

# **HIV COMMUNITY SERVICES PROGRAM**

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**HIV Case Management:  
Standards of Services**

**County  
Based  
Model**

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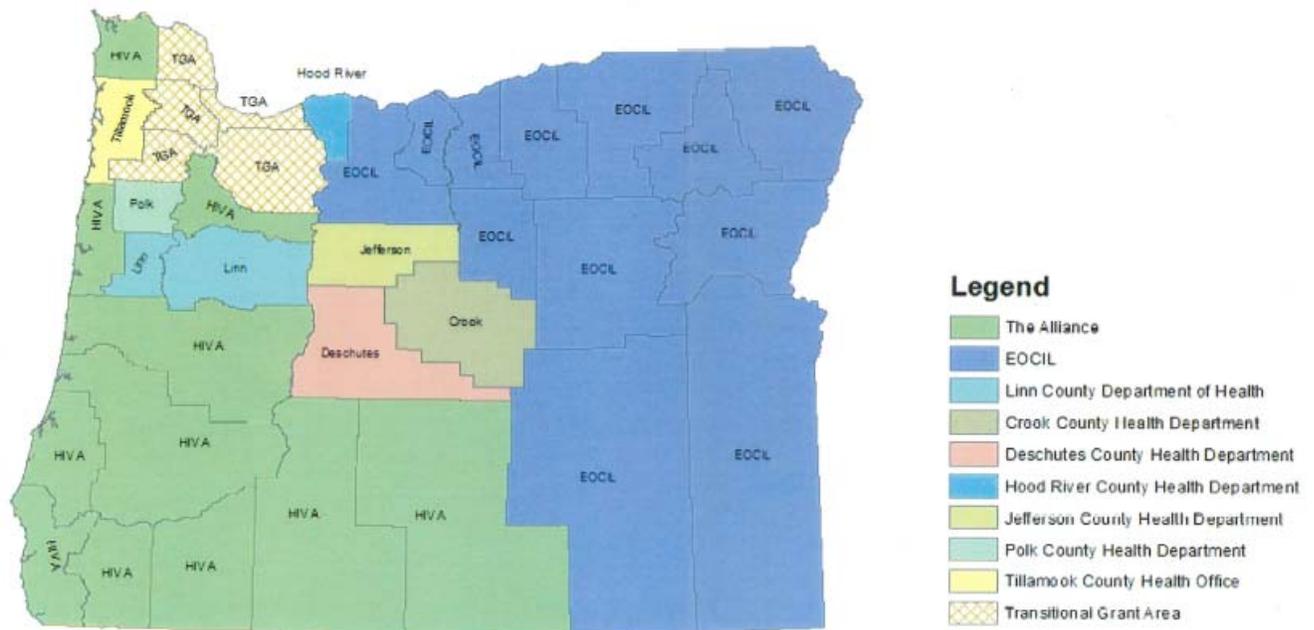
The Oregon Health Authority, HIV/STD/TB Program, HIV Community Services gratefully acknowledges the work of the Oregon HIV Case Management Task Force in providing the recommendations for edits changes and improvements in this document.

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 HIV Case Management Program Overview

The Oregon Health Authority, HIV Care and Treatment Program, is the Part B Ryan White grantee of the Department of Health and Human Services, HIV 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. Through successful case management, access to important supportive services, and assistance through Oregon's AIDS Drug Assistance Program, CAREAssist, people living with HIV 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 the remaining counties as indicated below. Counties in the Transitional Grant Area are served by Ryan White Part A funds which are granted to Multnomah County.



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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.

## 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. Providers should comply with all state and local laws, ordinances and rules governing the jurisdiction in which they practice. 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.

## **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 service

## **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/assessment, 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 assessment 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 screening. (Psychosocial Screening/Screening 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.

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

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

<b>Stages of Change</b>	<b>Goals</b>	<b>Strategies</b>	<b>Example Language</b>
<b>Pre-contemplation: Not thinking of change</b>	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.
<b>Contemplation: Thinking about change</b>	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?
<b>Preparation: Preparing for change</b>	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?
<b>Action: Changing behavior</b>	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?
<b>Maintenance: Maintaining change and preventing relapse</b>	Sustain gains made 1) Help client stay focused 2) Reduce chance of relapse 3) Normalize relapse.	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....?

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## 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 trauma informed care and to apply a Universal Precautions approach in work with clients. In the context of trauma informed care, universal precautions means assuming that all individuals presenting for services have experienced or been exposed to trauma and may have symptoms from this exposure that are not immediately obvious.

Briefly, a trauma informed system believes 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 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.
4. All clients must have an identified medical insurance provider documented in their client record or clear documentation in the CAREWare case notes about why this program expectation was not met and what is being done to accomplish this priority.
5. 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.

## **Transitional Case Management**

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

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

## HIV Case Management Standards

These standards are intended to provide direction to the practice of county based HIV Case Management in 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
- Triage
- Acuity Assignment
- Care Planning
- Referral and Advocacy
- Case Conference
- Follow-up and Monitoring
- Assessment/Screening
- 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

Each prospective client who requests HIV Case Management Services will receive a comprehensive intake process in order 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.

- A copy of the **HIV Care and Treatment Program Information Sheet** (OHA provided) must be provided to each client so they are made aware of the various data requirements associated with the program.
- The client's **Informed Consent** (agency provided) to participate in the case management program should be obtained at this time.

- Clients should understand the **Grievance Procedure** (agency provided) 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.
- A **Release of Information** form (agency provided) (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 assessment, it is expected that a Release of Information will be obtained annually. Part of the discussion should include information about the intent of the Release of Information, its components, and ways the client can nullify it. Clients should be informed of their right to **Confidentiality**. It is important not to assume that anyone - even a client's partner or family member - knows that the client is HIV positive. Part of this discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone, etc.) Case managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual has HIV or receiving social services.
- **Client's Rights and Responsibilities** (agency provided) form. The case manager reviews client rights and program responsibilities as part of the overall discussion of a client's participation in the case management system (in accordance with ORS 431.250, and 431.830). 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 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 request. 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. 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.
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.

<b>Documentation &amp; CAREWare Entry</b>	
Paper Forms	Information collected during intake should be documented on the <b>Intake/Eligibility Review Form</b> .
Create CAREWare Record	Create the CAREWare record at the time of Intake. The official enrollment date will be <b>the date informed consent was received</b> .
Demographics	Complete the Demographics tab.
Annual Review	Complete the Annual Review tabs.
Services	Enter staff time under “Intake/Eligibility Review”.
Case Notes	Enter a case note for every client contact.
Attachments	Intake forms may be uploaded on the attachment tab.
Referrals	If referral was made, it should be documented in referral tab.
Contacts/ROI	Any Contacts collected must be entered under the Contacts/ROI tab, and ROIs uploaded as appropriate.

## Annual Eligibility Review, Semi-annual Eligibility Review and Self-Attestation

Eligibility must be verified every 6 months while the client is actively engaged in Ryan White services.
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### Process

1. Clients are required to complete a full update annually from the date of enrollment. 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 Client Eligibility Review can be submitted as verification of eligibility. 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.
2. While a full eligibility review is required every year, self-attestation may be used every 6 months.
  - a. For clients who are enrolled in CAREAssist, the Six Month Self-Attestation form and a copy of the CAREAssist Eligibility Report should be printed for the file as documentation of eligibility.
  - b. 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.

<b>Documentation &amp; CAREWare Entry</b>	
Paper Forms	As appropriate, the CAREAssist Eligibility Report, Self-Attestation Form, and/or appropriate documentation should be included in the client file.
Demographics	Update the Demographics tab as needed.
Annual Review	Update the Annual Review tab as needed.
Services	Enter staff time under “Intake/Eligibility Review” using 15 minute unit.
Case Notes	Enter case note and any other relevant data.

## **Triage**

Clients with acuity 1 may complete a triage at the time of the annual update.

### **Purpose**

The triage is a process used for very low acuity clients to determine if there are existing or emerging needs and identify clients who may need a full screening or assessment.

### **Process**

1. The triage should be completed at the same time, and in conjunction with, the annual update and eligibility review.
2. Verify that client was an acuity 1 at last evaluation, and that there is evidence in CAREWare of a viral load lab test in the last 365 days. If there is no evidence of a viral load lab within the past year, OR the last viral load lab was unsuppressed (>200 copies/mL), OR there is any other indication from the Case Notes that the client should have a full, in-person screening and/or assessment, the triage should not be used. If the client's last viral load was unsuppressed, the client should be assigned an Acuity 3 and follow-up provided accordingly.
3. The triage can be administered by mail, email or phone. If using triage by mail, a letter describing the purpose and directions for completing the triage should be enclosed, along with a self-addressed stamped envelope. The client should be asked to return the form within 7 – 10 business days. If the client has not responded within 7 – to 10 business days, phone based follow-up should occur to ensure client received and understood form.
4. If client responds positively (yes to "1 or more"), follow-up should be provided within 7 days to determine whether a full, in person screening and/or assessment is warranted.
5. All clients are required to have a full screening and assessment at least once every 3 years.

<b>Documentation &amp; CAREWare Entry</b>	
Paper Forms	Completed triage form should be saved in paper client file and/or uploaded into CAREWare.
Services	Enter staff time under “Triage” using 15 minute unit.
Case Notes	Enter case note, using the triage case note template. Case note should document both justification for use of triage and any outcomes of the completed triage process.

## **Psychosocial Screening and Nurse Assessment**

Upon intake, and annually thereafter, case management client with acuity 2, 3, and 4 will participate in a face-to-face psychosocial screening and a face-to-face 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 working days following Intake and should be completed within two weeks. 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 should be completed by the appropriate parties and performed in accordance with the standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements.

3. Screening and assessment 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.
4. The process of screening and assessment 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 screening and assessment 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 screening/assessment process.
5. Ongoing clients should be assessed annually to identify unresolved and or emerging needs, guide appropriate revisions to the care plan, and inform decision making regarding discharge from case management services and/or transition to other appropriate services. Clients may be screened or assessed more frequently in the event of significant changes in the client's life that may result in a different acuity or significant update to the care plan. **Clients with an acuity 1 are required to have a full screening and assessment at least once every 3 years.**

<b>Documentation &amp; CAREWare Data Entry</b>	
Paper Forms	Document assessment and screening using the Nurse Assessment Form and Psychosocial Screening Form.
<b>Demographics</b>	<b>HIV Status and Risk Factor must be indicated on demographics tab.</b>
Annual Review	The Screening will reassess information previously collected, which may include changes to the client's housing arrangement, health insurance or income. This information must be entered and updated under the Annual Review tab. Mental health and substance use fields should now be updated based on outcome of screening.

	<ul style="list-style-type: none"> <li>o Mental Health Yes – Client offered referral at last screening. No – Client not offered referral at last screening. Not medically indicated – Do not use.</li> <li>o Substance Use Yes – AUDIT and/or DAST used at last screening. No – Neither AUDIT nor DAST used at last screening. Not medically indicated – Do not use.</li> </ul>
Services	Time associated with the completion of the Psychosocial Screening Form must be entered as a “Screening” and/or “Assessment”. This includes time associated with documentation and the collection of information from the client of other sources.
Case Notes	Documentation of the screening and assessment process, findings, recommendations, and referrals must be entered in the case notes using the “Screening” and “Assessment” templates.
Contacts/ROI	If the screening process includes the collection of any client Contacts they must be entered under the Contacts/ROI tab.
Attachments	Screening and Assessment forms may be uploaded under this tab.
Referrals	Referrals provided during the screening process must be documented under the Referrals tab.

## 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 an Assessment or Screening unless it has been longer than a year since the last Assessment, or the client's annual RN assessment is due within 30 days.
3. If any of the following conditions apply, the acuity is automatically a 4 and should be reassessed in 60 days: incarcerated within the last 90 days, diagnosed with HIV in the last 180 days, or currently homeless.
4. If client is virally unsuppressed ( $>200$  copies/mL) at last HIV viral load, or it has been more than 12 months since last reported viral load, the nurse acuity level is automatically 3 and the acuity must be reassessed in 60 days.
5. Follow up and monitoring guidelines are determined by the assigned acuity level. See following table.

## Acuity Level Guidelines

Level	Guidelines
<b>Level 1: 13 – 22 points</b>	<ul style="list-style-type: none"> <li>• Annual update.</li> <li>• Eligibility verified every 6 months.</li> <li>• Annual triage</li> <li>• Minimum contact (telephone or face-to-face) every 6 months to check on client’s current status.</li> <li>• Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 6 months</li> </ul>
<b>Level 2: 23 – 42 points</b>	<ul style="list-style-type: none"> <li>• Annual update.</li> <li>• Eligibility verified every 6 months.</li> <li>• Annual face-to-face nursing assessment and psychosocial re-screening.</li> <li>• Minimum contact (telephone or face-to-face) every 6 months to check on client’s current status.</li> <li>• Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 6 months</li> </ul>
<b>Level 3: 43 – 63 points</b>	<ul style="list-style-type: none"> <li>• Annual update</li> <li>• Eligibility verified every 6 months.</li> <li>• Annual face-to-face nursing assessment and psychosocial screening.</li> <li>• Minimum contact (telephone or face-to-face) every 30 days.</li> <li>• Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 6 months</li> <li>• Case Conferencing recommended every 30 days.</li> </ul>
<b>Level 4: 64 – 84 points</b>	<ul style="list-style-type: none"> <li>• Annual update</li> <li>• Eligibility verified every 6 months.</li> <li>• Annual face-to-face nursing assessment and psychosocial rescreening.</li> <li>• Minimum contact (telephone or face-to-face) every 2 weeks.</li> <li>• Care Plan developed, appropriate interventions identified and ongoing follow-up provided every 6 months</li> <li>• Case Conferencing recommended every 2 weeks.</li> </ul>

## Documentation

<b>Documentation &amp; CAREWare Data Entry</b>	
Paper Forms	Medical and psychosocial acuity forms may be completed and placed in the client file.
Forms	Acuity data will be entered in the “Acuity Form” and automatically imported into the Encounters tab.
Services	<p>When the acuity is updated in connection with completing a full Screening or Assessment, the service will be entered using the “Screening” or “Assessment” service.</p> <p>When the acuity is changed outside of a screening or assessment, “Case Management” should be used to record the service.</p>
Case Notes	A case note should be made in accordance with the service. If an acuity change is made without a full screening or assessment, the “Acuity Change” case notes template must be completed documenting the reasons for the change.

## Care Plan

Every client in HIV Case Management will have a comprehensive, individualized Care Plan that is reviewed and updated every 6 months at a minimum.

### Purpose

The Care Plan 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 activities 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.
2. 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.
3. 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. The Care Plan should be monitored to coordinate services, implement the plan, assess the efficacy of the plan, and provide periodic evaluation and adaptation according to the Acuity Standards.

7. 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.

8. The method for Care Plan documentation should be identified in agency policy and procedure. The Care Plan can be stored in either CAREWare or paper form. At a minimum, the Care Plan should include the client's name, goals, the specific activities for completing the goal, the person responsible for completing the activity, proposed deadline, any required referrals, status of both activities and overall goals, and date of most recent update. A copy of the Care Plan **should be offered** to the client at every update. Documentation includes CAREWare Case Notes that Care Plan has been reviewed, CAREWare referrals as appropriate and CAREWare services. If care plan document is not in CAREWare, an uploaded copy is recommended.

<b>Documentation &amp; CAREWare Data Entry</b>	
Services	Time associated with care planning should be recorded as “Care Plan”
Case Notes	Care Planning should be documented in the case notes. A Care Plan template is available in the case notes feature.

## 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 & CAREWare Data Entry	
Services	Time associated with referrals and/or advocacy must be entered as “Case Management”.
Case Notes	Documentation of client contact or contacts made on the client’s behalf must be documented in the case notes.
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. See <a href="#">CAREWare User Guide</a> or <a href="#">Referral Quick Guide</a> for more information. All referrals entered require a final status within 6 months from initial date of referral.</p> <ul style="list-style-type: none"> <li>• Pending – Status of all new referrals. If referral is pending, follow up with the client every two weeks with regards to the status of the referral.</li> <li>• Completed – When you have evidence that client has made initial contact with the agency to which you referred the client.</li> <li>• Lost to Follow up – After a reasonable amount of time, or a maximum of 3 months, during which time you have been unable to verify the outcome of the referral.</li> <li>• Rejected – If at any point in the referral process, the client informs you that they no longer need or desire the referral you provided.</li> </ul>

## 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 by Acuity.

### 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 care 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.

<b>Documentation &amp; CAREWare Data Entry</b>	
Demographic	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 the demographic tabs.
Annual Review	The annual review tab should be updated as appropriate.
Services	Time associated with follow up and monitoring must be entered as a service under: “Case Management”.
Case Notes	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.

## Case Conferencing

Case managers are required to case conference for clients who are an acuity 3 or 4, in accordance with the standards.

### Purpose

Ongoing communication and case conferencing happens as part of coordinating client care. Case conferencing is a formal, planned, structured activity, separate from routine contact, which 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 a Care Plan. Regular case conferences are strongly encouraged for clients who are virally unsuppressed, newly diagnosed, or have high overall acuity or in life areas of housing, mental health and substance use.

### Process

1. Case conferences can be internal to your agency, external to your organization (OHOP, CAREAssist, MDs, pharmacist, parole officers, mental health providers, caregivers, etc.) or a combination of both.
2. The frequency of case conferencing is dependent upon the client's acuity. A case conference (either internal or external) is recommended at least once every 30 days for acuity 3s and once every 2 weeks for acuity 4s.
3. It is the MCM's responsibility to schedule and document the Case Conference, and update the Care Plan as necessary.
4. When appropriate, the client should be involved in the case conference.

<b>Documentation &amp; CAREWare Data Entry</b>	
Paper Form	Case conferencing activity should be documented on the Case Conference form.
Services	Time associated with the case conferencing must be entered as “Case Conference”
Case Notes	Documentation of the case conference must be entered in the case notes. The case conference template may be used.

## **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/Assessment Form, Nurse Assessment/Assessment Form, HIV verification documentation and physician's notes (if applicable) should be sent via fax or mail to the new case management program. Case notes from the previous provider are viewable once client is active in new case management domain of CAREWare.

4. 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 6 attempts to contact the client over a period of 60 days, with no response from the client. A minimum of 4 different communication methods must be used. These methods may include, but are not limited to: phone calls, text messages, certified letters, email, home visits, and/or information provided by medical providers, pharmacists, emergency contacts, social media sites, jail rosters, CAREAssist, and OHOP. Communication methods must be consistent with local case management agency policy and procedure. In cases where there has been no response from the client after 60 days, a certified letter indicating intent to close out the client file 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. The letter should inform the client of the grievance and hearing options, as well as requirements for their return to case management services.

4. CAREAssist and/or OHOP should be notified of change in client status as necessary.

<b>Documentation &amp; CAREWare Data Entry</b>	
Demographics	<p>Information on demographics tab should be up to date prior to closing client. Ensure enrollment status is documented appropriately with a case closed date.</p> <ul style="list-style-type: none"> <li>• Referred or discharged indicates that you have               <ul style="list-style-type: none"> <li>○ Referred the client to another Part B funded provider.</li> <li>○ Closed the client because he/she requested closure from case management.</li> <li>○ Lost contact with a client and they are considered to be "lost to follow up".</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Been notified that client is deceased.</li> <li>• Removed indicates that the client was removed from your agency due to violation of rules.</li> <li>• Incarcerated indicates that the client is serving a criminal sentence in a correctional institution (prison or jail)</li> <li>• Relocated indicates that the client has moved out of the Part B Service area (to the Part A service area/Portland metro area or out of state or country).</li> </ul>
Annual Review	Ensure information on annual review tab is as up to date as possible.
Services	Time associated with Transfer and Discharge must be must be entered as “Transfer/Discharge”.
Case Notes	Documentation of the service includes a case note summarizing the effort made to contact the client through use of the Lost to Follow up template, and a note that CAREAssist has been notified of the change in the client's status.
Referrals	All Pending referrals should be closed accordingly.

## **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, have difficulty getting to the case manager’s office, or who have been non-responsive to case management requests. 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: 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 B: 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