with the requirements based upon the client's acuity level. The case manager will document any review of care planning activities that happened with the client in CAREWare case notes and make appropriate changes to the goals' status in the Care Plan, based on the information obtained during the follow-up activities.
5. Indirect contact with the client's family or caregiver, primary medical provider, service providers and other professionals also provides follow-up and monitoring information. This can happen through meetings, telephone contact, written reports and letters, review of client records, and through client and/or agency staffing. Building strong communication between the HIV medical case manager and the client's primary care provider is important to the client's overall quality of life, the client's ability to adhere to treatment regimens and the success of care coordination on behalf of the client.
6. Identifying and contacting people with HIV who were previously enrolled in HIV Community Services, and have been lost to follow-up or are not responding, is a component of monitoring. This is accomplished through periodic review of client files, requests from medical provider or referral from other outreach activities.

Documentation

Follow-up and monitoring activities must be documented in the **CAREWare Case Notes**, in the **CAREWare Referral Tab** and in the **CAREWare Care Plan**. Dates of follow-up, referrals and specific activities should be included in the documentation.

Psychosocial Rescreening and Nurse Reassessment

At least annually, all clients receiving case management services will have their needs reevaluated through a comprehensive face-to-face Psychosocial Rescreening and Nurse Reassessment.

Purpose

Clients are rescreened and reassessed to identify unresolved and or emerging need, guide appropriate revisions in the care planning and decision making regarding discharge from case management services and/or transition to other appropriate services.

Process

1. Active clients in case management will be rescreened and reassessed, at a minimum, annually. Case managed clients will be rescreened and reassessed more frequently in the event of significant changes in the client's life or as defined in process.
2. The Psychosocial Rescreening and Nurse Assessment should be completed by the appropriate parties and conducted according to established standards and criteria.
3. Rescreening and reassessment will include, but is not limited to, the original screening and assessment areas and progress on meeting care plan goals, changes, and additional mutually agreed upon goals.
4. The process of rescreening and reassessment should encourage active participation by the client and/or significant others, such as legal guardians, parents of minor children, as well as partner or spouse. The process of rescreening and reassessment may involve the collaboration between case manager, nurse and other health and human service providers, and individuals actively involved with the client. The client record may also be used to gather information for the rescreening/reassessment process.

A Medical Case Manager may perform a Nurse Reassessment at any time there are changes in a client's life that may result in a different acuity score and will require updating the client's Care Plan.

Documentation

Upload Nurse Assessment Form and Psychosocial Screening Form and complete a new Acuity Scale and Care Plan. Document findings as a narrative summary in the CAREWare case notes.

Transfer & Termination

The transfer and termination process guides the transfer of the client to another program case management program or termination from case management services.

Transfer

The purpose of a transfer process is to minimize disruption and assist a client moving between case management programs. The intent of this Standard is to require case managers to 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.

Transfer will occur when:

- Client moves out of the case manager's geographic service area
- Client needs are more appropriately addressed in other programs

Process

If a client informs a case manager that they will be moving outside of your service area and wishes to continue receiving case management services, the following should occur:

1. Communication between the two case management programs occurs to facilitate transfer of care. Both case management programs must have a current Releases of Information (ROI) from the client.
2. At a minimum, a copy of the most current Intake/Eligibility Review Form, Psychosocial Assessment/Reassessment Form, Nurse Assessment/Reassessment Form, HIV verification documentation and physician's notes (if applicable) should be sent via fax or mail to the new case management program.
3. If the client is moving to another Part B provider, the new case management program may choose to not complete the entire process (Intake/Update, Assessment and Screening) if it has been less than six (6) months since last completed. They may choose instead to do a modified intake process, and obtain enough additional information to assist them in developing an understanding of the current Care Plan. If the Intake/Update and Assessments/Screening

were completed more than six (6) months prior to the transfer, the new case management program should complete a new Intake, Psychosocial Screening and Nurse Assessment

Termination

Termination can only occur if a client's circumstances meet specific criteria, limited to the following:

- Client fails to meet eligibility requirements
- Client is lost to follow up or is unresponsive for more than 60 days
- Client moves into a system of care which provides institutional case management
- Client submits false, fraudulent or misleading information in order to retain benefits
- Client uses supportive services fraudulently
- Client consistently violates program responsibilities outlined in OAR 333-022-2070.

Process

Termination requires clear documentation of the reason(s) for termination, and notifying client of termination and the grievance and hearings process.

1. When possible, the reason for termination should be discussed with the client and options for other service provision are explored and documented.
2. In instances where the case management agency initiates termination:
 - The case manager should consult with supervisor about their intent to inactivate client.
 - The client must be informed of intent to inactivate via mail. The letter should inform the client of the grievance and hearing options, as well as requirements for their return to case management services.
 - The client must be informed of other community resources available that may be able to meet their needs.
3. A client is considered "lost to follow-up" when a case manager has made a minimum of 2 good faith attempts to contact the client, with no response from the client. This can be done through phone messages, letters, provider contacts, or home visits. In cases where there has been no response from the client, a certified letter indicating intent to terminate should be mailed to the client's last known mailing address. The letter should state that if the client does not respond within 2 weeks, or at the discretion of the case manager, their file will be closed.
4. CAREAssist and/or OHOP should be notified of change in client status as necessary.

Documentation

Information on demographics, annual review and referral tabs should be up to date prior to closing the client. If client was terminated, there should be clear documentation, in the form of a summary, in the CAREWare case note on the justification for termination.

Home Visit Safety Protocol

A written “Home Visit Safety Protocol” is required for every HIV case management agency funded by the HIV Community Services Program. A copy of this written protocol must be available upon request.

Purpose of a Home Visit Safety Protocol

Home visits are not required by this program. However, HIV case managers in the Ryan White Program may do home visits for clients who are too ill to travel or have difficulty getting to the case manager’s office. Therefore, a written safety protocol is required for every HIV case management program in Oregon. HIV case managers doing home visits have a duty to ensure that reasonable care for their own health and safety and that of their colleagues is enforced. A safety protocol that clearly delineates the required standards and activities will assist HIV case managers in Oregon to safely provide home visits to clients.

Process

If the local HIV case management agency does not have a “Home Visit Safety Protocol” already developed, then one must be written and approved through the local approval mechanisms at the contractor site.

Suicide Threat Protocol

A written “Suicide Threat Protocol” is required for every HIV case management agency funded by the HIV Community Services program. A copy of this written protocol must be available upon request.

Process: All contracted agencies should work with their own agency management and legal counsel to develop a written document that meets the requirements of the agency.

Appendix A: Acuity Scale Definitions and Points

Psychosocial Life Area	Level 1 (1 point)	Level 2 (2 points)	Level 3 (3 points)	Level 4 (4 points)
Basic needs EFA	Client is able to meet own basic needs. Client is able to access community assistance on their own as needed.	Occasional help to access assistance. Needs occasional EFA <2 times per year.	Difficulty accessing assistance. Often w/o basics. Accesses EFA 3-6 times per year.	Has limited access to food. Without most basic needs. Accesses EFA >7 times per year.
Transportation	Has reliable transportation. Is able to cover costs of transportation.	Needs occasional assistance <2 times per year.	No means. Under or un-served area. Needs assistance 3-6 times per year.	Serious impact on medical care. Needs assistance >7 times per year.
Risk Reduction	Understands risks and practices harm reduction behavior.	Poor understanding of risks. No exposure to high risk situations or behavior.	Has poor knowledge and/or occasionally engages in risky behavior.	Lacks knowledge and/or engages in significant risky behaviors.
Health Insurance/ Medical Care Coverage	Has own medical insurance and payer. Able to access medical care.	Has insurance/medical coverage. Enrolled in CAREAssist. Needs occasional assistance accessing medical care <2 times per year.	Needs CM assistance or referral to access insurance or CAREAssist. No medical crisis. Needs assistance accessing medical care 3-6 times per year.	Needs immediate assistance to access insurance or CAREAssist. Medical crisis. Does not have access to medical care.
Self Sufficiency	Independent. Follows up on referrals and accesses services on own.	Sometimes requires assistance in following up and completing forms.	Difficulty with follow-up; completing forms; accessing services.	Never follows-up; unable to complete forms on own; burns bridges.

Psychosocial Life Area	Level 1 (1 point)	Level 2 (4 points)	Level 3 (6 points)	Level 4 (8 points)
Housing/ Living Arrangement	Living in clean, habitable, stable housing. Does not need assistance.	Stable housing (subsidized or not). Occasionally needs assistance with housing <2 times per year.	Unstable housing (subsidized or not). OHOP violation or eviction imminent. Frequently accesses assistance 3-6 times per year or pays rent late. Not safe housing.	Unable to live independently. Recently evicted. Homeless. Temporary housing. Accesses assistance >7 times per year.
Mental Health	No history of mental health problems. No need for referral.	History and/or reports current difficulties/stress. Is functioning. Engaged in mental health care.	Experiencing severe difficulty in day-to-day functioning. Requires significant support. Needs referral to mental health care.	Danger to self and/or others, needs immediate intervention. Needs but is not accessing therapy.
Addictions	No difficulties with addictions. No need for referral.	Past problems and/or less than 1 year recovery. Not impacting access to medical care or ability to pay bills.	Current addiction – willing to seek help. Impacts ability to access medical care or ability to pay bills.	Current addiction – not willing to seek help. Unable to seek medical care or pay bills because of addiction.

Nursing Assessment Life Area	Level 1 (1 point)	Level 2 (4 points)	Level 3 (6 points)	Level 4 (8 points)
HIV Disease Knowledge	Verbalizes clear understanding.	Some understanding, ignorant in some areas.	Little understanding, needs counseling.	Ignorant of HIV disease progression, needs extensive assistance.
Adherence	Not currently prescribed medications or adherent to medications and appointments without assistance.	Adherent to medications and appointments the majority of time.	Misses at least half medications and/or appointments. Doesn't understand medications.	Resistant or unable to adhere to medication regimen. Sporadic medical care.
Medical Needs	Stable health with ongoing access to medical care. Not HIV symptomatic.	Needs medical care referral. Short-term acute condition. HIV symptomatic.	Poor health. HIV debilitating. Multiple diagnoses. Home bound.	Medical emergency. End stage. Intensive and complicated home care required. Uses ER only for primary care.
Nutritional Health	No signs of wasting. No significant weight problems or problems eating. BMI 18.5-24.9	Unexplained weight loss. Occasional episodes nausea, vomiting, diarrhea. Problems with food. Unexplained weight gain. BMI 18.5-24.9	Initial visual signs of wasting syndrome or physical malady. Chronic nausea, vomiting, diarrhea. Problems eating. BMI below 18.5 or 25.9-29.9	Advanced visual signs of wasting syndrome or other physical malady. Acute nausea, vomiting, diarrhea. Severe problems eating. Obese. BMI below 18.5 or 30.0 and above.
Oral Health	Currently in dental care, has seen a dentist within the past 6 months. No complaints of pain. Reports practicing daily oral hygiene.	Not seen a dentist within 6 months. Dentures need adjusting. Reports not practicing daily oral hygiene.	Observed problems with teeth, gums, mouth. Reports episodic pain. Reports episodic or moderate difficulty eating.	Current severe pain reported. Observed severe problems with teeth, gums, mouth. Few or no teeth. Significant difficulty eating.

Appendix B: 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 who have a newly positive test for TB should have a single chest x-ray to rule out TB disease.
- c. Staff/volunteers who have a previously positive TST or IGRA will 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.

Appendix C: 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);
- For clients who receive SSI/SSDI, 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 to being employed 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](#) webpage.
- Refer the client to the Positive Self-Management Program or other skills building programs;
- Complete required trainings on employment services for PLWH