

# **HIV CASE MANAGEMENT AND SUPPORT SERVICES PROGRAM**

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## **FY 2010 REPORTING PACKAGE**



## HIV CASE MANAGEMENT AND SUPPORT SERVICES PROGRAM FY 2010 REQUIRED REPORTS

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Contract agencies will not be required to run RW CAREWare generated reports; however, users are required to enter all demographic, service and clinical data fields within 30 days of the date of service.

### Reporting Calendar

REQUIRED REPORTS	DESCRIPTION	PERIOD	DUE DATE	SUBMIT TO
Quarterly Report Narrative Report Administrative Fiscal Form	1. Narrative Report: Written evaluation of the agency's success/barriers. 2. Administrative Fiscal Form: Includes administrative and service expenditures.	1. 7/1/09-9/30/09 2. 10/1/09-12/31/09 3. 1/1/10 - 03/31/10 4. 4/1/10 - 06/30/10	1. October 31, 2009 2. January 31, 2010 3. April 30, 2010 4. July 31, 2010	<i>Submit by:</i> <i>e-mail, fax, or hard copy</i>  Karen Smith DHS, Grants Assistant 800 NE Oregon St. #1105 Portland, OR 97232 Fax: 971-673-0177 <a href="mailto:karen.l.smith@state.or.us">karen.l.smith@state.or.us</a>
Quality Improvement: Client File Review 2009 Summary Report	Details the local client file review results.	2009 Annual Chart Review	October 31, 2009	<i>Submit by:</i> <i>e-mail, fax, or hard copy</i>  Karen Smith DHS, Grants Assistant 800 NE Oregon St. #1105 Portland, OR 97232 Fax: 971-673-0177 <a href="mailto:karen.l.smith@state.or.us">karen.l.smith@state.or.us</a>

CAREWare Tab [Subtab]	RW CAREWare Required Data Entry Fields
<b><u>Demographic</u></b>	<ol style="list-style-type: none"> <li>1. <i>Full Legal Name*</i></li> <li>2. <i>Date of Birth*</i></li> <li>3. <i>Ethnicity*</i></li> <li>4. <i>Race*</i></li> <li>5. <i>Gender*</i></li> <li>6. <i>Zip Code*</i></li> <li>7. <i>County</i></li> <li>8. <i>HIV Risk Factor*</i></li> <li>9. <i>HIV Status*</i></li> <li>10. <i>HIV Date*</i></li> <li>11. <i>AIDS Date* (if HIV Status is set to "CDC-defined AIDS")</i></li> </ol>
<b><u>Service</u></b>	<ol style="list-style-type: none"> <li>1. <i>Vital Status*</i></li> <li>2. Enrollment Status</li> <li>3. Enrollment Date</li> <li>4. For each service entered you must complete the following: <ol style="list-style-type: none"> <li>a. Date of service</li> <li>b. Service Name (select the appropriate sub-service)</li> <li>c. Contract that funds the service provided (should default to Part B)</li> <li>d. Units (# of service units provided)</li> <li>e. Price (not required for case management services)</li> </ol> </li> </ol>
<b><u>Annual Review:</u></b> <b><u>[Annual &amp; Quarters 1-4]</u></b>	<ol style="list-style-type: none"> <li>1. <i>Primary Insurance*</i></li> <li>2. <i>Housing/Living Arrangement*</i></li> <li>3. <i>Client's Annual Household Income*</i></li> <li>4. <i># of people residing in client's household*</i></li> <li>5. <i>Poverty level (CW automatically calculates)*</i></li> </ol>
<b><u>Encounters:</u></b> <b><u>[Labs]</u></b>	<p>For all lab tests enter these values:</p> <ol style="list-style-type: none"> <li>1. Test name (e.g. CD4 count)</li> <li>2. Date (using Rapid Entry)</li> <li>3. Operand (e.g. =)</li> <li>4. Result</li> <li>5. Assay (if applicable)</li> </ol> <p>Tests and values that should be entered include:</p> <ol style="list-style-type: none"> <li>1. CD 4</li> <li>2. Viral Load</li> <li>3. Acuity Level</li> <li>4. Acuity Score</li> <li>5. Adherence Level</li> </ol>

*\* The values in these fields can be overwritten by another Part B-funded agency that serves the client at the same time or after the client is served at your agency.*

# HIV Case Management and Support Services Program

## FY 2010 Quarterly Reports

### Instructions

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Quarterly Reports will be submitted by e-mail, fax or hard copy to:

**Karen Smith**  
**DHS, Grants Assistant**  
**800 NE Oregon St. #1105**  
**Portland, OR 97232**  
**Fax: 971-673-0177**  
[karen.l.smith@state.or.us](mailto:karen.l.smith@state.or.us)

Quarterly Reports are due:

- ❖ October 31, 2009 for the period 7/1/09-9/30/09
- ❖ January 31, 2010 for the period 10/1/09-12/31/09
- ❖ April 30, 2010 for the period 1/1/10-3/31/10
- ❖ July 31, 2010 for the period 4/1/10-6/30/10

The Quarterly Report consists of two parts. Part 1: Narrative Report, which includes an evaluation of the agency's successes and barriers. Part 2: Administrative Fiscal Form, consists of a form that will be completed by your fiscal/business department (in smaller counties this may or may not be a different person).

#### **PART 1: NARRATIVE REPORT**

Chronic disease management is an approach to health care that involves supporting individuals to maintain independence and to keep as healthy as possible through early detection and effective management of chronic conditions to prevent deterioration, reduce risk of complications, prevent associated illnesses and enable people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes and access appropriate support are all factors that influence successful management of an ongoing illness. People with HIV disease need support and information to become effective managers of their own health. Chronic conditions require not just medical interventions, but behavioral intervention as well. Clients with chronic conditions such as HIV disease play a large role in managing their conditions. Each client is at a different place in the process, and appropriate interventions are driven, to a large extent, by each client's desired outcomes. In order to meet identified needs case managers assist clients in setting self-management goals. In question 1 please describe the kinds of activities your clients are currently undertaking as a part of their documented Care Plans.

Additionally, please answer the remaining questions describing your experiences/challenges providing case management this quarter.

## PART 2: ADMINISTRATIVE FISCAL FORM

### I. CONTACT INFORMATION

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

### II. CASE MANAGEMENT:

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

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

1. Direct Services (Salaries) – case management: Enter the case management staff costs. This includes wages/salaries, fringe.
2. Direct Services (Salaries) – non-case management: This may include staff salaries and fringe benefits for receptionist, file clerk, direct service supervisory staff, etc.
3. Direct Program Costs: This may include materials, equipment and supplies directly related to the provision of case management.
4. Sub-Contracted Services: Includes the total for contracts covering provision of an approved service such as: a community based organization (CBO) providing case management services.
5. Administrative Costs: Rate % (Administrative Cap is 10%): *Indirect and Overhead costs are identified under Administrative costs in the Part B guidance from HRSA.* Administrative costs associated with the 10% cap include:
  - Depreciation or use allowance on buildings and equipment.
  - Operating and maintaining facilities.
  - General administration and general expenses, such as the salaries and expenses of executive officers, personnel administration, and accounting.
  - Overhead and indirect costs
  - Management and oversight activities of specific programs under Title II where the activities cannot be directly related to the delivery of services.

Administrative costs may also include fiscal services, payroll, program supplies, training (not sponsored by the HIV Case Management and Support Services Program) and routine agency charges for IS and other automatic agency required charge-backs. This category also includes any Indirect Charges which are defined as: any costs incurred for common or joint purposes that benefit more than one project, service, program or other distinct activity of an organization and cannot be readily identified with any one of them.

6. Total of 1-4: Total columns 1-5 (case management).

Under the column titled “**Year to Date (includes current reporting quarter)**” enter the expenses from the beginning of the fiscal year (July 1, 2009) to current quarter you are reporting.

### **III. SUPPORT SERVICES (all services excluding Case Management)**

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

1. Direct Client Services: This includes any service provided to a client, such as drug reimbursement, transportation, food cards, etc. It is not necessary to include detail of purchased service provided in this part of the fiscal report.
2. Sub-Contracted Services: Includes the total for contracts covering provision of an approved service such as: a fiscal agent paying for services provided outside the host agency, and other services which are provided on an ongoing basis.
3. Administrative costs: Rate % (Administrative Cap is 10%): Indirect and Overhead costs are identified under Administrative costs in the Part B guidance from HRSA. Administrative costs may also include fiscal services, payroll, program supplies, training (not sponsored by the HIV Case Management and Support Services Program) and routine agency charges for IS and other automatic agency required charge-backs. This category also includes any Indirect Charges which are defined as: any costs incurred for common or joint purposes that benefit more than one project, service, program or other distinct activity of an organization and cannot be readily identified with any one of them.
4. Total of 1-3: Total columns 1-3 (support services)

Under the column titled “**Year to Date (includes current reporting quarter)**” enter the expenses from the beginning of the fiscal year (July 1, 2009) to current quarter you are reporting.

**IMPORTANT: It is expected that total expenditures reported will match the data entered into RW CAREWare plus the units reported in Part 1- question 5 of this report (includes both case management and support services). Please explain any discrepancies.**

# HIV Case Management and Support Services Program

## FY 2010 QUARTERLY REPORT FORM

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**FY 2010 quarterly reports will be submitted to the HIV Case Management and Support Services Program no later than October 31, 2009, January 31, 2010, April 30, 2010 and July 31, 2010.**

Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Submitted By: \_\_\_\_\_

- Quarter 1 (due 10/31/09)
- Quarter 2 (due 01/31/10)
- Quarter 3 (due 04/30/10)
- Quarter 4 (due 07/31/10)

### **PART I: NARRATIVE REPORT**

1. HIV case management programs are looking at more ways to encourage clients to develop self-management skills. Looking at your caseload as a whole, please list the self-management activities your clients are currently undertaking as a part of a documented Care Plan.

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2. What significant successes have you had in this reporting period?

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3. What barriers to client participation in HIV care and treatment have you identified during this reporting period?

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4. Have there been any changes to the availability of services to clients in this reporting period (i.e. staff turnover, work load/hours of case management allocated)? For vacant position(s), provide an expected date when position(s) will be filled and include a description of your temporary staffing plan.

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5. How many case management units were spent conducting HIV Case Management and Support Services related work that cannot be linked to individual client(s). This time may include time spent in related meetings and trainings or administrative time that is conducted on behalf of all clients. **NOTE: Do not report this time if already entered into CAREWare. Do not double report units of service. You must enter client level data into CAREWare.** (1 unit= 15 minutes)

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6. Did you identify any technical assistance needs this quarter?

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**PART 2: ADMINISTRATIVE FISCAL FORM- FY 2010**

<b>I. CONTACT INFORMATION</b>		Page 1 of 1
1. Agency Name:	2. Phone Number:	3. Date Prepared:
4. Street Address, City, State and Zip Code	5. Contact Person:  Title:  e-mail:	6. Quarter #:
<b>II. Case Management</b>		
Fiscal Services- Expenditures	Current <u>Quarter</u> Expenses	Year To Date (beginning July 1, 2009)
1. Direct Services (Salaries) <b>case management</b>		
2. Direct Services (Salaries) <b>non-case management staff</b>		
3. Direct Program Costs		
4. Sub-Contracted Services		
5. Administrative Costs: Rate % (Administrative 10% Cap)		
<b>6. Total of 1-5 (case management)</b>		
<b>III. SUPPORT SERVICES</b>		
	Current <u>Quarter</u> Expenses	Year To Date (beginning July 1, 2009)
1. Direct Client Services <b>actual support services expenditures</b>		
2. Sub-Contracted Services		
3. Administrative Costs: Rate % (Administrative 10% Cap)		
<b>4. Total of 1-3 (support services)</b>		

**IMPORTANT:** It is expected that total expenditures reported will match the data entered into RW CAREWare plus the units reported in Part 1- question 5 of this report (includes both case management and support services). Please explain any discrepancies:

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# HIV Case Management Quality Improvement Program

## Client File Review

### Instructions

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Client File Review Summary Report will be submitted by e-mail, fax or hard copy to:

Karen Smith  
DHS, Grants Assistant  
800 NE Oregon St. #1105  
Portland, OR 97232  
Fax: 971-673-0177  
[karen.l.smith@state.or.us](mailto:karen.l.smith@state.or.us)

Client File Review Summary Report is Due: October 31, 2009

In an ongoing effort to improve the quality of HIV services funded by the Ryan White Program the HIV Case Management and Support Services Program requires all contract agencies to conduct an internal Client File Review annually. This local review provides an opportunity for the local programs to monitor their own performance and to make improvements based on their findings. While the review is required, at a minimum, annually, it is a process that benefits program quality when used consistently and regularly. Local programs are encouraged to integrate quality review activities into their agency Quality Improvement Plan.

- Select reviewer(s) who are not the HIV Case Manager(s). A reviewer could be the program supervisor or anyone who does not document in the HIV client files. In the case of subcontractors, the reviewer must be from the contracting agency.
- Use the “Client File Review Checklist” to review each client file (make copies of the master).
- **The reviewer will randomly select active client files to be reviewed.** Agencies must review a minimum of 10 HIV case management program client files or 25% of the total HIV Case Management program client files, whichever is more. Agencies with 10 or fewer clients in the HIV case management program will review 100% of the files.
- Use the “Client File Review Summary Report” to report the totals from the individual checklists after the file review. Total the “yes” and “no” responses from the individual checklist forms and write the numbers into the appropriate line on the form. The Summary Report is the only form to be submitted to the HIV Case Management and Support Services Program.
- “Current” refers to the past 365 days (12 months) unless otherwise stated.

**FILE #** \_\_\_\_\_

**Client File Review Checklist**  
(Use a separate checklist form for each file)

**AGENCY:** \_\_\_\_\_ **DATE OF REVIEW:** \_\_\_\_\_

**REVIEWER:** \_\_\_\_\_  
(Name and Title)

(Check One:)

	<b>Yes</b>	<b>No</b>	<b>Comments:</b>
<b>INTAKE</b>			
Date of Intake documented on the Program Requirements Checklist.			
Current client Intake/Update form completely filled out - to include complete demographic data and information.			
HIV status verified on Program Requirements Checklist.			
HIV status verified within 30 days of Intake (for new clients in past 2 years only).			
Current income verified and FPL calculated. FPL and date entered on Program Requirements Checklist.			
Current Release of Information (ROI) signed, dated and documented on Program Requirements Checklist. (Current = agency written policy on frequency of updating the ROI.)			
Client Rights & Responsibilities signed and dated by client and CM and documented on Program Requirements Checklist.			
Informed Consent signed and documented on Program Requirements Checklist.			
Documentation of client notification about Client Grievance process on Program Requirements Checklist.			
<b>ASSESSMENT/REASSESSMENT</b>			
Psychosocial Screening or Current Re-Screening form completed, dated and signed.			
Nurse Assessment or Current Nurse Reassessment form completed, dated and signed.			
Acuity Scale Worksheet has been completed, dated and signed – date matches the date of the last assessment/reassessment.			Acuity Level: _____
Acuity Level 3 and 4 clients have an RN signature on the most current Acuity Scale Worksheet.			
<b>CARE PLAN</b>			
Care Plan Form includes:			
a. Medical Case Management Goals			
b. Psychosocial Case Management Goals			
c. Assigned activities			
d. Outcomes			
e. One self-management goal identified			

f. Documentation that self-management goal completed			
Progress notes include:			
a. Dates of contact (day, month & year)			
b. Any action resulting			
c. Case manager signature for each contact			
Referral information and dates are documented in progress notes			
Referrals documented also have follow-up and outcomes documented in progress notes. (Select 3 referrals documented in progress notes to determine if follow-up happened for those three referrals.)			
A current Housing Plan is in the chart (if there is a referral to a Housing Coordinator.)			
<b>CLINICAL INDICATOR INFORMATION</b>			
Copy of lab work attached with current values?			Date:
Most current CD4 and VL lab values documented on Program Requirements Checklist?			
<b>CAREWARE QUALITY MANAGEMENT</b>			
Client file information matches information entered into CAREWare:			
a. HIV/AIDS Status			
b. Primary Insurance Provider			
c. Primary Medical Care			
d. Acuity Level			
e. Acuity Points			
f. Adherence Acuity Stage			
g. Adherence Acuity Points			
h. CD4/Viral Load			
Full legal name is entered into CAREWare.			
Service entries in CAREWare match client file progress notes. <i>(Randomly select 5 progress notes in the client file and match to electronic data entered in CAREWare to review accuracy of service data entered.)</i>	Date service entry reviewed: 1. 2. 3. 4. 5.	# of units entered into CAREWare: 1. 2. 3. 4. 5.	Did the service entry match the progress notes in the chart (Y/N)? 1. 2. 3. 4. 5.

**HIV Case Management Quality Improvement  
Client File Review  
Summary Report**

**AGENCY:** \_\_\_\_\_ **DATE OF REVIEW:** \_\_\_\_\_

**REVIEWER:** \_\_\_\_\_  
(Name and Title)

<b>Total number of client files reviewed:</b> _____	<b>Total # “YES”</b>	<b>Total # “NO”</b>
<b>INTAKE</b>		
Date of Intake documented on the Program Requirements Checklist.		
Current client Intake/Update form completely filled out - to include complete demographic data and information.		
HIV status verified on Program Requirements Checklist.		
HIV status verified within 30 days of Intake (for new clients in past 2 years only).		
Current income verified and FPL calculated. FPL and date entered on Program Requirements Checklist.		
Current Release of Information (ROI) signed, dated and documented on Program Requirements Checklist.		
Client Rights & Responsibilities signed and dated by client and CM and documented on Program Requirements Checklist.		
Informed Consent signed and documented on Program Requirements Checklist.		
Documentation of client notification about Client Grievance process on Program Requirements Checklist.		
<b>ASSESSMENT/REASSESSMENT</b>		
Psychosocial Screening or Current Re-Screening form completed, dated and signed.		
Nurse Assessment or Current Nurse Reassessment form completed, dated and signed.		
Acuity Scale Worksheet has been completed, dated and signed – date matches the date of the last assessment/reassessment.		
Acuity Levels (total for each level): # Level 1 _____ #Level 2 _____ #Level 3 _____ #Level 4 _____		
Acuity Level 3 and 4 clients have an RN signature on the most current Acuity Scale Worksheet.		
<b>CARE PLAN</b>		
Care Plan Form includes:		
a. Medical Case Management Goals		
b. Psychosocial Case Management Goals		
c. Assigned activities		
d. Outcomes		

e. One self-management goal identified		
f. Documentation that self-management goal completed		
Progress notes include:		
a. Dates of contact (day, month & year)		
b. Any action resulting		
c. Case manager signature for each contact		
Referral information and dates are documented in progress notes.		
Referrals documented also have follow-up and outcomes documented in progress notes. (Select 3 referrals documented in progress notes to determine if follow-up happened for those three referrals.)		
A current Housing Plan is in the chart (if there is a referral to a Housing Coordinator.)		
<b>CLINICAL INDICATOR INFORMATION</b>		
Copy of lab work attached with current values? # files with copy of current lab work: _____ # files with copy of lab work more than one year old: _____ # files with no copy of lab work: _____		
Current CD4 and VL lab values documented on Program Requirements Checklist?		
<b>CAREWARE QUALITY MANAGEMENT</b>		
Total number of active clients in CAREWare: _____		
Client file information matches information entered into CAREWare:		
a. HIV/AIDS Status		
b. Primary Insurance Provider		
c. Primary Medical Care		
d. Acuity Level		
e. Acuity Points		
f. Adherence Acuity Stage		
g. Adherence Acuity Points		
h. CD4/Viral Load		
Full legal name is entered into CAREWare		
Service entries in CAREWare match client file progress notes.	Total # of entries reviewed:	Total # that matched electronic file:

**Additional Reviewer comments:**