CARE COORDINATION FOR PEOPLE WITH HIV

PROGRAM MANUAL

Version 5.0

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Bureau of HIV/AIDS Prevention and Control
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POLICIES

- All HIV-infected persons, also referred to as Persons Living With HIV/AIDS (PLWHA), in NYC should have access to:
  - Comprehensive and holistic healthcare situated in a medical home as defined by the American College of Physicians[1]; and
  - Health promotion to promote self-sufficiency, optimal health and risk reduction.

- As needed, PLWHA should receive assistance:
  - Navigating the healthcare and social services systems;
  - Coordinating logistics such as transportation and childcare to ensure that they have ready access to their care providers;
  - Reviewing their eligibility for government-funded benefits and programs to provide the best possible financial assistance, medical insurance and stable housing; and
  - Overcoming personal and contextual barriers to antiretroviral treatment (ART) adherence.

- All PLWHA could expect that critical health information is available to providers when PLWHA need it, and that adequate security measures are in place to safeguard PLWHA confidentiality.

BACKGROUND

In the United States, the CDC estimates that 1,201,100 persons aged 13 years and older are living with HIV infection, including 168,300 (14.0%) who are unaware of their infection.[2] New York City (NYC) continues to be at the epicenter of the U.S. epidemic, with 117,618 New Yorkers reported with HIV/AIDS as of December 31, 2013.[3] While advances in medical care for PLWHA have been significant, disparities exist in health care access and health outcomes for PLWHAs. Factors associated with poorer health outcomes include

[1] American College of Physicians. Website: http://www.acponline.org. Accessed Mar. 26, 2015.
[2] CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2012. *HIV Surveillance Supplemental Report* 2014;19(No.3). Published November 2014. http://www.cdc.gov/hiv/statistics/basics/ataglance.html. Accessed Mar.26, 2015.
[3] New York City HIV/AIDS Annual Surveillance Statistics. New York: New York City Department of Health and Mental Hygiene, 2015. Updated January 2015. Website: http://www.nyc.gov/html/doh/downloads/pdf/ah/surveillance2013-table-all.pdf. Accessed Mar.26, 2015.

belonging to a racial/ethnic minority group, being an injection drug user, having a mental illness, being of a lower socioeconomic status, and being from other high-risk groups.[4,5,6,7] Many of these factors coexist among persons from racial/ethnic minority groups in NYC and accordingly these groups are more likely to be out of care and access care later.[8] These factors make the facilitation of access to and maintenance in HIV primary care a priority.

In the past decade, advances in HIV/AIDS treatment have resulted in lower mortality and longer life expectancy for PLWHA.[9] Greater disease prevalence in turn places greater demands on the HIV care system. At the individual level HIV/AIDS has evolved into a chronic illness; this requires a broad range of specialized services to meet patients' needs and the development of skills among patients to better facilitate self-management of HIV infection.

Despite advances in treatment and increased life expectancy for PLWHA, HIV treatment remains challenging. A high level of adherence to ART is needed to achieve viral load suppression.[10,11] A suppressed viral load is associated with better health outcomes and reduced potential for HIV transmission per risk encounter. The high adherence requirements of ART and the lifelong nature of HIV treatment are difficult and best met by those in stable life situations or with strong support systems.[12,13] Golin et al. documented a mean ART adherence of 71% in a prospective study, demonstrating the critical need for ART adherence support.[14]

The complexity of HIV/AIDS-related services makes navigation of the system(s) and accessing services difficult for those who are unaccustomed to the system. The New York City Department of Health and Mental Hygiene (NYC DOHMH) Care Coordination Program (hereafter referred to as the "Program") seeks to address HIV/AIDS healthcare disparities by facilitating access to care and other services via medical case management, navigation, promotion of self-reliance and patient education. It aims to combine elements

[4] Karpati et al. Health disparities in New York City. New York: New York City Department of Health and Mental Hygiene, 2004.
[5] HIV Epidemiology and Field Services Program. New York City Department of Health and Mental Hygiene. Unpublished data. Feb. 2008.
[6] Centers for Disease Control and Prevention. HIV among African Americans. Nov 2011. Available at: http://www.cdc.gov/hiv/topics/aa/index.htm. Accessed Mar.26, 2015.
[7] Centers for Disease Control and Prevention. HIV in the United States. Nov 2011. Available at: http://www.cdc.gov/hiv/resources/factsheets/us.htm. Accessed Mar. 26, 2015.
[8] HIV Epidemiology and Field Services Program. New York City Department of Health and Mental Hygiene. Unpublished data. Feb 2008.
[9] Antiretroviral Therapy Cohort Collaboration. Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies. *Lancet*. 2008 Jul. 26;372(9635):293-9.
[10] Paterson DL et al. Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Ann Intern Med*. 2000;133:21-30.
[11] Bangsberg DR. Less than 95% adherence to non-nucleoside reverse-transcriptase inhibitor therapy can lead to viral Suppression. *Clin Infect Dis*. 2006;43:1 Oct.:939-941.
[12] Ibid.
[13] Bangsberg DR. Preventing HIV antiretroviral resistance through better monitoring of treatment adherence. *J Infect Dis*. 2008;197 Suppl. 3:S272-S278.
[14] Golin et al. A prospective study of predictors of adherence to combination antiretroviral medication. *J Gen Intern Med*. 2002;17:756-765.

of the HIV Navigation Model and the Chronic Care Model to define and implement an HIV-specific Care Coordination model within the integrated continuum of care.

With increased treatment efficacy, early and continuous engagement in medical care is more important than ever for improving patient outcomes. To that end, factors associated with poor adherence to medical care plan and antiretroviral medications need to be addressed. These factors include: mental health issues; substance use; inadequate housing; lack of transportation; legal difficulties; inadequate access to food; being of racial/ethnic minority; social stigma; lack of knowledge about HIV/AIDS; health care provider bias and miscommunication; health care provider lack of knowledge or adherence to HIV/AIDS clinical guidelines. Once barriers to treatment have been eliminated and the patient is receiving comprehensive care, they should experience a decrease in viral load (VL), an increase in CD4 counts, and a decrease in disease stage advancement with adherence to their prescribed ART medication. By reducing VL in individuals and periodic assessment of HIV transmission risk with harm reduction counseling and partner notification where needed, HIV transmission may ultimately be reduced in the community.

PURPOSE

This program manual is intended to:

- Be provided to Ryan White Part A funded Care Coordination Programs as per the terms of the contract (solicited through the Care Coordination Request for Proposal).
- Be a reference for medical case management or Care Coordination providers for the purpose of care coordination for PLWHA.
- Provide programmatic guidance to standardize the implementation of Care Coordination Programs.
- Provide instructions on documenting and reporting Care Coordination activities.
- Complement the Public Health Solutions (PHS) contractual and fiscal documents.

OBJECTIVES OF HIV CARE COORDINATION

- Support and coach patients to become self-sufficient so that they are able to manage their medical and social needs autonomously.
- Provide linkage to care to patients in a timely and coordinated manner and maintain medical stability and suppressed viral load.
- Provide patients with home-based navigation, coordination of medical and social services, and support and coaching.
- Work together with patients to support treatment (medication) adherence.
- Assist patients with building skills and knowledge needed to achieve and maintain a stable health status.

ELEMENTS OF THE PROGRAM MANUAL

1.0 Practice Standards

1.1 Screen all patients for eligibility in the Care Coordination Program and coordinate with similar programs so patients receive streamlined services.
1.2 Assess needs at intake and schedule follow up for medical and social services.
1.3 Perform detailed and ongoing assessments of social services and benefits.
1.4 Develop and maintain the care plan thereby facilitating access to a medical home by all patients.
1.5 Gather and maintain detailed contact information and logistical needs.
1.6 Provide health education/promotion to all patients.
1.7 Incorporate treatment adherence interventions as needed.
1.8 Assist patients to attain self-sufficiency and successfully graduate.
1.9 Establish and maintain a relationship between medical staff and Program staff that facilitates access to and discussion of relevant patient information
1.10 Ensure that current consent to release HIV related information is on file for each patient.
1.11 Make sure that confidentiality laws or related institutional policies are not violated during transfer of sensitive personal health information.
1.12 Develop programmatic monitoring protocols and quality management activities.
1.13 All services **must** be documented and reported appropriately. Refer to the Care Coordination eSHARE Mapping (Appendix LL) and the Guide to Care Coordination Forms (Appendix MM).

1.13.1 Agencies must maintain paper copies of **all** Care Coordination forms in the patient chart if the information is not documented in an electronic medical record. Access to electronic medical records must be made available to NYC DOHMH and PHS as requested:

1.13.2 If electronic medical records are used, agencies still **must** always maintain paper copies of the following Care Coordination forms in a patient chart:

- Ryan White Part A Care Coordination Program Agreement (Appendix N)
- HIPAA Compliant Authorization for Release of Medical Information (if needed) (Appendix P)
- Intake Assessment Form (only the General Well-Being section, also known as the SF-12) (Appendix U)
- Reassessment Form (only the General Well-Being section, also known as the SF-12) (Appendix HH)

1.13.3 **eSHARE is neither an electronic medical record system nor a patient charting system; therefore, the system currently in place for charting patient services must be maintained. eSHARE is *only* for reporting data, *not* for documentation. Any data entered in eSHARE *must* have supporting documentation maintained in the patient chart.**

2.0 Components of Care Coordination

2.1 Care Navigation

2.1.1 Care Navigation guides patients in knowing where, when, and how to access all health and related services, and increases access to appropriate resources.

2.1.2 Care Navigation services covered in this section include the coordination of:

- Primary medical care
- Specialty care
- Mental health care
- Substance abuse services
- Imaging and other diagnostic services
- Laboratory services

2.1.3 The Program ensures that the patient has the relevant information for all appointments by:

2.1.3.1 Reviewing the Comprehensive Care Plan with the patient and the provider. Providing the patient with reminders of upcoming appointments or plans in the following ways:

2.1.3.1.1 Once a primary care appointment is scheduled, make sure the patient is aware of the date, time, and location.

2.1.3.1.2 At every face-to-face contact the Program should remind the patient of all upcoming appointments.

2.1.3.1.3 Patients receiving health promotion *less frequently than once (1) per week* should receive at least three reminders prior to each scheduled appointment

2.1.3.1.4 Patients receiving health promotion *once per week* should receive at least two (2) reminders prior to each scheduled appointment.

2.1.3.1.5 Reminder phone calls are documented on the Services Tracking Log (Appendix KK).

2.1.4 The Program ensures that the patient has the relevant logistical arrangements necessary for all appointments by:

- Offering to accompany the patient
- Providing accompaniment to every routine primary care appointment for all patients receiving high-intensity services, if requested (refer to §6.3.6).
- Assessing whether the patient requires assistance with transportation.
- Assessing whether the patient requires assistance with childcare (if applicable).
- Assessing whether the patient requires language interpretation services (if applicable). Note: Minors (<18) are **NOT ALLOWED** to be used as interpreters.

2.1.5 The Program ensures access to appropriate transportation resources as required. These include but are not limited to:

- Access-A-Ride (Appendix C).
- Metrocard provided by the Program for use on public transportation.
- Note: When a scheduled service is a Medicaid billable service, the Program must ensure the provision of the benefits, but not provide it directly.
- A taxi or car service voucher when justified (e.g., a patient cannot wait for Access-A-Ride and urgently needs transportation to go to a relevant appointment or service). This may not be used during an emergency in which an ambulance should be called.
- A ride in a vehicle owned or leased by the Program or Program staff. All regulatory and liability issues must be addressed in advance.

2.1.6 The Program assists the patient in scheduling and rescheduling appointments, as required.

2.1.7 The Program ensures appropriate childcare resources as required. These include but are not limited to:

- Asking whether the patient requires assistance with childcare every time a reminder is provided.
- Offering to refer the patient to appropriately credentialed childcare services at an affiliated agency location if available.
- Childcare must **not** be provided by Care Coordination Program staff.
- Payment for childcare in the patient's home when circumstances do not allow bringing the child to the care center.

- HRSA prohibits payment to individual patients and therefore, Programs must develop a system to reimburse childcare providers.[15]
- Refer to the Childcare information presented in Appendix D.

2.1.8 The Program monitors its success at providing navigation service by following up with the service provider the same day as the scheduled service in all instances to ensure the patient attends their relevant appointments.

2.1.9 In order to ensure that confidentiality law or related institutional policies are not violated during transfer of sensitive personal health information, the Program must ensure that a valid HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information form is always on file for each patient [Appendix P (English), Appendix Q (Spanish)].

2.1.9.1 This form is for the patient to release medical and HIV related information and **NOT** a HIPAA form. It is HIPAA-Compliant.

2.1.9.2 Under no circumstances can changes be made to existing forms. It is a signed, legal document and any edits must be made to a new form and signed again by the Patient.

2.1.9.3 Review the form at least annually. New forms must be completed whenever changes occur or at least every 1-3 years.

2.1.10 The Program should detail planned navigation activities and services in the patient's Comprehensive Care Plan.

2.1.11 The Program documents all care navigation activities and services in the patient chart and reports them in eSHARE in the Services Tracking Log (Appendix KK).

2.2 Health Promotion (Education, Coaching and Medication Adherence)

2.2.1 The Program ensures optimal health literacy for all patients by providing health promotion on the biology of HIV, disease management, communication with providers, risk reduction and healthy behavior, and ART adherence via a structured curriculum.

2.2.2 The NYC DOHMH provides a standard health promotion curriculum.

2.2.2.1 The curriculum is a guide with topics that include conversations with key components which should be addressed, but it does not have to be delivered as a didactic script.

[15] Health Resources and Services Administration, HIV/AIDS Programs. Website: http://hab.hrsa.gov/. Accessed Mar. 26, 2015.

2.2.2.2 The curriculum should be delivered in a way that is suitable to meet your patient's educational, developmental, language, gender, sexual and cultural needs.

2.2.2.3 The curriculum consists of 18 topics: nine (9) are considered core topics, eight (8) are considered discretionary, and one (1) is a final wrap up. Topics may be repeated or continued and are patient-driven to allow for flexibility in topic order. These topics are outlined in more detail in the Health Promotion Topics Included in Curriculum guide (Appendix H).

2.2.3 The Program ensures that all Program staff providing health promotion receives ongoing trainings on the curriculum. The NYC DOHMH trains Program staff who in turn train other Program staff at their agencies.

2.2.3.1 Each agency **must** have a minimum of two (2) trainers who have completed the Health Promotion Training of Trainers (TOT) and at least one (1) trainer must be available to conduct each training at the agency.

2.2.3.2 These trainings should be ongoing and conducted at least once (1) every two (2) months. Each training should be at least one (1) hour in length; however, two (2) hours is recommended.

2.2.4 All patients **must** receive individual health promotion sessions, since the intent is to incorporate coaching and counseling content that is individualized to the patient.

2.2.5 Group health promotion sessions are **optional** and may be conducted according to patient preference in addition to the **required** individual sessions.

2.2.5.1 Group health promotion sessions **must** have a minimum of three (3) patients in attendance.

2.2.5.2 The recommended number of participants in a group session is 4-6 patients.

2.2.5.3 It is recommended that no more than two (2) topics be covered during a group session.

2.2.5.4 The recommended number of facilitators for group health promotion sessions is two (2).

2.2.6 All individual health promotion sessions **must** be documented in patient charts and reported in eSHARE using the Services Tracking Log (Appendix KK).

2.2.7 All group health promotion sessions **must** be documented in group notes and filed in a group binder. However, individual notes for group participants are **strongly recommended** as a best practice.

2.2.7.1 The following elements **must** be documented in all group notes:

1) Service Type	6) Site of Service
2) Service Date	7) Descriptive, narrative summary of group service
3) Service Start Time	8) Staff Signature
4) Service End time	9) Staff Signature Date
5) Staff Name (Printed)	

2.2.7.2 Group notes **must** contain a descriptive, narrative summary of 1) what took place during the group, 2) what topics were covered, and 3) what issues were raised.

2.2.7.3 Any documentation of group sessions containing client names (e.g., sign-in sheet) must be filed separately from individual client charts.

2.2.7.4 Group notes **must never** be copied into individual client charts.

2.2.8 The individual and group health promotion session documentation details **must** be consistent with the S.M.A.R.T. goals and objectives developed in the comprehensive care plan.

2.2.9 All patients in **low intensity** tracks **must** receive at a minimum the following health promotion topics (see Table 3 on pg. 45-46):

2.2.9.1 Basic HIV disease information and disease management tailored to the patient's circumstances.

2.2.9.2 Safer sex and prevention of HIV transmission to sex partners.

2.2.9.3 Guidance on how to make medical appointments and communicate effectively with medical providers

2.2.9.4 Habits for healthy living.

2.2.9.5 *For substance users, including injection drug users*, harm reduction techniques including but not limited to non-sharing of injection equipment with fellow injectors. The Program should also provide access to sterile injecting equipment either via participating as an Expanded Syringe Access Program (ESAP) provider or via linkage (refer to Appendix F for a list of authorized needle exchange programs).

2.2.9.6 Health promotion should occur at the frequency as indicated for the track in which the patient is enrolled. Each health promotion session (encounter) should be linked to a goal or goals in the patient's Comprehensive Care Plan.

2.2.9.7 Each health promotion session **must** be linked to a goal or goals in the patient's Comprehensive Care Plan and individual sessions should last at least 20-40 minutes.

Group health promotion sessions should last at least 40-60 minutes.

2.2.9.7.1 It may take more than one (1) session (encounter) to complete a topic, and at times different conversations could be incorporated into one (1) session if it is determined that there is a need for the information to be presented.

2.2.9.7.2 Topics may be repeated.

2.2.9.7.3 Health promotion topics and conversations may be conducted in stand-alone sessions (encounters) focused solely on health promotion or may be incorporated into other service type encounters (e.g., accompaniment).

2.2.9.7.4 Ideally, each patient should cycle through the curriculum once prior to graduation.

2.2.9.8 For patients who continue to receive Program services beyond the completion of all health promotion topics, content should be repeated with the patient's needs in mind. Patient sexual risk behavior assessment is completed and safer sex education (Prevention with Positives) – except for the chronically abstinent – is delivered in abbreviated form optimally at every primary care encounter but at least once every four (4) months. Risk behavior assessment and safer sex education should be augmented by brief counseling from PCP at every visit.

- Individual health promotion sessions should take place at a location of the patient's choosing, which may be the patient's home or another location in the field (mutually agreed-upon location). The patient may also choose to receive the health promotion at the medical or care coordination site(s). Group health promotion sessions **must only** take place at the agency's program site(s).

2.2.9.9 If necessary, a single health promotion topic can be covered over more than one (1) session over the course of a calendar year.

2.2.10 All patients in **high intensity** tracks **must** receive at a minimum the following health promotion content (see Table 3 on pg. 45-46):

2.2.10.1 An expanded skills-based curriculum whose table of contents is included in Appendix H.

2.2.10.2 Each health promotion session includes pill counting (e.g., pillbox or blister pack review) for all patients prescribed ART who are not receiving DOT.

2.2.10.3 All patients receiving high intensity services receive health promotion once per week.

2.2.10.4 After the induction phase of three months, those patients who have shown clinical and behavioral improvement with weekly interventions can transition to a less frequent intervention level (refer to Appendix G) to once (1) per month (this is not an option during the induction phase).

2.2.10.5 Individual health promotion sessions take place in the patient's home or another location in the field (mutually agreed-upon location). Group health promotion sessions **must only** take place at the agency's program site(s).

2.2.10.6 A health promotion session may be timed to coincide with a primary care visit and delivered on site in those instances.

2.2.10.7 Each health promotion session should be linked to a goal or goals in the patient's Comprehensive Care Plan and individual sessions should last at least 20-40 minutes. Group health promotion sessions should last at least 40-60 minutes.

2.2.10.7.1 It may take more than one (1) session to complete a topic, and at times different conversations can be incorporated into one session if it is determined that there is a need for the information to be presented.

2.2.10.7.2 Ideally, each patient should cycle through the curriculum once prior to graduation.

2.2.11 Health promotion conversations are documented on the Services Tracking Log (Appendix KK). The Curriculum Coverage Log (Appendix BB) is an optional form and may be used per agency discretion.

2.2.12 Individual notes **must** be written for **each** patient who attends a group health promotion session. Group sessions **must** be reported in eSHARE using the Group Services Tracking Log (Appendix CC).

2.2.13 For patients taking ART, pill counting is required — knowing in advance the expected number of pills in the prescription (and in each compartment of the pillbox or blister pack) and counting those that remain after their scheduled dosing time has elapsed.

2.2.14 See Table 3 on page 45-46 for a description of the Low Intensity and High Intensity service levels.

2.3 Social Services and Benefits Assessment

2.3.1 Overview: the Program is responsible for assessing social services and benefits needs.

2.3.2 *Time Requirement*: the initial assessment of social services needs and benefits eligibility must occur within two (2) weeks of enrollment into the Program using the Intake Assessment Form (Appendix U).

2.3.3 Housing Assessment

2.3.3.1 Should be conducted at least every six (6) months.

2.3.3.2 Regular housing assessments should include:

- Ongoing assessments of the adequacy of current housing for all patients.
- Ongoing verification of the address and stability of the current housing arrangement. Ongoing assessments of whether storage of prescribed ART and/or other prescribed medications is possible.
- Ongoing Assessments of current rent (e.g., rent payment, arrears, etc.).

2.3.3.3 Housing Eligibility assessment

- Any patient with an identified housing need should be evaluated for eligibility in a housing program. Programs can use AccessNYC for eligibility screening (refer to Appendix E).[16]

2.3.3.4 Housing program application:

- Patients found to be eligible for one (1) or more housing or housing assistance programs should be assisted in completing all the forms and gathering the required documentation needed for completion of the application process.
- The Program should follow-up with the patient on submission of applications.
- If the application is not accepted, reassessment for other eligibilities should be performed.
- Programs should consult with DOHMH's Housing Opportunities for People with AIDS (HOPWA) Program for further information about eligibility.[17]

2.3.4 Health insurance and other benefits

2.3.4.1 At enrollment, all patients are evaluated for their current insurance status.

2.3.4.2 If needed, the program should assess eligibility for all NYC, Local, State and/or Federal insurance and benefits

[16] Access NYC. Website: https://a858-ihss.nyc.gov/ihss1/en_US/IHSS_homePage.do. Accessed Mar. 4, 2015.
[17] Housing Opportunities for Persons with AIDS (HOPWA). Contact phone (347) 396-7454.

programs. Guidance for eligibility and referral services can be found using AccessNYC (Appendix E). [18]

2.3.4.3 Patients not already receiving benefits from the HIV/AIDS Services Administration (HASA) should also be assisted with an application.[19]

2.3.4.4 Patients found to be eligible for one or more benefits and/or programs should be assisted in completing all the forms and gathering all the requisite support documentation that are necessary to apply to the programs.

2.3.4.5 The Program should follow-up with the patient on submission of applications.

2.3.4.6 If the application is not accepted, reassessment for other eligibilities should be performed.

2.3.4.7 All patients are reevaluated annually for eligible health insurance and other benefits.

2.3.4.8 When the service is provided by a HASA case manager, at enrollment and annually thereafter, the Program must document the coordination of benefits assistance, including:

- HASA case manager identifier and locating information;
- Benefits currently provided to the patient or programs the patient is currently enrolled in;
- Plans with regard to other benefits or programs (e.g., applications submitted);
- Date of last communication with HASA; and
- Staff communicating and contact information.

2.3.5 Validation of documented needs assessments

2.3.5.1 Review the current assessment(s) previously done by affiliated staff and ensure it is up-to-date and accurate.

2.3.5.2 If information is up-to-date and accurate there is no need to duplicate the social services and benefits assessment.

2.3.6 Reassessments should be e conducted within six (6) months of the previous assessment/reassessment) and are documented on the Reassessment Form (Appendix HH).

2.4 Directly Observed Therapy (DOT)

2.4.1 In most instances, Care Coordination Programs provide modified DOT services, e.g., not seven (7) days a week, not all prescribed doses. DOT must be offered to all patients indicated for and

[18] Access NYC. Website: https://a858-ihss.nyc.gov/ihss1/en_US/IHSS_homePage.do. Accessed Apr. 22015.
[19] HIV/AIDS Services Administration (HASA). Website: http://www.nyc.gov/html/hra/html/directory/hasa.shtml. Accessed Apr.2, 2015.

prescribed ART, and/or other prescribed non-ART medications (psychotropic, opportunistic infections, and/or Hepatitis C) who meet the criteria for DOT outlined in the Criteria for Transition between Service Levels (Appendix G).

2.4.1.1 For those who meet the DOT eligibility criteria at enrollment, the offer **must** be made at enrollment.

2.4.1.1.1 If this initial offer is declined by the patient, then subsequent offers **must** be made at least once (1) per quarter.

2.4.1.2 For those who do not initially meet the DOT eligibility criteria, the patient should be continually assessed for DOT need and the offer should be made if the patient becomes eligible. Refer to Criteria for Transition between Service Levels (Appendix G).

2.4.1.3 Offers of DOT and the outcomes of those offers **must** be documented in the patient chart.

2.4.2 DOT is a service for patients who are willing to take prescribed ART. DOT is also available for patients with mental health and/or opportunistic infection diagnoses, and/or positive HCV status, and are willing to take other prescribed medications. Patients described below are eligible to receive offers of DOT:

2.4.2.1 Those who have had difficulty adhering to their prescribed ART regimen either independently or with support (e.g., pill box, blister pack, health promotion, counseling, etc.).

2.4.2.1.1 If these patients accept the offer of DOT services for prescribed ART medications, they **must** be enrolled in Track D.

2.4.2.2 Those who have had difficulty adhering to either psychotropic medications, HCV medications, and/or opportunistic infection medications.

2.4.2.2.1 If these patients accept the offer of DOT services for prescribed non-ART medications, they do not need to be enrolled in Track D but should be placed in the most appropriate track.

2.4.2.3 Those who are currently on ART with concurrent mental health diagnoses, OI diagnoses, and/or HCV positive status and have had difficulty adhering to either prescribed ART and/or non-ART medications (psychotropic medications, HCV medications, and/or opportunistic infection medications).

2.4.2.3.1 If these patients accept the offer of DOT services for prescribed ART medications, they **must** be enrolled in Track D.

2.4.2.3.2 If these patients accept the offer of DOT services for prescribed non-ART medications, they do not need to be enrolled in Track D but should be placed in the most appropriate track. See Table 1 below.

Table 1: Prescribed Medication Type(s), DOT Eligibility, and Track Eligibility

Choose one:	Track A	Track B	Track C1	Track C2	Track D
Prescribed only ART	N/A ✖	No DOT for ART ✖	No DOT for ART ✖	No DOT for ART ✖	REQUIRED DOT for ART ✔
Prescribed only non-ART	Optional DOT for non-ART ✔	N/A ✖	N/A ✖	N/A ✖	N/A ✖
Prescribed both ART and non-ART	N/A ✖	No DOT for ART ✖ Optional DOT for non-ART ✔	No DOT for ART ✖ Optional DOT for non-ART ✔	No DOT for ART ✖ Optional DOT for non-ART ✔	REQUIRED DOT for ART ✔ Optional DOT for non-ART ✔

✔ = DOT for either ART or non-ART allowed

✖ = DOT for either ART or non-ART not allowed

2.4.3 DOT services **must** include the observation of the patient's self-administration of the prescribed dose, reported side effects, and documentation of the DOT encounter in the patient's chart.

2.4.3.1 DOT services can include the self-administered prescribed dose being **either** directly observed (agency staff visually observes patient's self-administration of a prescribed dose) **or** indirectly confirmed (agency staff uses pill box, blister packs or other means to verify that the patient self-administered a prescribed dose).

2.4.3.2 Each DOT service provided to a patient **must** have a **separate** progress note.

2.4.3.3 The six (6) required elements for documentation of a DOT encounter in a progress note **must** include:

1. Service Date • Date must match date of actual service or patient encounter
2. Service Start Time/End Time • Start Time must be the time the DOT encounter began, not the time of the directly observed (or indirectly confirmed) self-administration of the prescribed dose • End Time is optional
3. Worker(s) Providing • List all CC staff involved
4. Site of Service Delivery • Client Home: CC staff and Patient are together in the patient home • Other Field Site: CC staff and Patient are together at field site • Program Site: see §2.4.4.2 below **NOTE:** The Site of Service Delivery for a DOT encounter **must never** be Phone
5. Service Type • Describe that CC staff conducted a DOT service
6. Service Details • First: Describe whether the self-administered prescribed dose was **either** directly observed (CC staff observes the patient self-administration) **or** indirectly confirmed (CC staff uses pill box, blister packs or other means to verify that the patient self-administered a prescribed dose). • Second: Describe the type of prescribed medication self-administered (ART, Psychotropic, Opportunistic Infections, and/or Hepatitis C)

2.4.4 DOT should be provided to serve patients in the service site that is most likely to yield clinical success. Appropriate settings include:

2.4.4.1 Field-based DOT, which occurs at the patient's home or another mutually-agreed upon field-based location of the patient's choosing. Patients are responsible for the storage of their prescribed medications.

2.4.4.1.1 Field-based DOT services **must** be available to all eligible patients.

2.4.4.2 Clinic-based DOT**, which occurs at a Program location and/or a primary medical care site:

2.4.4.2.1 Medication dispensed and/or distributed on site:

2.4.4.2.1.1. Dispensing and/or distributing prescribed medications on-site is neither a programmatic requirement, nor an expectation

2.4.4.2.1.2. Agencies that dispense and/or distribute prescribed medications must have proper medication storage facilities

2.4.4.2.1.3. Agencies must review their dispensing and/or distribution processes with their own agency's legal department to ensure that it is compliant with all Federal, State, and Local laws and regulations

2.4.4.2.2 Medication neither dispensed nor distributed on-site – Patients may bring their prescribed medications to the site for DOT services, which may be conducted by either clinical or non-clinical Program Staff (e.g., DOT Specialist, Patient Navigator, etc.).

****ANY** deviations from this definition **MUST** be approved by NYC DOHMH**
For more information refer to New York State law Article 137, Pharmacy[20]

2.4.5 DOT **must** be conducted through face-to-face encounters and should **never** be conducted via telephone.

2.4.6 A written or verbal agreement to participate in DOT services is required to be documented in the patient charts. The following protocol should be used for offering and providing DOT services:

2.4.6.1 DOT is offered or encouraged when other interventions are not successful. Clinical guidelines for selecting DOT as an intervention and for discontinuing DOT are described in the Criteria for Transition between Levels of Service (Appendix G).

2.4.6.2 Patients receiving DOT **must** also receive weekly health promotion (refer to §2.2.7). If the patient is enrolled in Track D, after a sustained period of clinical (CD4 counts and VL) and behavioral improvement, the patient may transition from Track D to a lower intensity service level. Patient should continue receiving health promotion at the appropriate frequency based on the newly enrolled Track.

2.4.6.3 DOT should be provided at least five (5) days per week. When possible, the agency should work to accommodate those patients who take medications before leaving the house in the morning and those taking medications in the evening.

2.4.6.4 DOT may be provided fewer than five (5) days per week on a case by case basis with proper documented justification.

2.4.6.5 When self-administration of medications cannot be observed directly by Program staff, modifications to the

[20] New York State Office of the Professions. http://www.op.nysed.gov/prof/pharm/article137.htm. Accessed: April 27, 2015

intervention may be conducted. These modifications may include but are not limited to:

- Program staff directly observing one (1) dose per day and recording the outcome of the second dose by means of a pillbox or blister pack check at the next face to face encounter with the patient.
- For patients with on more than once-per-day regimens, the one (1) dose may be observed and recorded by a friend or family member.

2.4.6.6 If a patient's regimen is such that no dose can be observed by Program staff (e.g., patient is prescribed a regimen that requires taking the dose in the evening prior to going to bed), the Program staff and the patient should discuss the relative risks and benefits associated with the current regimen and discuss the patient's willingness to change that regimen. The Program staff should always document medication adherence, adverse side effects or other issues observed or reported by a patient during a DOT encounter.

2.4.6.7 Any observation of an acute change in the patient's health or social circumstance which may affect the patient's ability to successfully adhere to the prescribed regimen should necessitate a discussion with the Program staff and the patient.

2.4.6.8 The recommended time frame for providing DOT services should be six (6) to nine (9) months. When the patient completes the period and demonstrates adherence greater than 95%, the Program staff should transition the patient to a lower intensity service level.

2.4.6.8.1 Should the patient receive DOT services for longer than the recommended period above, justification for this **must** be properly documented in the patient's chart.

2.4.7 DOT notes **must** be documented in patient charts and ART medication adherence must be reported in eSHARE by means of completing a Monthly DOT Log (Appendix FF) and Services Tracking Log (Appendix KK).

2.5 Other social support

2.5.1 The Program should ensure that patients have access to support from their community and their peers.

2.5.2 The Program should maintain formal relationships with these community organizations that provide services (e.g., Peer-driven support groups & safe spaces/communal spaces where patients can gather with their peers).

3.0 Roles and Responsibilities

3.1 Overview

3.1.1 The main purpose of this section is to provide an overview of each position, as well as specify their roles and responsibilities.

3.1.2 The responsibilities described below may be arranged differently and staff titles may vary at each Program. One (1) person may assume the responsibilities of more than one (1) role in some instances as required. Generally a package of responsibilities **should not be** divided among individuals.

3.1.3 Attendance of appropriate staff (e.g., staff with managerial responsibilities) **must** be ensured for **all** required meetings and webinars (e.g., Annual Provider Meeting).

3.1.4 The Recommended Staffing Plan (Appendix I) contains staff titles and provides more detail with regard to tasks.

3.2 Program Director

3.2.1 Has overall responsibility for operations of the Program.

3.2.2 Recruits, hires, and supervises all key personnel (Care Coordinators, DOT Specialists, and Patient Navigators),with the exception of the Medical Center Liaison. Reviews all Program processes, progress, and performance. Produces summary reports to communicate this information to NYC DOHMH and PHS. Oversees all monitoring, reporting and quality management activities of the Program.

3.2.3 Provides supervision and support to Program staff, as needed.

3.2.3.1 Conducts regular reviews that include face-to-face assessment of staff competency and chart-based review of staff work.

3.2.4 Ensures coordination of resources and logistics for staff training.

3.2.5 Coordinates Program activities with participating organizations and oversees administration of all relevant protocols and updates.

3.2.6 Acts as a liaison between the agency and NYC DOHMH and PHS.

3.2.7 **Must** attend (or ensure appropriate representation for their agency) at **all** required meetings and webinars (e.g., Annual Provider Meeting). If unable to attend, **must** ensure that appropriate staff with managerial responsibilities attends in their place.

3.3 Care Coordinator

3.3.1 When the Agency and the PCP are co-located, the Care Coordinator :

3.3.1.1 Verifies eligibility and conducts programmatic duplication checks to ensure that similar services are not already provided or available by another payer.

3.3.1.2 Conducts patient orientation activities and enrolls the patients into the Program.

3.3.1.3 Performs the Intake Assessment.

3.3.1.4 Creates and updates Comprehensive Care Plans for the patients, including incorporating the medical treatment plan from the PCP.

3.3.1.4.1 Facilitates interdisciplinary conversations with all internal and external persons involved in patient care and treatment.

3.3.1.5 Provides clinic-based health promotion for low intensity patients as required.

3.3.1.6 Provides supervision and support to Patient Navigators and DOT Specialists, as needed.

3.3.1.6.1 Conducts regular reviews that include face-to-face assessment of staff competency and chart-based review of staff work.

3.3.1.6.2 The recommended supervisory responsibility is 3-5 Patient Navigators with a recommended caseload of 60-75 patients.

3.3.2 When the Agency and the PCP are not co-located, the Care Coordinator performs the same functions as highlighted above except some of the Care Coordinator's duties may be completed by the Medical Center Liaison (MCL) (refer to §3.4) in order to maintain contact with the PCP, including:

- Generating and/or updating the clinical/medical sections of the Comprehensive Care Plan; and
- Clinic-based health promotion for low-intensity patients.

3.3.2.1 Instances where the MCL has either generated or updated the Comprehensive Care Plan, the Care Coordinator must collaborate with the MCL on the details of the plan.

3.3.2.2 The Care Coordinator should be able to meet with the PCP even when not co-located..

3.4 Medical Center Liaison (MCL)

3.4.1 Facilitates communication about patient management between PCPs and Care Coordinators during orientation activities as well as on an ongoing basis.

3.4.2 Shares all patient information (e.g., appointment dispositions, laboratory results, etc.) with Care Coordinators.

3.4.3 Participates in the generation of and updates to the Comprehensive Care Plan while collaborating with Care Coordinators (refer to §3.3.2).
3.4.4 May conduct Care Coordination activities such as health promotion for low-intensity patients, as needed (refer to §3.3.2).
3.4.5 May **not** provide back-up or supervision to staff employed at the Program agency.
3.4.6 May provide back-up or supervision to program staff employed at the same medical center.
3.4.7 A recommended caseload for an MCL should not exceed 200 patients.

3.5 Patient Navigator

3.5.1 Provides all home-based Care Coordination services to the patients.
3.5.2 Educates, coaches and empowers patients.
3.5.3 Accompanies patients to primary care appointments and other health care and social services appointments, as needed.
3.5.4 Coordinates ongoing navigation and logistical support for appointments including providing: reminders, transportation support, childcare arrangements, and other support as needed.
3.5.5 Administers the health promotion curriculum and tracks the patient's health promotion needs.
3.5.6 Assists the Care Coordinator in conducting reassessments and follow-ups.
3.5.7 Works collaboratively with other Program and Medical staff and provides information needed to create and update Comprehensive Care Plans.
3.5.8 Supports and provides backup for other program staff as needed.
3.5.9 Depending on Program needs, may provide DOT services.
3.5.10 The recommended caseload is 14-20 patients.

3.6 DOT Specialist – Field

3.6.1 Observes face-to-face, and records, patient self-administration of prescribed: ART regimen, and/or psychotropic medications, and/or opportunistic infection medications, and/or Hepatitis C medications.
3.6.2 Assesses for and reports any treatment related side-effects.
3.6.3 A recommended caseload is seven (7) patients.

3.7 DOT Specialist – Clinic

3.7.1 Observes face-to-face, and records, patient self-administration of prescribed: ART regimen, and/or psychotropic medications, and/or opportunistic infection medications, and/or Hepatitis C medications.

3.7.2 Assesses for and reports any treatment related side-effects.
3.7.3 May administer the dose to the patient if allowed by law and institutional policy.
3.7.3.1 Clinic policy often requires a licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) to administer the dose.
3.7.4 A recommended caseload is 14-20 patients.

3.8 Clinical Supervisor

3.8.1 Meets regularly with Program staff to provide skills training on clinical issues, to discuss casework and to address other professional issues in a structured way. The purpose is to assist staff with learning from their experiences and progress, as well as to ensure high quality of services to the patients.
3.8.2 Should provide supervision to all Program staff Clinical supervision must be provided by a licensed mental health provider (e.g., LCSW, LMSW, LMHC, psychiatrist, psychologist).
3.8.3 The clinical supervisor and Program staff members who have managerial duties should meet monthly to collaborate and support each other's supervision of the team.

3.9 Medical Provider Roles and Responsibilities

3.9.1 Provides medical care to patients participating in the Program.
3.9.2 Provides an affiliation agreement so that Program staff, if not employed by the PCP facility, can access all relevant patient health information necessary to do their job.
3.9.3 Participates in all referral and case conference activities as described. This includes:
3.9.3.1 Providing names of patients who have missed appointments or are lost to care.
3.9.3.2 Discussing Care Coordination with patients, encouraging enrollment for those who need the support, and making a referral at the time of the visit.
3.9.3.2.1 Referral responsibilities include completing the PCP Referral Disposition Form (Appendix M), handing off the patient to the Care Coordinator or Medical Center Liaison at the time of the appointment and discussing the reasons they are referring the patient to the program.
3.9.3.3 Participating in a minimum of quarterly formal case conferences for each patient with Care Coordination staff. Case conferences may include discussion of one patient or multiple patients (e.g., rounds).

3.9.4 Responds promptly to Program staff by relaying clinical concerns (e.g., patient non-adherence to ARV regimen).

3.9.5 Promptly apprises relevant Program staff of significant clinical events such as:

- Hospitalization;
- A new diagnosis; or
- Change in treatment regimen.

3.9.6 Documents the medical treatment plan in the patient's medical record which should be accessible by the Program staff. The medical treatment plan is the basis of the Program's Comprehensive Care Plan.

3.9.7 For patients who remain in care with the affiliated PCP after graduation from the Program, the PCP should continually assess the patient's adherence to the treatment plan, clinical status and behavioral issues that may affect successful treatment of HIV.

- If appropriate, the PCP may refer the patient back to the Program.

3.10 NYC DOHMH

3.10.1 Funds the Care Coordination Program via Ryan White Part A funds.

3.10.2 Provides programmatic technical assistance.

3.10.3 Provides training/education of Program staff.

3.10.4 Monitors program implementation and data completeness.

3.10.5 Ensure that all required data is reported to Health Resources and Services Administration via the Ryan White HIV/AIDS Program Services Report (RSR).[21]

3.10.6 Evaluates program performance and health outcomes.

3.10.7 Provides quality management guidance and support.

3.11 Public Health Solutions

3.11.1 Master Contractor hired by NYC DOHMH to help manage Ryan White Part A funded contracts.

3.11.2 Provides contractual and fiscal technical assistance.

3.11.3 Monitors contract implementation and compliance.

4.0 Eligibility, Case-Finding, Referral Source, Enrollment, and Intake

4.1 Patient enrollment eligibility:

[21] HRSA Ryan White HIV/AIDS Program Services Report (RSR). Website: http://hab.hrsa.gov/manageyourgrant/clientleveldata.html. Accessed on Apr. 10, 2013.

4.1.1 Patients must be at least 18 years of age (or emancipated minors) and meet one (1) of the following criteria in order to be eligible for the Care Coordination Program. Criteria include PLWHA who:

4.1.1.1 Are newly diagnosed with HIV;

4.1.1.2 Were lost to care as defined by having at least one primary care visit in the past two (2) years at the facility and not having any primary care visits for the past nine (9) months at the facility;

4.1.1.3 Have difficulty keeping appointments; or receive sporadic, irregular care; or have never been in care; or

4.1.1.4 Have indications of ART challenges including those who:

4.1.1.4.1 Are ART naive and starting treatment AND have one (1) or more of the following *associated factors*:[22] [23]

- High pretreatment or baseline viral load measures of HIV-1 RNA (depending on the specific regimen used), defined as > 100,000 copies/mL;
- Low pretreatment or nadir CD4 T-cell count < 200 cells/mm^3;
- Prior AIDS diagnosis;
- Comorbidities (e.g., depression, active substance use); or
- Presence of drug-resistant virus.

4.1.1.4.2 Are ART experienced and re-starting ART with one (1) or more of the *factors* listed in §4.1.1.4.1 **OR** one (1) of the following:

- Prior treatment failure, with development of drug resistance or cross-resistance;
- Previously prescribed ART regimen that was deemed ineffective or inappropriate for the patient (e.g. experienced potent negative side effects).

4.1.1.4.3 Are on ART and experience recurrent virologic rebound after successful suppression.

- A definition of virologic failure is having two (2) sequential viral load measures of HIV-1 RNA >1,000 copies/mL.

[22] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. Nov. 2014; 1-282. Website: http://www.aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf. Accessed Apr. 3, 2015.

[23] NYC Health, Antiretroviral therapy. Website: http://www.nyc.gov/html/doh/html/living/nyc-hivart.shtml. Accessed Apr. 3, 2015.

4.1.2 The duration of enrollment should be considered on a case by case basis, but should generally not exceed one (1) year for most patients. Patients who have been enrolled in Care Coordination for more than one (1) year may continue to receive services at the appropriate intensity level. This is done at the discretion of the Program staff and medical staff. Justification **must** be documented in the patient's chart.

4.2 Case finding prior to PCP referral ("Return to Care")

4.2.1 The Program should conduct case finding activities to find patients who are lost to care and meet the eligibility criteria to be enrolled in the Program.

4.2.2 Patients who are lost to care are defined as those who have had a medical visit at the primary care facility within the last two (2) years but not within the last nine (9) months.

4.2.3 A list of such patients should be produced by the medical provider(s) affiliated with the Program. This list should be updated on a quarterly basis, every three (3) months, with new patients who meet the lost to care definition and meet the eligibility criteria to be enrolled in the Program.

4.2.4 Once patient contact information is verified, Program staff should initiate patient contact using outreach methods similar to the Program's Missed Appointments procedure (§6.3.12).

4.2.5 The Program should develop their own tracking tool to maintain a log of case finding activities.

4.2.6 For patients who are located through this process, the Program must determine whether they would like to return to the referring medical provider.

4.2.7 For patients who are located through this process, the Program must also determine whether they are engaged in medical care elsewhere, enrolled in another care coordination program, and/or enrolled in a Comprehensive Medicaid Case Management Program such as a Medicaid Health Home.

4.2.7.1 For patients engaged in medical care elsewhere, the Program should:

- Receive written consent from the patient prior to releasing information to the other program by using the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).
- Arrange transfer of the patient's medical record to the new provider. The records must be accompanied by a HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).

4.2.7.2 For patients not engaged in medical care elsewhere and willing to return, the Program should:
- Schedule a medical appointment;
- Offer accompaniment to the medical appointment; and
- Assess the patient's need to determine placement in a Program track at the appropriate degree of intensity.

4.2.7.3 For patients temporarily unable to return to care (e.g. planned vacation, incarceration, hospitalization, rehabilitation, etc.) but planning to return in the future:
- Program staff should inform the affiliated PCP of the patient's situation and document in the tracking tool.
- Maintain contact with the appropriate personnel who are aware of the patient's situation and approximate return (e.g. social worker, substance abuse counselor, parole officer, etc.).

4.2.7.4 If the patient was found but declines to return to care:
- Program staff should explore the patient's reasons. , Program staff should inform the affiliated PCP of the patient's situation and document in the tracking tool.

4.2.7.5 For patients permanently unable to return to care (e.g. death, long-term incarceration or rehabilitation, or permanently moved out of area)
- Inform the affiliated PCP of the patient's situation and document in the tracking tool.

4.2.8 If the patient is eventually enrolled in Care Coordination, the summation of the Return to Care activities for that patient can be documented in the Services Tracking Log (Appendix KK) as a Case Finding service type and reported in eSHARE.

4.2.8.1 The Case Finding service type is used to document the pre-enrollment case finding activities after the patient is enrolled. This service type is used once (1) to sum the total amount of time spent on pre-enrollment case finding activities, and the Service Date should be on the same date as the Enrollment Date.

4.3 Referral source

4.3.1 Referral by an affiliated PCP who identifies a patient with a need for Care Coordination.

4.3.2 Referral by a source other than the affiliated PCP, examples include:

4.3.2.1 Referral by the Riker's Island Transitional Healthcare Coordination Consortium (THCC) linking a recently released individual to care or other similar programs.

4.3.2.2 Lateral transfer from another Care Coordination Program.

4.3.2.3 Patient self-referral or referral from another service provider.

4.3.2.4 Affiliated pediatric unit referring youth in need of care coordination services or other specialized units serving unique patient populations. The Care Coordination Program is not designed for persons under the age of 18. Emancipated minors, however, may be treated like adults with regard to enrollment in the Care Coordination Program.

4.3.2.5 The inpatient medical service or emergency department of an affiliated hospital identifying a patient with a need for these services.

4.3.2.6 External source linking a patient to care such as the DOHMH Field Services Unit (FSU) returning a patient who has been lost to follow-up or referring a newly diagnosed patient. FSU assists with partner notification and linkage to care.

4.3.2.7 The agency's program may recruit enrollees by outreaching to persons in the field after determination by chart or electronic medical record review that they have been lost to follow-up (refer to §4.2).

4.3.2.8 An agency that provides HIV testing services.

4.3.3 Referrals received from the Emergency Department (ED) and similar programs that conduct HIV screening or may identify PLWHA during non-business hours.

4.3.3.1 Such programs should have dedicated staff, for example an HIV counselor, who should refer the patient.

4.3.3.2 The ED should ensure that patient's contact information (e.g. name, phone number, address) is current so that once the patient is discharged from the facility the agency program could contact and locate the patient. The name and contact information of at least one (1) individual who may know where the patient is, should be collected.

4.3.4 Direct referral conducted via outreach, Care Coordination medical provider, other service provider, patient self-referral or other Ryan White affiliated medical providers.

4.3.4.1 Referral from another source implies that the patient would receive primary HIV care services at one of the affiliated medical sites. The referral to the agency Program is presented as an ancillary service of the selected primary care practice.

4.3.4.2 The referring agency staff should either accompany the patient to the agency program or PCP's office, or make an appointment for the patient with the agency program or PCP's office.

4.3.4.3 The accepting agency program or PCP should then meet with the patient and complete either a Pre-Referral to CC Program Form (Appendix L) and/or a PCP Referral Disposition Form (Appendix M).

4.3.4.4 Referral is considered complete when the accepting agency program acknowledges receipt of the referral.

4.3.4.4.1 The agency program is obligated to ensure that the patient attends the initial PCP visit so that the PCP may determine if the patient is eligible for the Program.

4.3.4.4.2 The agency program has no obligation to serve the patient until the PCP refers the patient to the Program and intake has been completed.

Note: Persons who are found to be ineligible for the Program after medical screening should be referred to a more appropriate program (e.g., mental health services, substance abuse treatment, etc.).

4.4 Referral process

4.4.1 Referral from a PCP

4.4.1.1 A provider who deems that a patient is clinically indicated for the Care Coordination program, should first obtain verbal assent from the patient to enroll. The provider needs written consent if referring outside of the PCP facility. Consent must be documented.

4.4.1.2 The PCP then completes the PCP Referral Disposition Form (Appendix M) documenting ART status and psycho-behavioral and clinical need. This may be documented on the Care Coordination HIPAA Compliant Authorization for Release of Medical Information (Appendix P).

4.4.1.3 The PCP, along with the Care Coordinator or the Medical Center Liaison, meets with the patient to introduce the agency Program. Further detail on the patient handoff is provided in §5.3.

4.4.2 Referral by a source other than the partner medical provider

4.4.2.1 All patients must enter the program with a PCP Referral Disposition Form (Appendix M) from their PCP. However, patients may be identified for the Care

Coordination Program by persons other than their PCP prior to the official PCP referral. Patients should not leave their current case management program or their current medical provider if they are unwilling.

4.4.2.1.1 If the Care Coordination Program has a patient whom it believes would be appropriate for Care Coordination, or receives a direct referral from an outside agency, the agency program should explain to the patient that they are choosing to receive primary care at one (1) of the agency program's affiliated sites. The agency program staff then completes the Pre-Referral to CC Program Form (Appendix L). This form should be given to the Program-affiliated PCP that the patient has chosen so that the new PCP can evaluate the patient and complete the PCP Referral Disposition Form (Appendix M). The Program should check primary care appointment status and schedule as needed.

4.4.2.1.2 If the Care Coordination Program receives a referral from a non-Care Coordination affiliated site (e.g., rapid HIV testing provider, Riker's Island Transitional Consortium, DOHMH STD or TB Clinic, etc.), a Pre-Referral to CC Program Form (Appendix L) should be completed, either by the referring agency or the Care Coordination Program. The Program should check primary care appointment status and schedule an appointment within 48 hours of referral to occur as soon as possible, but no more than two (2) weeks from the date of referral.

4.4.2.1.2.1. This process should occur through a telephone discussion, working with the referring agency to ensure that the referred patient has a scheduled medical appointment prior to the patient leaving the referring agency's office.

4.4.2.1.2.2. If the referring agency is making a referral based on a preliminary positive rapid HIV test result only, the Care Coordination Program and/or Medical provider collects a confirmatory

test specimen and sends it for processing.

4.4.2.1.3 Once the patient has been engaged in medical care, the Care Coordination Program should share the required documentation of linkage with the referring agency. This documentation includes the date the appointment was kept by the referred patient, along with proof of the kept appointment.

4.4.2.1.3.1. Documentation required by DOHMH from the referring provider as proof of appropriate linkage must be one (1) of the following:

- CD4 count test, and/or result, from the agency to which the patient was referred
- Viral load test, and/or result, from the agency to which the patient was referred
- Copy of a medical note with the word 'HIV' or 'AIDS' indicating the patient's diagnosed condition
- Orders and/or a prescription for any ART
- Letter or note from staff at the treating agency to which the patient was referred, stating that the medical visit was HIV and/or AIDS-related

4.4.2.2 The Program should address urgent and emergent needs and support appointment adherence.

4.4.2.3 PCP meets with the patient to re-confirm HIV status and evaluate the patient's need for Care Coordination services.

4.4.2.4 If the PCP determines the patient is in need of care coordination services, after obtaining verbal assent, then proceed as follows:

- The PCP then completes the PCP Referral Disposition Form (Appendix M) documenting reason for referral and recommended starting track.
- The PCP and Care Coordinator meet with the patient after the primary care visit to review Comprehensive Care Plan and patient goals.

4.4.2.5 If the PCP determines that care coordination services are not currently a good option for the patient, he/she

completes the PCP Referral Disposition Form (Appendix M) documenting the reason for not referring the patient.

4.4.2.6 The accepting Program would track all referrals with regard to the disposition, e.g., enrolled, declined, lost to follow-up prior to enrollment.

4.5 Intake

4.5.1 As per HRSA guidelines, Ryan White Part A funds must be used as the payer of last resort. Only services that are NOT billable to other payers (such as Medicaid Health Homes) are reimbursable with Ryan White Part A funds.

4.5.2 At intake, Program staff must verify whether the client is enrolled in any of these NYC-funded and/or NYS-funded medical case management programs:

- Medicaid Health Homes;
- Comprehensive Medicaid Case Management Program including, but not limited to, the Medicaid Health Homes.
- Another Ryan White funded Care Coordination Program (CCP).

4.5.3 A patient may be dually enrolled in the Care Coordination Program, as well as in Medicaid Health Homes or in a Comprehensive Medicaid Case Management Program in these instances:

- Patients who are not eligible for Medicaid or are not enrolled in a Medicaid Health Home may continue to be served with the full range of CCP services.
- All eligible patients, regardless of their enrollment in Health Homes, may be provided specific and defined CCP services that are not provided by Health Homes.
- Patients who are enrolled in Health Homes and need additional support may be enrolled in CCP for limited services.

4.5.4 Patient may not be enrolled in this CCP and another identical Ryan White funded CCP. Program staff must ensure that this CCP is used as the payer of last resort.

4.5.4.1 Under no circumstance should a patient receive an identical service from more than one agency**.** When such duplication is discovered, the Program and the provider of the other services should discuss with the patient which agency best suits their needs.

4.5.4.2 Programs would collaborate and coordinate with other CCP to ensure that PLWHA receive comprehensive, non-duplicative – but complementary – services. PLWHA with numerous complex social and/or health/mental health needs would be referred to other

agencies that target those specific issues and coordination of services would continue.

4.5.5 Assessments

4.5.5.1 During the first two (2) weeks of enrollment, the following assessments must occur:

4.5.5.1.1 Baseline assessments of clinical and psychosocial status (Intake Assessment Form),

4.5.5.1.2 For patients on prescribed ART, a baseline assessment of the patient's adherence to the regimen over the past three (3) months should be conducted by the Program staff using the Adherence Assessment (Self-Report) Form (Appendix W or X).

4.5.5.1.3 If not on prescribed ART, assessment of whether there are clinical indications for ART initiation.

4.5.5.1.4 Social Services and Benefits Assessment

4.5.5.1.4.1. The Program is primarily responsible for assessing social services and benefits needs using the Intake Assessment Form (Appendix U)

4.5.5.1.5 Development of a Comprehensive Care Plan, to be completed with the patient.

4.5.5.1.6 Assessment of whether patient would prefer to receive health promotion services individually and/or in groups.

4.5.6 Orientation

4.5.6.1 Orientation would begin at the PCP's health facility. The Care Coordinator or the Medical Center Liaison conducts the orientation with the patient. The Patient Navigator may assist with orientation as needed.

4.5.6.2 The purpose of the orientation is to:

1. Explain the purpose, structure and benefits of the Program.
2. Introduce the Patient Navigator, if possible. If a formal introduction to the Patient Navigator is not possible, give the Navigator's contact information to the patient and explain that a Patient Navigator would deliver most of the care coordination services. Also provide contact information for the Care Coordinator.
3. Ensure appropriate and complete contact information is on record (including a contact number at which the patient could be reached during business hours, cell phone, home number, etc.) and a friend or relative

that would know the patient's whereabouts and could be contacted in the event that communication with the patient is unsuccessful. The Contact Information Form (Appendix R) and the Common Demographics Form (Appendix T) should be used to document this information.
    - Find out if the patient's HIV status has been disclosed to this contact person and use appropriate confidentiality procedures.
4. Explain the importance of notifying the Program and PCP in the event of a hospitalization or travel.
5. Address urgent needs such as need for housing, domestic violence, etc.
6. Ensure medical treatment follow-up is in place.
7. Ensure all the requisite elements for comprehensive assessment – including a benefits assessment - and plan are scheduled.

4.5.6.3 Check childcare and transportation needs with regard to care access up to and including the next scheduled appointment. Orientation processes that allow the Program to begin services include:

4.5.6.3.1 Describe the needed services, obtain the patient's agreement to participate and document on the Ryan White Part A Care Coordination Program Agreement (Appendix N).

4.5.6.3.2 Obtain appropriate releases of information and document on the HIPAA Compliant Authorization for Release of Medical Information (Appendix P) if needed.

4.5.6.3.3 Record detailed contact information and document on the Contact Information Form (Appendix R).

4.5.6.3.4 Determine logistics for an initial home or field visit and document on the Logistics for Navigator Form (Appendix S).

4.5.6.3.5 This is accomplished immediately after the referral and hand off from the PCP. In some circumstances, the patient may not have the time necessary to complete this activity right away. In these instances, ensure that the Ryan White Part A Care Coordination Program Agreement (Appendix N) and the HIPAA Compliant Authorization for Release of Medical Information (Appendix P) are

completed to allow Program to follow-up with patient.

4.5.6.4 Primary care appointments

4.5.6.4.1 Patients referred through a source other than the affiliated medical provider should have a primary care appointment scheduled as soon as possible so that the affiliated PCP could evaluate the patient for the Care Coordination Program.

4.5.6.5 The Care Coordinator or the Medical Center Liaison at the clinical site is primarily responsible for the orientation to Care Coordination, the Intake Assessment, the initial Adherence Assessment, and the Comprehensive Care Plan. The Patient Navigator may assist with orientation as needed.

4.5.6.6 In addition to forms mentioned above in §4.5.6.3, essential items would be documented on the Intake Assessment Form (Appendix U), the Comprehensive Care Plan (Appendix Y), the Adherence Assessment Form (Appendix W or X), and Services Tracking Log (Appendix KK).

5.0 Initial Comprehensive Care Plan

5.1 Overview

5.1.1 The initial Comprehensive Care Plan starts with the referral from the PCP and incorporates the interdisciplinary assessments described in §4.5. The Care Plan generates a timeline of care navigation activities and goals that cover the period until the next regularly scheduled primary care visit. The plan is patient-centered and incorporates the patient's goals.

5.1.2 The plan must be documented in writing, clearly addressing each identified need. The Program may develop a care plan form or use the optional DOHMH Comprehensive Care Plan Form (Appendix Y). This Plan, as well as the Intake Assessment Form (Appendix U), identifies the service level and frequency of care coordination activities.

5.1.3 The Program staff member completing the Care Plan (typically the Care Coordinator) must sign the form. Every activity on the Care Plan needs to list a responsible party, target date, outcome and outcome date.

5.1.4 The Care Coordinator is primarily responsible for implementing and following up with the Care Plan regardless of which program staff

completes the Care Plan. The patient is an active participant in the creation of the Care Plan.

5.1.5 The plan incorporates behavioral health, nursing, and other specialist and allied health professional plans as indicated. The Care Plan:

- Summarizes the medical plan in patient's record
- Summarizes the social worker's plan, if available
- Adds the support services and logistical plan
- Adds medical appointment, treatment adherence, health promotion curriculum, and other needs and goals

5.1.6 All care plans **must** be client-centered and **must** include the following 14 required elements:

1. Client Name	8. Frequency of Services
2. Date of Service Plan	9. Client Signature
3. Review Period	10. Client Signature Date
4. S.M.A.R.T. Goals/Objectives	11. Staff Signature
5. Target End Dates	12. Staff Signature Date
6. Goal Status (Achieved/Not Achieved)	13. Primary Care Physician's (PCP) Signature
7. Date Goal was Achieved	14. Primary Care Physician (PCP) Signature Date

5.2 **Time Requirement:** The initial Comprehensive Care Plan is completed within two (2) weeks of enrollment to the Program. Subsequent Care Plans may be updated at any point as needed but at a minimum of every six (6) months.

5.3 **Hand-off, case conference, and case review**

5.3.1 Initial hand-off

5.3.1.1 A brief face-to-face meeting between the PCP and Care Coordination team is held for initial hand-off at the time of referral.

5.3.1.2 All relevant information (e.g., social services need, clinical status, behavioral health details such as current drug use, both patient's and PCP's perspectives of the barriers to care and treatment, etc.) is shared amongst the team during the hand-off.

5.3.1.3 At a minimum, attendance at the initial hand-off should include the PCP along with the Care Coordinator or the Medical Center Liaison, and if possible the Patient Navigator. If appropriate and possible, the patient should attend as well.

5.3.1.4 If a Patient Navigator or Care Coordinator was not assigned to the patient prior to the hand-off, the Program Director assigns Program staff as soon as possible.

5.3.1.5 Document the initial hand-off on the Services Tracking Log (Appendix KK) using the eSHARE service type "Case Conference."

5.3.2 Chart-based case review

5.3.2.1 Ongoing chart reviews

5.3.2.1.1 The purpose of chart reviews is for staff members to ensure that the program model is followed.

5.3.2.1.2 These could be done alone or with the supervisor and do not have to coincide with the PCP visit.

5.3.2.1.3 These reviews are used to inform or trigger a case conference when necessary.

5.3.2.1.4 All Care Coordinators meet with Patient Navigators no less than once (1) per week to review cases. **These chart reviews are not case conferences. They are considered supervision and quality improvement activities.**

5.3.2.1.5 Patient Navigators select challenging cases from the prior week for review with Care Coordinator.

5.3.2.1.6 All cases should be reviewed by the Care Coordinator at least once per quarter.

5.3.2.1.7 The Program Director meets with Care Coordinators once per week and review cases selected from those in item 6.3.2.1.5.

5.3.2.2 Quarterly Reviews - The Program Director reviews all cases in the portfolio once per quarter. (Refer to §11.0 and §12.3)

5.3.3 Case conference

5.3.3.1 A case conference occurs any time a clinical evaluation (e.g., a physician visit) generates new information that could impact the patient's care plan.

5.3.3.2 A status change that might impact the medical treatment plan also triggers a case conference (e.g., loss of housing, pregnancy, etc.).

5.3.3.3 In most instances, a face-to-face meeting (scheduled or unscheduled) between the PCP and the Program (e.g., the Care Coordinator or Patient Navigator accompanying the patient to their PCP visit) immediately following a visit satisfies the requirement for a formal case conference.

5.3.3.4 In some instances this is not feasible. For example:

5.3.3.4.1 The patient has active behavioral health problems, and the input of a mental health provider is required.

5.3.3.4.2 The patient has other medical needs (e.g., pregnancy), and the input of a medical specialist (e.g., obstetrician) is required.

5.3.3.4.3 In these cases, a conference may be deferred or it may be accomplished by phone/conference call or both, but it must be completed within ten (10) business days of the clinical evaluation.

5.3.3.5 A case conference is documented on the Case Conference Form (Appendix GG).

5.3.3.6 A **formal case conference** occurs for each patient at least once per quarter and includes any case conference where all elements included on the Case Conference Form (Appendix GG) are covered with required attendees present.

5.3.3.6.1 Required attendees include:

- Program Staff (CC and/or PN and/or MCL)
- Clinician (MD/DO/NP/PA)

5.3.3.6.2 Optional attendees include:

- Patient

5.3.3.7 An **informal case conference** occurs as frequently as needed and does not require completion of the Case Conference Form (Appendix GG).

5.3.3.7.1 Required attendees include:

- Program Staff (CC and/or PN and/or MCL)
- Non-Program Staff (Clinician, Social Worker, Mental Health Provider, Nutritionist, etc.)

5.3.3.7.2 Optional attendees include:

- Patient

5.3.3.8 Case conferences are structured, interdisciplinary meetings involving all parties providing direct service to the patient. Programs with network partners that are not co-located could consider allowing off-site team members to participate via telephone when an in-person

case conference is not possible. In general, in-person case conferences are recommended.

5.3.3.9 Another option for formal case conferences is when a Patient Navigator accompanies a patient to a primary care visit, or whenever a primary care site has a care coordinator or a medical center liaison on site, patient visits should conclude with a meeting between at least one of the above (PN, CC, or MCL) and the PCP.

5.3.3.9.1 When no Care Coordination staff on the premises, the PCP instead contacts the Care Coordinator at the conclusion of the visit to update him/her. This should occur rarely.

5.3.3.9.2 When a status change occurs outside the context of PCP evaluation, the Care Coordination staff contact the PCP as soon as possible after they become aware of the status change. This should occur rarely.

5.3.3.9.3 If the medical provider already has a mechanism for interdisciplinary case conferences in place, the conversation may be deferred until the next meeting.

6.0 Induction Phase & Ongoing Care Coordination

6.1 Program flow at a glance

6.1.1 Phases

6.1.1.1 **Induction:** The Induction Phase in Care Coordination is defined as the first three (3) months after the patient enrollment. This initial period is a critical time to familiarize the patient with the program and begin health promotion discussions from the Facilitator's Guide for Health Promotion. As such, for the first three (3) months after enrollment, every patient **must** start with **at least weekly** health promotion sessions.

6.1.1.1.1 Patients not indicated for and not prescribed ART medications can initially be enrolled in Track C2 in order to receive weekly health promotion sessions. After the Induction phase is over, if the patient continues to not be prescribed and initiated ART, the patient **must** immediately be enrolled in Track A.

6.1.1.1.2 Incoming patients who have already accepted offers of DOT services for prescribed ART, may initially enroll in Track D and as such

must also receive weekly health promotion sessions.

6.1.1.2 **Ongoing:** After the Induction phase, the patient must receive ongoing Care Coordination services at a mutually agreed-upon frequency. This may include being transitioned to a different track of either lower or higher intensity. Refer to Table 2 and Table 3 below as well as the Criteria for Transition Between Service Levels (Appendix G).

- Low intensity: A, B
- High intensity: C1, C2, D

6.2 Induction into the Program

6.2.1 *Duration*: The induction phase consists of the first three (3) months of service and allows the Program staff to comprehensively evaluate the patient's abilities and needs in the areas of medication, social support, appointment adherence and health promotion. The end of the induction period should correspond with a regularly-scheduled medical appointment. During the induction phase, all patients are to receive at least weekly services.

6.2.1.1 Patients not indicated for and not prescribed ART medications can initially be enrolled in Track C2 in order to receive weekly health promotion sessions. After the Induction phase is over, if the patient continues to not be prescribed and initiated ART, the patient **must** immediately be enrolled in Track A.

6.2.2 *Components*: The Induction phase starts new patients on the Program and includes:

1) Care Navigation;
2) Weekly Health Promotion;
3) Social Services and Benefits Assistance;
4) DOT for high intensity patients. (Refer to §2.4)

6.2.3 Newly enrolled patients prescribed medications should be assessed for readiness to use treatment adherence support/reminder tools (e.g. pill boxes, blister packs, phone alarm) as early as possible.

6.2.4 Care Navigation Activities

6.2.4.1 To not only ensure attendance, but also provide support and allow for skills-building in order to become more self-sufficient in the healthcare environment, patients in the Induction phase are accompanied to all primary care appointments from their homes. If the home is not a suitable location because of safety, disclosure, or other barriers, the accompaniment should originate at an alternative, mutually-agreed upon field location.

6.2.5 Health Promotion (refer to §2.2)

6.2.5.1 Patients in the Induction phase receive Health Promotion sessions from Program staff at least once (1) per week.

6.2.5.2 During the Induction phase, the recommended list of topics for health promotion is based upon the patient's clinical status. The patient and Patient staff may decide together to prioritize conversations differently, as well as postpone conversations to a later date. See Table 2 below for more details.

6.2.5.3 An initial adherence assessment for incoming patients with prescribed medications **must** be conducted within two (2) weeks of enrollment. During the Induction phase, continuous adherence assessments should be conducted and documented on the appropriate adherence assessment form [Appendix X – Adherence Assessment (Self-Report)].

Table 2: Health Promotion in the Induction Phase of Care Coordination

Intervention Intensity	Patient Characteristics	Suggested Health Promotion Topics	Frequency of Conversations	Site of Service
Tracks A, C2, or D	Track A – incoming patients not prescribed ART Track C2 – incoming patients who are prescribed ART and not receiving DOT services for ART, but may be receiving DOT services for other medications (psychotropic, opportunistic infections, and/or Hepatitis C) Track D – incoming patients who have accepted initial offers of DOT for prescribed ART medications	• Me and HIV (Core) • What is HIV and How Does It Affect My Body (Core) • Medical Appointments and Providers (Core) • What is Adherence? (Core)	Weekly	Should be in the patient's home/field, but may also include program site(s) (e.g. groups).

6.2.6 Social Services and Benefits Assessment

6.2.6.1 Patients in the Induction phase should receive continuous social services and benefits assessments following the initial assessments conducted during intake. Refer to §2.3 for details.

6.2.7 DOT

6.2.7.1 Incoming patients who have already accepted offers of DOT services for prescribed ART, may initially enroll in Track D during the Induction phase.

6.2.7.2 Incoming patients who have already accepted offers of DOT services for other medications (psychotropic, opportunistic infections, and/or Hepatitis C), must initially enroll in at least Track C2 during the Induction phase.

6.2.7.3 Refer to §2.4 for details.

6.3 Ongoing Care Coordination

6.3.1 Following the Induction phase of the Care Coordination program, the patient receives ongoing services according to their level of need - high or low intensity. With each subsequent visit to the PCP, the patient's health promotion and medication adherence needs should be re-assessed and the Comprehensive Care Plan should be updated accordingly.

6.3.2 *Duration*: The duration of enrollment should be considered on a case by case basis, but should generally not exceed one (1) year for most patients. It is up to your program to evaluate each patient for readiness for graduation. Patients who have been receiving ongoing Care Coordination for more than one (1) year may continue to receive services at the appropriate intensity level at the discretion of the Program and medical provider and justification **must** be documented. (Refer to §8.0 Graduation)

6.3.3 *Components*: Ongoing care coordination includes the following:

- Care Navigation;
- Health Promotion;
- Social Services and Benefits Assessment;
- DOT (as warranted).

6.3.4 Decisions to scale back, maintain or intensify services

6.3.4.1 Medical and Program staff should collaborate during case conferences to make decisions regarding service intensity and track changes. Criteria for these decisions include behavioral, social and clinical factors, as well as patient readiness and willingness.

6.3.4.2 Any changes in intensity of Care Coordination services (track change) should be logged via the Status Change

Information Form (Track and Treatment Status) (Appendix II).

- Intervention tracks are entered through the Patient Status Change form in eSHARE. Only track changes that have been entered into the Patient Status Change form count toward payment calculations. Identification of the new track in a Case Conference Form is not sufficient to affect payment.

6.3.4.3 A patient who continues to not be prescribed and initiated ART after the Induction Phase is over **must** immediately be enrolled in Track A.

6.3.4.4 A patient exhibiting improvement at reassessment should be assessed for willingness to move to a less intense track, while a patient experiencing significant challenges in their current track (e.g. viral load greater than 10,000 or increase without resistance, onset of a new opportunistic infection, onset/relapse of substance abuse, etc.) should be assessed for willingness to move to a more intense track, including Track D.

6.3.4.5 Refer to Appendix G for detailed criteria for movement between levels of service. These are guidelines and clinical nuance is warranted.

6.3.4.6 Patients with brief interruptions in their program engagement (e.g. short-term incarceration, hospitalization, rehabilitation, etc.) should continue with their previous service level (track) upon reengagement.

6.3.4.6.1 If the interruption lasts longer than one (1) month, then the case should be suspended (See §7.0).

6.3.4.7 Patients with interruptions with an indefinite period (e.g. long-term incarceration, hospitalization, rehabilitation, etc.) should be assessed for case closure (See §7.0).

6.3.4.7.1 If disengaged for longer than three (3) months, the case should be closed upon verification.

6.3.4.8 Any medication interruptions should be noted on the Reassessment Form (Appendix HH) and the Status Change Information Form (Track and Treatment Status) (Appendix II).

6.3.5 Common decisions regarding service levels

6.3.5.1 If the patient declines ART initiation:

6.3.5.2 A patient who continues to decline ART initiation during ongoing Care Coordination warrants a change to Track A. Program staff should continue to assess patient readiness and willingness to initiate ART. These offers

must be documented in client records (e.g. progress notes, charts, etc.).

6.3.5.3 If frequency of patient engagement is less than recommended as per their current track:

- A patient who demonstrates difficulty engaging with the Program at the frequency recommended for their current track should be assessed by Program staff for readiness and willingness to move to a lower intensity track. Program staff should meet to discuss what may be most appropriate for the client.

6.3.5.4 If the patient declines a recommended service level:

- A patient may decline a recommended service level and continue to receive services at a lower intensity than clinically indicated.
- When a patient declines a service level, re-offer that level regularly. These offers should be documented in progress notes and client charts.
- If all efforts fail to effectively engage the patient after transitioning to a lower intensity service, then the Program may dis-enroll the patient and refer to a more appropriate program.

6.3.5.5 If progress is made towards graduation

- The duration of enrollment should be considered on a case by case basis, but should generally not exceed one (1) year for most patients. It is anticipated that patients with indication for Low Intensity service would not require the service for more than one (1) continuous year.

6.3.6 Care Navigation Activities (See §2.1)

6.3.6.1 Patients in ongoing Care Coordination should continue to be accompanied from their homes or a mutually-agreed upon location to all medical appointments, as needed.

6.3.6.1.1 If the home is not a suitable location because of safety, disclosure, or other barriers, the accompaniment should originate at the alternative, mutually-agreed upon field location.

6.3.6.2 Accompaniment activities include:

- Helping the patient prepare for a visit;
  - Listing problems, concerns, questions;
  - Role-playing or practicing discussion of difficult topics with the doctor;
- Supporting communication between the patient and the PCP during the appointment, as needed;

- Reviewing the medical treatment plan after the visit, as needed.

6.3.7 Health Promotion (See §2.2)

6.3.7.1 Patients should continue to receive health promotion services during ongoing Care Coordination as outlined below in **Table 3**.

Table 3: Intervention Types for Ongoing Care Coordination*		
Intervention Intensity	**Service Level (Track)**	**Intervention Activities**
Low Intensity	**A** (limited to persons with no indication for ART or those who are not prescribed and/or will not be taking ART in the immediate future)	Health Promotion Curriculum: Delivered **quarterly**. Suggested topics include: • **Topic 1:** Introduction to the Health Promotion Curriculum (Core) • **Topic 2:** Me and HIV (Core) • **Topic 7:** What is HIV and How Does it Affect My Body (Core) • **Topic 8:** Identifying and Building Social Support Networks (Core) • **Topic 10:** Medical Appointments and Providers (Core) • **Topic 11:** Health Maintenance (Discretionary) • **Topic 12:** Harm Reduction – Sexual Behavior (Discretionary) • **Topic 13:** Harm Reduction – Substance Use (Discretionary) • **Topic 14:** Harm Reduction – Safety in Relationships (Discretionary) • **Topic 15:** Healthy Living – Diet and Exercise (Discretionary) • **Topic 16**: Wrap Up • **Topic 17**: Harm Reduction – Tobacco Use (Discretionary) • **Topic 18**: Me and Hepatitis C (Discretionary) Accompaniment to PCP appointments Medication Adherence: None

NOTE: Table 3 continues below.

	B	Health Promotion Curriculum: Delivered **quarterly** in conjunction with primary care visits and at any home visits. ALL health promotion curriculum topics are suggested, which include all of the topics listed for Low A, plus • **Topic 3:** Using a Pillbox (Core) • **Topic 4:** Handling your ART Medications (Core) • **Topic 5:** What is Adherence? (Core) • **Topic 6:** Side Effects (Discretionary) • **Topic 9:** Adherence Strengths and Difficulties (Core) Accompaniment to PCP appointments Medication Adherence: Quantitative measurement of adherence by self-report **in conjunction with PCP and home visits**
High Intensity	**C1**	Health Promotion Curriculum: Delivered **monthly**, generally in the patient's home or other suitable site in the field. **ALL** health promotion curriculum topics are suggested. Accompaniment to PCP appointments Medication Adherence: Pill counting monthly
	C2	Health Promotion Curriculum: Delivered **weekly**, generally in the patient's home or other suitable site in the field. **ALL** health promotion curriculum topics are suggested. Accompaniment to PCP appointments Medication Adherence: Pill counting weekly
	D (limited to persons receiving DOT services for prescribed ART)	Health Promotion Curriculum: Delivered **weekly**, generally in the patient's home or other suitable site in the field. **ALL** health promotion curriculum topics are suggested. Accompaniment to PCP appointments Medication Adherence: DOT **daily** (M-F)

*Service Levels (Tracks) are described in Criteria for Transition between Service Levels (Appendix G)

6.3.8 Social Services and Benefits Assistance (See §2.3)

6.3.8.1 Reassessment

6.3.8.1.1 During ongoing Care Coordination, Program staff **must** continue to review the plan with regard to social services and benefits assistance **at least** once (1) every six (6) months, or as needed.

6.3.8.1.2 Programs should reassess client's housing status as needed and for assisting with recertification for HASA and Human Resources Administration (HRA)[24].

6.3.8.1.3 Programs **must** check for duplication of services at least once (1) every six (6) months, and update the patient's status accordingly.

6.3.8.1.3.1. Patients enrolled in Medicaid services (e.g. Health Homes) and who are **ineligible** for Ryan White funded services must be dis-enrolled from Care Coordination. This should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix JJ).

6.3.8.1.3.2. Patients enrolled in Medicaid services (e.g. Health Homes) and who are **eligible** for Ryan White funded services may receive continuity of service through the Care Coordination program. This should be documented immediately on the Reassessment Form (Appendix HH) and entered into eSHARE in order to have the new status count towards payment calculations. Refer to §4.5.3.

6.3.8.2 The Reassessment Form (Appendix HH) should be used to document the information collected during this process.

6.3.9 Directly Observed Therapy (DOT): Refer to §2.4 for details.

6.3.9.1 After the Induction Phase, clients who have been receiving DOT services should continue to do so during ongoing Care Coordination. Clients receiving DOT for ART medications after the Induction phase should be enrolled in Track D. Clients receiving DOT for non-ART medications (e.g. psychotropic, opportunistic infections, and/or Hepatitis C) can be enrolled in any track.

6.3.9.2 Clients who meet the criteria to begin DOT services after the Induction Phase must be offered DOT.

[24] NYC Human Resources Administration. Website: http://www.nyc.gov/html/hra/html/home/home.shtml. Accessed March 17, 2015.

6.3.9.3 All offers of DOT services must be documented in client records (e.g. progress notes, charts, etc.).

6.3.10 ART Adherence

6.3.10.1 All patients in tracks B, C1, C2 and D who are continuously enrolled and not suspended must have at least ONE (1) adherence assessment entered in eSHARE quarterly.

6.3.10.2 Follow the guidelines listed below regarding usage, key points, frequency, staff responsible, documentation and eSHARE reporting for each of the ART adherence assessment forms: Adherence Assessment Form (Self-Report Form), Pill Box Log Form, and Monthly DOT Log Form.

6.3.10.3 **Adherence Assessment Form (Self-Report Form)** is used for patients in Tracks B, C1, C2 and D who are currently on prescribed ART (including pills, liquids, and injectables) to document the **patient's self-reported** adherence assessments. Use this form in addition to the Pill Box Log Form and the Monthly DOT Log Form. This form **MAY** be used for non-ART medications (including psychotropic, opportunistic infections, and/or Hepatitis C) **but** the adherence percentage **MUST NOT** be reported into eSHARE.

6.3.10.3.1 Frequency – Complete the baseline assessment within the first two (2) weeks of enrollment, then ongoing, at least once every three (3) months in preparation for a formal case conference. The Case Conference Form requires information from the most recently completed Adherence Assessment Form.

6.3.10.3.2 Alternatively, for patients in Tracks B, C1 or C2 who use neither pill boxes nor blister packs, complete the Adherence Assessment form (in lieu of the Pill Box Log form) and eSHARE entry at the frequency below:

- Track B: At every Quarterly visit.
- Track C1: At every Monthly visit.
- Track C2: Once (1) per month at one (1) of the Weekly visits.

6.3.10.3.3 Document the self-reported adherence assessment on the Services Tracking Log (Appendix KK) and the Adherence Assessment Form – Daily (Appendix W) or Non-Daily (Appendix X).

6.3.10.4 **Pill Box Log Form** is used for patients in Tracks B, C1 and C2 who are currently on prescribed ART (including pills, liquids, and injectables) **and not receiving DOT** to document pill box counts conducted by Care Coordination staff. **Do not** document patient's self-reported adherence status on the Pill Box Log form. This form **MAY** be used for non-ART medications (including psychotropic, opportunistic infections, and/or Hepatitis C) **but** the adherence percentage **MUST NOT** be reported into eSHARE.

6.3.10.4.1 Blister packs may be used to measure adherence on the Pill Box Log, as long as the empty packs are available to verify the number of pills taken each day to the number of prescribed pills each day.

6.3.10.4.2 Frequency – Complete pill counts at the frequency specified below per track:

- Track B: At every Quarterly visit, review the available pill boxes and/or blister packs going back no more than four (4) weeks.
- Track C1: At every Monthly visit, review the available pill boxes and/or blister packs going back no more than four (4) weeks.
- Track C2: Once (1) a month at **one (1)** of the Weekly visits, review the available pill boxes and/or blister packs going back to the prior week. **Once (1) a month,** enter the adherence percentages calculated from the completed paper form into eSHARE.

6.3.10.4.3 Document the pill box count on the Services Tracking Log (Appendix KK) and the Pill Box Log Form - Daily (Appendix DD) or Non-Daily (Appendix EE).

6.3.10.5 **Monthly DOT Log Form** is used for patients in Track D who are currently on prescribed ART (including pills, liquids, and injectables) and receiving DOT for ART. The Monthly DOT Log form is used **at each** DOT visit to document **the direct or indirect** observation by Care Coordination staff of pills taken. Do not document patient's self-reported adherence status on this form. This form **MAY** be used for non-ART DOT but the adherence percentage **MUST NOT** be reported into eSHARE.

6.3.10.5.1 Direct observation indicates encounters where the Care Coordination staff **visually observes** the patient self-administer the medication dose.

6.3.10.5.2 Indirect observation indicates encounters where the Care Coordination staff does **NOT visually observe** the patient self-administer the medication dose but **DOES visually observe** that the medication has been depleted one (1) dose by conducting a pill count.

- Indirect observation includes unobserved doses or days that occur when Care Coordination staff are not present (e.g. taken before navigator arrives for scheduled visit, weekends, etc.).

6.3.10.5.3 Frequency – Update this paper form at every DOT visit. **Once (1) a month**, enter the adherence percentages calculated from the completed paper form into eSHARE.

6.3.10.5.4 Daily Forms and Non-Daily Forms are available for the Adherence Assessment Form and the Pill Box Log.

6.3.10.5.5 Use **only** one (1) form (either Daily or Non-Daily form) per adherence assessment per patient.

6.3.10.5.6 The ART Daily Regimens Only form is used for patients who are prescribed the same number of ART doses each day of the week.

6.3.10.5.7 The ART Non-Daily Regimens Only form is used for patients who are prescribed a different number of ART doses on different days of the week.

6.3.10.5.7.1. If the patient is taking at least one (1) prescribed Non-Daily ART in their regimen, then use the Non-Daily Forms [Adherence Assessment (Self-Report) and/or Pill Box Log] to document the entire ART regimen of daily and non-daily ART doses. Please note that the number of doses will vary each day for patients who are taking both daily and non-daily ARTs.

6.3.11 Ongoing Comprehensive Care Plan updates

6.3.11.1 The Care Coordinator (with support from the Patient Navigator) should meet with the patient to update the current Comprehensive Care Plan **at least** once (1) every six (6) months during ongoing Care Coordination.

6.3.11.1.1 The PCP provides the medical treatment plan updates for the Comprehensive Care Plan.

6.3.11.2 Reassessments should occur when the patient's situation changes. These changes are opportunities to discuss with the patient related circumstances and needs, and may result in updates to the Comprehensive Care Plan. Changes that require reassessment and Comprehensive Care Plan updates may include:

- Homelessness;
- Substance use
- Any event that may require emotional support and counseling services;
- Patient deciding to adjust goals or priorities;
- Enrollment in other case management program (e.g. Medicaid Health Homes).

6.3.12 Missed appointment procedure

6.3.12.1 When a patient misses a scheduled appointment with program staff or medical staff :

- A supervisor must be notified;
- Missed appointments may be documented on the **optional** Referrals/Appointments Tracking Log (Appendix Z);
- At a minimum, daily telephone calls must be made to the patient starting the day of the missed appointment;
- Phone calls should be made at different times of the day to increase likelihood of making contact with patient;
- A home/field visit is necessary after three (3) sequential business days of failed outreach by phone. However, the Program need not wait three (3) days to initiate home/field outreach;
- Home/field visits should continue at least once (1) per week until the patient is located;
- Subsequent visits to the most recently updated address are not warranted if it becomes apparent that the patient has permanently moved;
- A letter to the patient is necessary after two (2) sequential weeks of failed outreach by phone and home/field visits;

- The letter must not include any information that might disclose the patient's protected health information. As such, the letterhead and the envelope used to send the letter should not contain the Program Site name[25];
- The letter should express concern about the patient's well-being and ask them to contact the Program Staff;
- Internet-based searching for persons whose address may have changed should be conducted when the patient has been absent for more than four (4) weeks.
- Possible Internet resources include, but are not limited to:
  - http://a072-web.nyc.gov/inmatelookup/
  - http://www.411.com/
  - http://www.intelius.com/
  - http://vitalrec.com/
  - http://ssdi.rootsweb.ancestry.com/
  - http://www.lexisnexis.com/terms/privacy/data/people.asp
  - http://www.zabasearch.com/
- A second (2) letter to the patient is necessary after two (2) sequential months of failed outreach by phone and/or home/field visits. This letter should specify that the patient's case will be closed;
- Document outreach for patient re-engagement activities on the Services Tracking Log (Appendix KK) using service type "Outreach for Patient Reengagement" and document appointment details and disposition on the Referrals/Appointments Tracking Log (Appendix Z).

7.0 Case Suspension and Case Closure

7.1 Overview

7.1.1 Services end when the agency Program and/or the patient: (1) suspends services temporarily; (2) graduates; (3) voluntarily withdraws or declines treatment; (4) transfers medical care to a non-affiliated medical provider; (5) experiences difficulty engaging with the agreed-upon program services; (6) is permanently lost to follow-up; or (7) is permanently unable to participate.

7.1.2 All case closures and case suspensions should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix JJ) and reported in eSHARE.

[25] HIPAA 'Protected Health Information': What Does PHI Include? Website: http://www.hipaa.com/2009/09/hipaa-protected-health-information-what-does-phi-include/. Accessed March, 13 2015.

7.2 Case Suspensions

7.2.1 Anticipated absences from the program for at least one (1) month should lead to the patient's suspension (e.g. scheduled trips, incarceration, hospitalization, rehabilitation, etc.). Suspension should be documented in the Patient's chart at the time Program staff confirms the reason for the patient's absence. The suspension start date reported in eSHARE **must** be one (1) day **after** Program staff receives this confirmation. This is because services reported on the same day as suspension will not be recognized by eSHARE, which affects payment. Patients suspended in eSHARE can be easily resumed without re-enrolling.

7.2.2 Unanticipated absences from the program for at least two (2) months without successful contact (i.e. patients who missed an appointment with Program Staff and received outreach follow-up activities – see §6.3.12) should be documented in the Patient's chart at the time Program staff confirms the reason for the patient's absence. The suspension start date reported in eSHARE **must** be one (1) day **after** the completion of outreach follow-up activities. This is because services reported on the same day as suspension will not be recognized by eSHARE, which affects payment. After all efforts have been made to locate the patient and the patient has not been located after two (2) sequential months of outreach, the enrollment may be either suspended or closed at the program's discretion.

7.3 Case Closures

7.3.1 If the patient is lost to care and/or has been unable to return to care for **at least three (3) months**, the case must be closed. Once the patient's case is closed, the patient may be eligible for re-enrollment at a later time.

7.3.2 Close the patient's case if the patient is permanently unable to participate. Reasons may include:

- Death;
- Long-term incarceration;
- Commitment to other institution; or
- Moved out of the Eligible Metropolitan Area (EMA).

7.3.3 Case closure date entered into eSHARE **must** be one (1) day after the last service provided, including non-face-to-face services. This is because services reported on the same day as closure will not be recognized by eSHARE, which affects payment.

7.3.4 The Health Resources and Services Administration (HRSA) rule for retaining administrative and programmatic records for patients whose cases have been closed is three (3) grant years after the full reconciliation of the grant. The New York State (NYS) rule for adult

social service records retention is six (6) years, thus the NYS rule trumps the HRSA rule for client charts because it is more stringent.

7.4 Voluntary Withdrawal

7.4.1 A patient may decline further service at any time. If a patient chooses to permanently dis-enroll from the Program, the patient may continue to receive primary care at the Program site.

7.4.2 When a patient seeks to withdraw but does not meet the criteria to graduate, the Program must inquire why the patient wishes to terminate services and assess readiness and willingness to continue engagement with the Program in the near future.

7.4.2.1 If an attempt to encourage continued engagement with the patient is not successful, the Program should engage in the following steps:

- Notify the PCP of the decision during either an informal or formal case conference;
- Dis-enroll the patient from the Program;
- Document the reason for closing the case on the Status Change Information Form (Case Closure/Suspension) (Appendix JJ);
- Close the enrollment in eSHARE;
    - Case closure date entered into eSHARE **must** be one (1) day after the date of the last service provided to the patient.
- Offer a referral to another program, as needed.

7.4.3 The patient may re-enroll in the Program after graduation, if they meet the initial eligibility requirements for enrollment.

7.5 Lateral Transfer

7.5.1 A patient may request transfer to another Care Coordination program

7.5.1.1 Care Coordination services are always delivered within an integrated system. If at any time the patient prefers medical care at another health facility and transfer is arranged, the patient will subsequently receive Care Coordination services within the system of the accepting facility.

7.5.1.2 The Program must coordinate a lateral transfer with the current clinical provider, and assist in transfer of the patient's medical records and Care Coordination records. The patient's written consent must be documented on the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).

7.5.1.2.1 If the Program receives a request to transfer the patient's medical records to another health facility without previous discussion with the patient, the Program should:

- Contact the patient to assess their reasons for leaving the agency's program.
- Obtain patient consent to transfer their case and records.

7.5.1.3 The patient's case remains open at the referring Program until the accepting Program acknowledges receipt of the relevant records and the patient attends the first medical appointment with the accepting Program.

7.5.1.3.1 It is the responsibility of the referring Program to provide services to the patient until the lateral transfer is completed.

7.5.1.3.2 Starting on the date of the first medical appointment with the accepting program, it is now the responsibility of the accepting Program to provide services to the patient.

7.5.1.4 At this point the referring Program closes the enrollment.

7.5.1.5 Transfer to the accepting Program must be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix JJ) and reported in eSHARE.

8.0 Graduation

8.1 Graduation

8.1.1 Graduation criteria for patients not receiving ART may include:

- Demonstrated the ability to navigate the health care system;
- Developed a sense of self-sufficiency (e.g., seeks resolutions to their needs, less dependent on others and shows initiative);
- Kept all scheduled medical and social services appointments;
- Established tools and resources to assist with being able to keep appointments in the future;
- Obtained and maintained needed services (e.g., housing, entitlements, benefits, medical, social, etc.);
- Resolved major issues identified in the Comprehensive Care Plan; and

- Developed a sustainable social support network.

Note: If health issues such as substance use and/or mental health co-morbidities emerge or re-emerge that do not justify re-engagement with the Care Coordination program, then refer the Patient to an appropriate treatment program.

8.1.2 Graduation criteria for patients receiving ART may include:

- Maintained medication adherence >95%;
- Maintained an undetectable viral load for at least six (6) consecutive months;
- Demonstrated improvement with other clinical criteria (e.g., decreased hospitalizations, other medical conditions stabilized, no new opportunistic infection diagnoses);
- Demonstrated the ability to navigate the health care system;
- Developed a sense of self-sufficiency (e.g., seeks resolutions to their needs, less dependent on others and shows initiative);
- Kept all scheduled medical and social services appointments;
- Obtained and maintained needed services (e.g., housing, entitlements, benefits, medical, social, etc.);
- Resolved major issues identified in the Comprehensive Care Plan; and
- Developed a sustainable social support network.

8.1.3 The patient may re-enroll in the Program after graduation, if they meet the initial eligibility requirements for enrollment.

8.1.4 The Health Resources and Services Administration (HRSA) rule for retaining administrative and programmatic documents for graduated patients whose cases have been closed is three (3) grant years after the full reconciliation of the grant. The New York State (NYS) rule for adult social service records retention is six (6) years, thus the NYS rule trumps the HRSA rule for client charts because it is more stringent.

9.0 Preventing Secondary Transmission of HIV[26]

9.1 Overview

9.1.1 Preventing secondary transmission of HIV refers to any activity that helps PLWHA to avoid transmitting HIV to others, avoid becoming

[26] Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Website: http://aidsinfo.nih.gov/Guidelines/HTML/1/adult-and-adolescent-treatment-guidelines/29/. Accessed Mar. 24, 2015.

infected with other illnesses (e.g., hepatitis, sexually transmitted infections, and different strains of HIV) and live a healthy lifestyle.

9.1.2 The key components of preventing secondary transmission include:

- HIV risk behavior assessment;
- Partner notification; and
- Early treatment of HIV.

9.2 HIV risk behavior assessment

9.2.1 The PCP should conduct an assessment of HIV risk behavior regularly for each patient. The assessment should address the patient's sexual, substance use and social behaviors.

9.2.2 The Program staff **must** conduct an assessment at intake of the client's HIV risk behavior (sections VI and VII on the Intake Assessment Form – Appendix U). Ongoing reassessments **must** be conducted at least every six (6) months (sections V and VI on the Reassessment Form – Appendix HH).

9.2.2.1 The program staff should also have ongoing health promotion discussions with clients regarding safer sex, substance use, and other HIV risk behaviors.Program Staff should provide condoms to patients who request them.

9.2.2.2 Condoms may be obtained from the free NYC condom distribution program.[27]

9.3 Partner notification

9.3.1 If patients disclose HIV-negative sex partners and/or needle sharing partners, the Program should attempt to elicit the names and contact information of these partners, conduct domestic violence screening, and then refer the named partners to the NYC DOHMH Contact Notification Assistance Program (CNAP).

9.3.2 For assistance with eliciting or referring partners to the NYC DOHMH, contact a CNAP coordinator at (212) 693-1419.

9.4 Early treatment of HIV

9.4.1 DOHMH recommends offering ART to any person living with HIV, regardless of the person's CD4 cell count. The recommendation is based on evidence that ART can improve the health of people living with HIV and that ART can prevent transmission of HIV from an HIV-infected person to an uninfected sexual partner.[28]

[27] NYC Condom Distribution Program. Website: http://www.nyc.gov/html/doh/html/living/condoms-where.shtml. Accessed Mar.24, 2015.
[28] NYC DOHMH, Antiretroviral therapy. Website: http://www.nyc.gov/html/doh/html/living/nyc-hivart.shtml. Accessed Mar. 24, 2015.

10.0 HIV Patient Confidentiality

10.1 Funded providers/organizations **must** follow all applicable confidentiality and privacy laws, including Federal (e.g., HIPAA[29]), State (e.g., Article 27-F[30]) and local laws in order to protect patient privacy.

11.0 Quality Management

11.1 Expectations

11.1.1 Care Coordination Programs funded by Ryan White Part A must participate in the NYC DOHMH quality management program funded by Part A of the Ryan White Treatment Modernization Act.[31]

11.1.2 The Program is expected to develop a Quality Management Program, which includes:

- Developing a Quality Management Plan;
  - Elements in the Quality Management Plan include Statement of Purpose, Structure, Quality Goals, Improvement Plans, Staff and Patient Involvement, Sustainability, and Evaluation.
- Participating in quality assurance activities as contractually required;
- Compliance with relevant Care Coordination quality indicators; and
- Collecting and reporting of data for use in measuring performance.

11.1.3 The Program Director is responsible for developing processes for quality assurance chart reviews.

11.1.3.1 All charts must be reviewed once per quarter by the Program Director with the Care Coordinator and the Patient Navigator.

11.1.3.2 It is strongly recommended that the Program staff create chart review tools to systematically document quality improvement efforts.

11.1.4 The Program should continue to monitor patients who have graduated to ensure retention in care.

11.2 Client satisfaction

11.2.1 Client satisfaction surveys developed by NYC DOHMH will be administered on a biennial basis.

[29] HIPAA. Website: http://www.hipaa.com/. Accessed Mar. 24, 2015.
[30] New York State Confidentiality Law and HIV. Website: https://www.health.ny.gov/publications/9192.pdf . Accessed Mar. 24, 2015.
[31] For more information, refer to http://nationalqualitycenter.org. Accessed Mar. 24, 2015

11.2.2 Agencies **must** participate in the surveys developed by NYC DOHMH. In addition, agencies may also conduct their own client satisfaction activities (e.g., suggestion box, surveys, etc.).

11.3 **Grievances**

11.3.1 Each agency **must** have an established grievance procedure.

11.3.2 Grievances should be reviewed on a monthly basis to ensure they have been appropriately addressed.

12.0 Training and Supervision Requirements

12.1 Training Requirements

12.1.1 All staff **must** receive initial and ongoing training to orient them to organizational and program-specific information.

12.1.2 Employee orientation **must** take place within one (1) month of being hired and include orientation to agency operations, policies and procedures, contract requirements, overview of HIV/AIDS, and HIV confidentiality and Health Insurance Portability and Accountability Act (HIPAA) training including the timeframe for completion.

12.1.3 All staff funded to provide direct services to patients **must** receive ongoing trainings and education at least annually, including:

- Essentials of medical case management training delivered by NYC DOHMH or designee (initial upon hire; annual refresher course);
- Program manual training delivered by NYC DOHMH or designee (initial upon hire; annual refresher course);
- Health Promotion Curriculum training delivered by your agency [ongoing, at least once every two (2) months]. (Refer to §2.2.3);
- Education on new and emerging developments within the field of HIV/AIDS care, treatment, and prevention;
- Harm reduction approaches for substance use trainings;
- Mental health trainings (non-mental health and non-medical program staff must be properly trained to provide appropriate referrals and to respond to emergencies according to the processes of the Program site); and
- Cultural Competency trainings.

12.1.4 Documentation of staff trainings must be maintained on-site and available for review during site visits.

12.1.5 Staff training needs should be identified during staff supervision and performance evaluations.

12.1.6 Additional training should be provided by Program Directors, as needed.

12.1.7 NYC DOHMH-sponsored programmatic or implementation-related trainings that are specific to the service category are **mandatory**. The program **must** allow staff to attend these trainings.

12.2 Clinical Supervision Requirements

12.2.1 Clinical supervision may include: providing skills training on clinical issues, discussing casework, and addressing other professional issues in a structured way.

12.2.2 **All** staff providing direct services to patients **must** receive clinical supervision.

12.2.3 Clinical supervision should be conducted **at least** two (2) times a month or a **minimum** of 60-120 total minutes per month.

12.2.4 Clinical Supervision **must** be conducted by a licensed mental health provider (e.g., LCSW, LMSW, LMHC, psychiatrist, psychologist)

12.2.5 It is **strongly recommended** that clinical supervision not be provided to staff members by their direct supervisors.

12.2.6 Clinical supervision sessions can be conducted individually and/or in groups.

12.2.7 It is recommended that mental health providers are provided with their own clinical supervision as required by their appropriate licensing requirements.

12.3 Programmatic Supervision Requirements

12.3.1 Programmatic supervision may include: reviewing administrative issues, discussing the program model, assessing current case loads, and ensuring that training requirements are met.

12.3.2 **All** staff providing direct services to patients **must** receive programmatic supervision.

12.3.3 Programmatic Supervision should be conducted **at least** once (1) a month.

12.3.4 Programmatic Supervision may be conducted individually and/or in groups.

12.3.5 Programmatic supervision may be conducted by the Program Director, Care Coordinator and/or any other Care Coordination staff with managerial responsibilities.

APPENDICES

APPENDIX A – Common Acronyms in Ryan White HIV/AIDS Services

ACA: Affordable Care Act

ADAP: AIDS Drug Assistance Program

ADHC: Adult Day Health Care

AI: AIDS Institute of the New York State Health Department

AIDS: Acquired Immunodeficiency Syndrome

AIRS: AIDS Institute Reporting System (released in 1996 as the URS - the Uniform Reporting System)

ART: Antiretroviral Therapy

ARV: Antiretroviral

BHIV: New York City Department of Health and Mental Hygiene's Bureau of HIV/AIDS Prevention and Control

CAB: Community Advisory Board

CAP: Corrective Action Plan

CBO: Community-Based Organization

CARE Act: Ryan White Comprehensive AIDS Resource Act

CC: Care Coordination OR Care Coordinator

CD4: Cluster of Differentiation 4

CDC: Centers for Disease Control and Prevention

CHC: Community Health Center

CFP: Community Follow-up Program

CHAIN: The Community Health Advisory Information Network, the New York EMA's longitudinal survey of HIV-positive individuals, initiated in 1994 by the Columbia University Joseph L. Mailman School of Public Health.

CHW: Community Health Worker

CLER: Client-Level Enrollment Report

CLSR: Client-Level Services Report

CM: Contract Manager

CMS: Case Management Services

CNAP: Contact Notification Assistance Program

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985

CSS: Client Satisfaction Survey

CTP: New York City Department of Health and Mental Hygiene's HIV Care and Treatment Program

CY: Contract Year

DAC: Designated AIDS Center

DOB: Date of Birth

DOT: Directly Observed Therapy

DSRIP: Delivery System Reform Incentive Program

DV: Domestic Violence

Dx: Diagnoses

EHR: Electronic Health Records

EIC: Engagement in Care

EMA: Eligible Metropolitan Area

EMR: Electronic Medical Records

ePNR: Electronic Program Narrative Report

eSHARE: Electronic System for HIV/AIDS Reporting & Evaluation

ESAP: Expanded Syringe Access Program

FFS: Fee-for-Service

FPL: Federal Poverty Level

FSU: New York City Department of Health and Mental Hygiene's Field Services Unit of the Bureau of HIV/AIDS, Epidemiology Program

HAART: Highly Active Antiretroviral Therapy

HASA: New York City Department of Social Services, Human Resources Administration, HIV/AIDS Services Administration

HATMA: Ryan White HIV/AIDS Treatment Modernization Act of 2006

HHC: New York City Health and Hospitals Corporation

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

HIVQUAL: HIV Quality guidelines of the New York State Department of Health

HOPWA: Housing Opportunities for People with AIDS program funded by Department of Housing and Urban Development's Office of HIV/AIDS Housing

HP: Health Promotion

HPA: Housing Placement Assistance

HIPAA: Health Insurance Portability and Accountability Act

HRSA: U.S. Health Resources and Services Administration

IDU: Injection Drug Use

IOC: Integration of Care Committee of the Planning Council

IPT: Income Predictor Tool

IPV: Intimate Partner Violence

LPAP: Local AIDS Pharmaceutical Assistance Program

MAI: Minority AIDS Initiative

MCL: Medical Center Liaison

MCM: Medical Case Management

MCO: Managed Care Organization

mDOT: Modified DOT

MIR: Master Itemization Report

MOU: Memorandum of Understanding

MRA: Maximum Reimbursable Amount

MSM: Men who have Sex with Men

MSMW: Men who have Sex with Men and Women

NAC: Needs Assessment Committee of the New York City EMA's HIV/AIDS Planning Council

NDRI: National Development and Research Institutes, Inc.

NYC DOHMH: New York City Department of Health and Mental Hygiene

NYCHSRO: New York County Health Services Review Organization

NYSDOH: New York State Department of Health

OBMC: Outpatient Bridge Medical Care

OI: Opportunistic Infection

OMC: Outpatient Medical Care

PACT: Prevention and Access to Care and Treatment

PCP: Primary Care Provider

PCSM: Primary Care Status Measures

PD: Program Director

PEP: Post-Exposure Prophylaxis

PHL: Public Health Laboratories

PLWHA: People Living With HIV/AIDS

PMPD: Per-Member-Per-Day

PN: Patient Navigator

PNAP: Partner Notification Assistance Program

PO: Project Officer

POLR: Payer of Last Resort

PrEP: Pre-Exposure Prophylaxis

PSRA: Priority Setting and Resource Allocation Committee of the New York City EMA's HIV/AIDS Planning Council

QI: Quality Improvement

QLN: New York State AIDS Institute Quality Learning Network

QM: Quality Management

QMP: Quality Management Plan

REU: Research and Evaluation Unit of the Bureau of HIV/AIDS Prevention and Control at the NYC Department of Health and Mental Hygiene

RFP: Request for Proposal

RITC: Rikers Island Transitional Consortium

RSR: Ryan White Services Report

RTC: Return to Care

RW: Ryan White

RWCC: Ryan White Care Coordination

RWPA: Ryan White Part A

Rx: Prescription Medication

SFSR: Services/Forms Scheduling Report

SNAP: Supplemental Nutrition Assistance Program

SNP: Special Needs Plan (Medicaid)

SRO: Single Room Occupancy

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection

STL: Services Tracking Log

TA: Technical Assistance

T-TAP: Training and Technical Assistance Program of the Bureau of HIV/AIDS Prevention and Control at the NYC Department of Health and Mental Hygiene

Tx: Treatment

VAS: Visual Analog Scale

VL: Viral Load

VLS: Viral Load Suppression

YMSM: Young Men who have Sex with Men

APPENDIX B – Definitions Referenced in the Program Manual

Accompaniment: A health promotion activity designed to increase adherence to a patient's treatment plan. For example, a Patient Navigator accompanies the patient from his/her home to medical appointments. If the home is not a suitable location because of safety, disclosure concerns, or other obstacles, the accompaniment originates at an alternative, mutually-agreed upon location in the community (e.g., somewhere the patient hangs out, the patient's favorite park, or other set location near his/her home or work). The most crucial part of an accompaniment is attendance at the PCP visit with the patient. Accompaniment is intended for PLWHA who struggle with conventional treatment regimens and who may be ambivalent about following through with the appointment. The goal is to provide social support and help the patient connect to medical care in order to improve patient health outcomes and reduce rates of hospitalization.[32]

Affiliate Provider: Any health care or related agency or organization with operational policies or protocols that address the logistical, ethical, and legal issues of - and therefore facilitate - sharing health information for the panel of patients that it shares with another provider.

Benefits: Publicly-funded services administered by local, State or Federal government to assist certain families or individuals in need. Services or cash assistance may include social security, Medicaid or Medicare, food stamps or housing assistance.

Care Coordination: The deliberate integration of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services, as defined by McDonald et al.[33] The opposite of care coordination is fragmentation of care, which is often seen when the relationship between a single practitioner and a patient does not extend beyond specific episodes of illness or disease.[34]

Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through using communication and available resources to promote quality cost-effective outcomes, as defined by the Case Management Society of America.[35]

Case Review: An internal process during which the Program Director reviews cases with significant activity or complexity on a weekly basis. The purpose of the case review is to ensure that navigation and health promotion activities are proceeding appropriately. Program Directors should perform a case review in a summary fashion for every patient at least once per quarter. Concerns or determinations arising from either of these case reviews should be brought to case conference with the rest of the team.

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[32] Behforouz HL, Farmer PE, Mukherjee JS. From directly observed therapy to accompagnateurs: enhancing AIDS treatment outcomes in Haiti and Boston. *Clinical Infectious Disease*. 2004;38:S429-36.
[33] McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft S, McKinnon M, Paguntalan H, Owens DK. Care Coordination**.** Vol. 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. Jun. 2007. p.41.
[34] Haggerty JL et al. cited in Bodhenheimer T. Coordinating Care—A Perilous Journey through the Health Care System. *NEJM.* 358;10, Mar. 6, 2008. p.1064.
[35] Case Management Society of America. Available at: http://www.cmsa.org/ABOUTUS/DefinitionofCaseManagement/tabid/104/Default.aspx. AccessedMar. 25, 2015.

Case Conference: An interdisciplinary meeting during which all Care Coordination team members involved in providing care to the patient (e.g., clinician, Program Director, Care Coordinator, Medical Center Liaison, Patient Navigator, DOT Specialist, clinical specialists, clinical supervisor) participate and contribute to the process of reviewing documentation and developing the care plan for a patient. Each patient should be discussed at a case conference at least once per quarter. A case conference may also be an interdisciplinary meeting (scheduled or unscheduled) held directly following a medical appointment that includes the clinician, a Care Coordination staff member, and may also include the patient.

Chronic Care Model: This model uses a proactive disease management approach to support and empower individuals with chronic illnesses to gain and maintain independence in their health. The goal is to help improve the quality of life of the patient by building skills to promote adherence to a treatment regimen, prevent deterioration, reduce risk of complications, prevent associated illnesses, and in order to do this, the model encourages active participation from the patient. The model uses elements such as clinical information systems, self-management support and delivery system design to be consistent with established clinical practice guidelines in an effort to improve chronic disease care.[36]

Coaching: A health promotion activity that employs a counseling technique to help individuals improve or maintain their health status by empowering them to become self-sufficient. Coaching is intended to provide non-judgmental emotional and logistical support to the patient to encourage an increase of adherence to their medical plan.

Community Health Worker (CHW): A person who establishes a relationship built on trust with their patients by bridging the gap between the clinic and the community. CHWs help health care systems overcome personnel and financial shortages by providing high-quality, cost-effective services to community members in their homes, and by catching serious conditions at an early stage, before they become more dangerous and expensive to treat. CHWs help patients overcome obstacles (e.g., lack of health information, social services, transportation, and social stigma).[37] CHWs are known by various roles, such as Program Manager, Patient Navigator, Care Coordinator, DOT Specialist, Health Educator, Health Volunteer, Medical Provider, Social Worker, Nutritionist/Dietitian, and Outreach Specialist.

Comprehensive Care Plan: A written plan developed by the patient's medical providers and Care Coordination team in order to achieve treatment goals. A service plan is one component of the care plan, which consists of activities (logistical and procedural) that the patient and care Coordination team would engage in to carry out the care plan. The care plan identifies activities, prospective dates for each planned activity and anticipated resources required to ensure care plan adherence.

Cultural Competency: Attitudes, behavior and policies of service providers which could accommodate language, values, beliefs, and behavioral differences of the individuals they serve in a cross-cultural setting.[38]

Directly Observed Therapy (DOT): A trained CHW (e.g., Patient Navigator or DOT Specialist) conducts daily observations of the patient taking his/her prescribed medications. DOT provides

[36] Improving chronic illness care. The chronic care model. Available at: http://www.improvingchroniccare.org. AccessedMar. 25, 2015.
[37] Community Health Workers. Available at http://www.pih.org/pages/community-health-workers/. Accessed on Feb. 27, 2013.
[38] Fortier JP, Bishop D. Setting the agenda for research on cultural competence in health care: final report. Edited by C. Brach. Rockville, MD. U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality. 2003. Available at: http://www.ahrq.gov/research/cultural.pdf. Accessed Feb. 27, 2013.

intensive and daily support to patients. The CHW encourages the patient to take the prescribed medication in the correct dosage and at the correct time. If the patient is not ready to take his/her medications, the Care Coordination Program's goal is to help the patient explore their unique barriers to taking their medications as prescribed. DOT is a resource for those persons who are having great difficulty adhering to an anti-retroviral regimen independently or with the support of intensive health promotion but are willing to take ART. In most instances, Care Coordination Programs provide **modified DOT** services, e.g., not seven (7) days a week or not all doses of medications be taken is observed.

Health Literacy: "The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[39]

Health Promotion: "Any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals, groups or communities."[40] Health promotion may include activities such as medication adherence support, accompaniment, coaching, and teaching health education. The level of health promotion interventions would vary according to the patient's intensity of needs.

Intensity, Low: The description of interventions that requires health promotion or a related activity *at least once per quarter* [i.e., every three (3) months]. This is appropriate for PLWHA who are not currently prescribed an ART regimen or have been stabilized for a period of time on ART and who consistently attend their HIV medical appointments.

Intensity, High: The description of interventions that requires health promotion or a related activity *at least once per month* and possibly as frequently as once per day. This is appropriate for PLWHA that are on ART.

Interdisciplinary Team: A team that includes professionals representing the disciplines required for a comprehensive approach to meeting the needs of the patient. At a minimum, the team consists of a clinical provider and the Care Coordinator/Navigator, who collaborate to improve patients' health outcomes.

Logistical Support: The provision or arrangement of necessary services and resources in order to carry out the treatment plan including transportation and childcare services. Other factors that must be taken into consideration for the delivery of the care plan include health literacy, patient's preferred language and social barriers (e.g., family violence).

Lost to Follow-up: A term that describes when a patient has not been located after two (2) sequential months of outreach efforts to locate the patient.

Medical Case Management: The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB)[41] defines medical case management as "a range of patient-centered services that link patients with health care, psychosocial, and other services. Coordination and follow-up of medical treatments are components of medical case management. Services ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of patients' and key family members' needs and personal support systems. The service includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens. Key activities include (1) initial

[39] HHS, National Institutes of Health, National Library of Medicine (NLM). In: Selden, C.R.; Zorn, M.; Ratzan, S.; et al.; eds. *Health Literacy, January 1990 through 1999*. NLM Pub. No. CBM 2000-1. Bethesda, MD: NLM, February 2000, vi. Available at: http://www.nlm.nih.gov/archive/20061214/pubs/cbm/hliteracy.html. Accessed Mar. 24, 2015.
[40] Healthy People 2020 Information Access Project. *Health Communication*. Office of Disease Prevention and Health Promotion. Available at hpartners.org/hp/ Accessed Mar. 24, 2015.
[41] Refer to http://www.hrsa.gov/about/organization/bureaus/hab/. Accessed Mar. 24, 2015.

assessment of service needs; (2) development of comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) patient monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the patient. It includes all types of case management, including face-to-face meetings, phone contact, and any other forms of communication.[42]

Medical Home Model: A model of care that links patients to a personal physician or other provider at the center of a complex health care system. The medical home model utilizes the chronic care model to promote self-sustaining health skills. The personal physician is the patient's main point of entry to the health care system who then interfaces with the Care Coordination Program and the entire team of healthcare professionals to provide consistent integrated and appropriate medical care.[43]

Medical Treatment Plan Adherence: Adherence to all medical appointments and referrals and obtaining lab tests/imaging when ordered. This is distinct from the (medication) treatment adherence described below.

Medication Adherence: Adherence to the recommended treatment regimen by taking all prescribed medications as indicated by the prescriber. Medication adherence is described quantitatively as percentage of medication doses divided by dose prescribed taken over a period. Specific interventions are used to improve adherence.

Navigation Model: The navigation model aims to advocate for, communicate with, and identify resources for the patient, thereby coordinating the complex health care and social services necessary to ensure improved patient outcomes. Patient Navigators generally focus on partnering with and empowering the individual requiring services. The model also includes supportive counseling and coaching (i.e., active discussion and education, empowerment and encouragement).

NYC HIV Care Coordination: The NYC DOHMH HIV Care Coordination model combines elements of medical case management, navigation and chronic care models to both help patients in becoming self-sufficient and to assist them in accessing needed care and services. The four components of the Care Coordination model that work together for the client include Patient Navigation, Health Promotion, Treatment Adherence, and Benefits and Services Coordination. In addition, the three aspects of the Care Coordination model that are shared across all four components are Assessment and Planning, Information Sharing, and Outreach for Re-engagement. Various theory-based methods could be used to assist the patient to achieve set goals, such as strengths-based or trans-theoretical approaches, while the focus remains on navigating the system to obtain needed services and coaching for self-sufficiency.

Out of Care: A term used to define patients who have received primary care services with a provider within the last two (2) years and have not been seen in primary care for the past nine (9) months at that specific facility.

Outpatient Bridge Medical Care: Ryan White Part A OBMC was developed to provide outpatient medical care to HIV-infected individuals who are receiving sporadic or no medical care, and to link them to HIV primary care services at a HIV medical care clinics within an eight-month period.

[42] The Ryan White HIV/AIDS Treatment Modernization Act (HATMA) of 2006 changed to include medical case management as a core service. Available at: http://hab.hrsa.gov/newspublications/careactionnewsletter/november2008.pdf. Accessed Mar. 24, 2015.
[43] American College of Physicians. The advanced medical home: a patient-centered, physician-guided model of health care. Jan. 22, 2006.

OBMC services are meant to provide temporary primary care in an out-of-clinic setting and are not intended as a long-term primary medical care solution.

Patient Advocacy: Activities designed to help people protect their rights and help them obtain needed information, services and benefits (including medical, social, legal, and financial). Advocacy does not include coordination and follow-up of medical treatments. Advocacy should be done as part of Care Coordination in an effort to build upon cooperation and collaboration among providers.

Primary Care Provider: The primary medical care provider (i.e. physician, nurse practitioner, physician assistant) responsible for the patient's comprehensive medical treatment plan including HIV care.

Quality Management: A method of program/service evaluation that is designed to assure the highest quality of service is provided.

Ryan White Core Services: Core medical services designated by the U.S. Health Resources and Services Administration that must collectively account for no less than 75% of each year's Part A spending plan. Core medical services funded by the New York EMA include AIDS Drug Assistance Program; outpatient/ambulatory medical care; medical case management; mental health services; substance use services; early intervention services; home care; and health care.

Ryan White Non-Core Services: Non-core services provided through Part A by the New York EMA include Housing services, including emergency rental assistance, emergency transitional housing, and housing placement; legal services; food bank/home-delivered meals; psychosocial support services.

APPENDIX C – Access-A-Ride

The MTA New York City Access-A-Ride (AAR) program provides transportation for persons with disabilities who are unable to use public bus or subway services. This program offers shared ride, door-to-door paratransit service 24 hours a day, 7 days a week in all five boroughs of New York City.

In order to participate in this program, applicants must be assessed by a healthcare professional and if appropriate, undergo functional testing at a Transit Office Assessment Center. The certifier will send their assessment report to the Transit Office, who will notify the applicant of their decision within 21 days. If an applicant is denied eligibility or given conditional eligibility, they have a right to appeal the decision within 60 days of notification. Although most AAR customers need to be recertified every five years, those customers whose disability is unlikely to improve or for whom their disability will become more severe, can simply update their information in lieu of this process.

Once approved for the AAR program, customers can call the Paratransit Reservations Office one to two days in advance of their trip to make a reservation. Furthermore, for those customers who travel from the same location to the same destination at the same time of day for each trip, can arrange a subscription service and will only need to call if they would like to cancel their trip. Finally, customers pay for their trip the same fare they would pay on mass transit (i.e., exact change or TransitCheck coupons). Customers may be accompanied by one paying guest, as well as a personal care attendant (who rides free of charge), if needed and pre-approved by the Transit Office.

The role of the Care Coordination would be to assist PLWHAs with the following tasks:

- Applying and recertifying enrollment in the AAR program
- Appealing New York City Transit Office decisions
- Determining if a personal care attendant (relative, spouse, friend, or a professional attendant) is needed during their PLWHA's travel
- Creating and canceling AAR reservations and subscriptions

Additional information about the AAR program can be found at http://www.mta.info/nyct/paratran/guide.htm.

APPENDIX D – Childcare Services

This section clarifies what is required of entities providing childcare services in New York City.

Any entity providing child supervision services at the same location where the patient is receiving funded services does not have to apply for and receive a child care permit from New York City, pursuant to NYC Code 47.01(c)(2)(E). This exemption applies to any medical or social services provider providing child care to children of patients receiving medical case management services at the same premises. The medical or social services provider would fall under the definition of "Other Business".

In order to meet this exemption criterion, both of the following must be met:

1. The parent/guardian must remain at the same address as the site where the child care is being provided.
2. A particular child does not spend more than 8 hours per week in care.

If a patient is receiving medical case management services at a medical provider, the funded program can provide daycare services at the patient's home while the patient is receiving services without a childcare permit as allowed under State regulation 18 NYC RR 415.1(2)(i) This would be classified as a "Legally Exempt In-Home Child Care Service" .

In order to meet this criterion, the following must be met:

1. Child care must be furnished in the child's own home by a caregiver who is chosen and monitored by the child's caretaker.
2. The caregiver must be at least 18 years of age, or less than 18 years of age **and** meets the requirements for the employment of minors as set forth in article 4 of the New York State Labor Law; provided, however, that the child's caretaker must provide the caregiver with all employment benefits required by State and/or Federal law, and must pay the caregiver at least the minimum wage, if required.

Care Coordination program staff members are not allowed to provide child care services.

Any entity providing child supervision services must obtain a permit if the child care took place at a location other than where the parent/guardian is receiving services.

APPENDIX E – Benefits Programs Listed through AccessNYC[44]

Families with Children
- Child Care
- Head Start
- Out-of-School Time (OST)
- Universal Prekindergarten (UPK)

Employment and Training Programs
- In-School Youth Employment Program (ISY)
- New York State Unemployment Insurance
- NYCHA Resident Employment Services (RES)
- Senior Employment Services (SES)
- Summer Youth Employment Program (SYEP)
- Workforce1

Financial Assistance Programs
- Cash Assistance
- Child and Dependent Care Tax Credit (Federal and New York State)/New York City Child Care Tax Credit
- Child Tax Credit (Federal)/Empire State Child Credit (New York State)
- Earned Income Tax Credit (EITC) (Federal, New York State and New York City)
- Home Energy Assistance Program (HEAP)

Food and Nutrition Programs
- Commodity Supplemental Food Program (CSFP)
- Food Stamps
- School Meals
- Summer Meals
- Women, Infants and Children (WIC)

Health Care Services
- Nurse-Family Partnership (for first time pregnant women)

Health Insurance Programs
- Child Health Plus B
- Family Health Plus/Medicaid
- Healthy NY
- Medicaid (coverage for adults)
- Medicaid (coverage for children)
- Medicaid Excess Income/Medicaid
- Prenatal Care Assistance Program/Medicaid

Housing Programs
- Disability Rent Increase Exemption (DRIE)
- Disabled Homeowners' Exemption (DHE)
- School Tax Relief (STAR)
- Section 8 Housing Assistance
- Senior Citizen Homeowners' Exemption (SCHE)
- Senior Citizen Rent Increase Exemption (SCRIE)
- Veterans' Exemption

[44] AccessNYC. Website: https://a858-ihss.nyc.gov/ihss1/en_US/IHSS_homePage.do. Accessed Mar. 24, 2015.

APPENDIX F – New York City Harm Reduction Syringe Access Programs[45]

[45] New York City Harm Reduction Syringe Access Programs. Website: http://www.nyc.gov/html/doh/downloads/pdf/basas/syringe_exchange.pdf . Accessed 02/12/2014.

-BROOKLYN-

After Hours Project
718-249-0755

- 10am-6pm M-Th, 9am-5p Fri
- Case management
- HIV testing
- Hep testing and vaccines

Family Services Network of NY
718-573-3358

- 8am-4pm MTWF, 10a-6p Th
- AIDS services
- Legal services
- Meal and nutrition services

VOCAL
718-802-9540

- 12pm-6pm Mon-Fri
- Support groups
- Hep C testing
- Referrals

-STATEN ISLAND-

Community Health Action of SI
718-808-1300

- Case management
- Housing services
- Food pantry
- Job counseling
- HIV testing
- Outpatient drug treatment
- HIV prevention and education
- Hep screening and vaccines

-BRONX-

BOOM! Health
718-292-7718

- 9am-8:30pm M T Th F
- 12p-3:30p Wed, 10a03p Sat
- SRO hotel outreach
- Case management
- Meals, showers, clothing
- Acupuncture
- Mental health services
- Housing services
- HIV testing
- Hepatitis testing and vaccines
- Educational and support groups
- Women's and trans' services

NY Harm Reduction Educators
718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hep screening and vaccines
- Case management

St. Ann's Corner of Harm Reduction
718-585-5544

- 9am-5pm MTWF, -6:30p Th
- Mental health counseling
- Support groups
- Acupuncture and massage
- Showers, clothing, hot lunch
- HIV testing
- Educational groups

New York City Harm Reduction Syringe Access Programs

A List of Services Offered

2014

Bureau of Alcohol & Drug Use Prevention, Care & Treatment

NYC Health

-MANHATTAN-

NY Harm Reduction Educators
718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hepatitis screening and vaccines
- Acupuncture
- Recovery readiness program
- Case management

Housing Works (HW clients only)
212-966-0466 x1167

- 8am-5pm Mon-Fri and last 2 Saturdays of the month
- Legal services
- Transitional housing
- Permanent housing
- Health care
- Dental care
- Case management
- Job training
- Mental health services
- Transgender services

Lower East Side Harm Reduction Center
212-226-6333

- 9am-7:30pm
- Case management
- Mental health services
- Housing specialist
- Acupuncture
- Hepatitis C testing
- Hepatitis A/B vaccine

-MANHATTAN-

Positive Health Project
212-465-8304

- 12p-5pm Mon-Fri (7pm Th)
- Mental health services
- Case management
- HIV and Hep C testing
- Vaccinations
- LGTBQI services
- Acupuncture

Washington Hts CORNER Project
212-923-7600

- 9a-5p MWF, -6p TTh, -3p S
- Mental health services
- Case management
- Referrals to HIV testing
- Hep C testing
- Clothing
- IDs

StreetWork LES (youth only)
646-602-6404

- 3pm-7pm TThF, 2-5pm M
- Emergency shelter
- Case management and groups
- Psych and medical services
- Meals, showers, supplies

Harlem United
212-924-3733

- 9am-5pm Mon-Fri
- Transitional housing
- Access to medical care
- Harm reduction counseling
- HIV testing, ADAP
- Mental health services

-QUEENS-

AIDS Center of Queens County
718-472-9400

- 9am-5pm Mon-Fri
- Food and clothing
- Acupuncture and massage
- Buprenorphine
- Case management
- Housing services
- Legal services
- HIV, STI and Hep C testing
- Mental health services

For more information, call 1-800-LIFENET (1-800-543-3638)

Para mas información, llama al 1-877-AYUDESE (1-877-298-3373)

APPENDIX G – Criteria for Transition between Service Levels

Instructions for use:

1. In the leftmost column find your patient's current service level.
2. Move across the row until you find the criteria that best describe your patient's current state.
3. The corresponding column heading identifies what service level should now be assigned to your patient.

From \ To	Low Intensity - A	Low Intensity - B	High Intensity – C1	High Intensity – C2	High Intensity - D
Low Intensity - A	Needs navigation support on behavioral grounds and needs continued health promotion[46]	N/A	N/A	Starting ART	N/A
Low Intensity - B	ART is discontinued indefinitely.	Undetectable VL **AND** Treatment Adherence >90% **AND** no clinical or social complications **OR** patient has been at this level for less than 75 days[1]	Detectable VL <10,000 **AND** social or behavioral indication that adherence may have waned	VL>10,000 **OR** recent increase without resistance **OR** new opportunistic infection	VL>10,000 **OR** recent increase without resistance **OR** new onset of substance use **OR** new opportunistic infection
High Intensity – C1	ART is discontinued indefinitely.	Undetectable VL **AND** no clinical or social complications **OR** VL stable >/=6 months on the same treatment, without more effective options	VL<10,000 **AND** no clinical or social complications **OR** patient has been at this level for less than 75 days	VL>10,000 or recent increase without resistance **OR** new opportunistic infection	VL>10,000 **OR** recent increase without resistance **OR** new onset of substance use **OR** new opportunistic infection

[46] Maintenance at this level is time limited; no patient should require more than 12 months.

From \ To	Low Intensity - A	Low Intensity - B	High Intensity – C1	High Intensity – C2	High Intensity - D
High Intensity – C2	ART is discontinued indefinitely.	Patient refuses weekly health promotion	Undetectable VL **AND** no other clinical or social complications	VL<10,000 **AND** no clinical or social complications **OR** VL >10,000 **AND** patient refuses DOT **OR** patient has been at this level for less than 75 days	VL >10,000 or recent increase without resistance
High Intensity - D	ART is discontinued indefinitely.	Patient refuses DOT and weekly intervention	VL<1,000 **AND** no social or clinical complications **AND** mastered health promotion curriculum	VL <10,000 **AND** patient has not yet mastered the curriculum	VL >10,000 **OR** patient has been at this level for less than 75 days

Additional Factors Affecting Movement Between Levels of Care:

i. Adherence to scheduled prescribed medication regimens may influence decisions to change levels of care. An adherence of >95% may influence the care providers to decrease the level of care coordination services. An adherence of <80% may influence the care providers to increase the level of care coordination services.

ii. Patients may be moved directly to DOT at any point if the VL becomes 10,000 without any detectable resistance or if any clinical or social complications are present.

iii. Patients are assessed quarterly to determine eligibility for DOT services. Patients who are eligible for DOT services should receive an offer to participate in an appropriate track (See Table 1, pg. 17).

iv. Patient who do not have lab results as a consequence of non-adherence with medical recommendations should be treated as if they had a VL>10,000.

v. Patients who decline DOT services should generally receive weekly health promotion (C2); those who decline health promotion should still receive low intensity services (B) with frequent offers to intensify to the indicated level.

vi. Any of the following may be considered clinical or social complications for the purposes of determining level of care:
   1. New OI
   2. Clinical deterioration while on prescribed HIV medications
   3. Change in living situation such that patient's medication adherence may be affected
   4. Recent increase or new onset in substance use that may affect medication adherence

APPENDIX H – Health Promotion Topics Included in Curriculum

Health Promotion Topic	Learning Objectives
1. Introduction to the Curriculum (Core)	• Introduce the curriculum • Initial adherence assessment • Goal setting • Comprehensive Care Plan • Patient Workbook storage
2. Me and HIV (Core)	• Identify the patient's life goals as they relate to HIV
3. Using a Pillbox (Core)	• Understand the proper use of a pillbox • Demonstrate the ability to organize medications and take ART medication correctly
4. Handling your ART medications (Core)	• Understand, discuss and demonstrate steps to be taken for medication refills, storage and preventing stock outs
5. What is Adherence? (Core)	• Understand the importance of medication adherence • Understand what adherence means for them • Understand and demonstrate ability to incorporate medication regimen into daily routine
6. Side Effects (Discretionary)	• Understand side effects of medications prescribed to patient • Develop a plan for identification and management of side effects
7. What is HIV and how does it affect my body? (Core)	• Understand HIV as a disease, its transmission, difference between HIV and AIDS • Understand the immune system, CD4 count and HIV viral load • Understand opportunistic infections
8. Identifying and Building Social support networks (Core)	• Map a non-Program social support network • Understand how to contact identified support people • Comprehend the role of their doctors • Understand what kind of support he/she can expect from each of these people
9. Adherence strengths and difficulties (Core)	• Identify three (3) areas of strength in adherence based on time in health promotion • Identify three (3) areas of difficulty in adherence based on time in health promotion
10. Medical appointments and providers (Core)	• Understand the importance of communicating with the provider • Develop a plan for preparing for appointments

Health Promotion Topic	Learning Objectives
	• Manage a list of medical providers and their contact information • Demonstrate how to schedule appointments • Understand how to coordinate transportation to all relevant appointments
11. Health maintenance (Discretionary)	• Introduction to health maintenance • Routine questions and answers at the doctor's office • Roles of different service providers
12. Harm Reduction – Sexual Behavior (Discretionary)	• Understand harm reduction and the importance of safe sex • Understand risks associated with various sexual behavior • Identify a plan for safer sex practices
13. Harm Reduction – Substance Use (Discretionary)	• Understand strategies for reducing health risks when using substances. • Develop a plan for staying adherent to ART when using substances • Know how to access available resources
14. Harm Reduction – Safety in Relationships (Discretionary)	• What is harm reduction? • Healthy Relationships • Identifying Safe/Unsafe situations • Personal Safety Plan
15. Healthy Living: Diet and Exercise (Discretionary)	• Healthy eating assessment • Why does eating health matter for HIV • Food safety • Setting healthy eating goals
16. Wrap Up	• Review Patient Workbook tools • Review goals
17. Harm Reduction – Tobacco Use (Discretionary)	• What is harm reduction? • Why reducing tobacco use is important for people with HIV • Common strategies for reducing risk • Create a harm reduction plan
18. Me and Hepatitis C (Discretionary)	• What is Hepatitis C and how does it affect my body? • How is Hepatitis C transmitted? • What are available HCV Treatments

APPENDIX I – Recommended Staffing Plan

Staff Title	Function	Recommended Minimum Credentials	Supervises:	Supervised by:
Program Director	• Provides oversight and management of the program. • Oversees monitoring, reporting and quality assurance activities.	• MPH, MSW, MPA, or MBA OR • BSN, PA, NP with formal managerial training OR • Other relevant Master's degree with formal managerial training • AND 3+ years of experience managing services similar to those described in RFP	Care Coordinator	Agency Decision
Care Coordinator	• Responsible for implementation of the service plan, supported by Patient Navigators. • Coordinates and oversees the implementation of the comprehensive plan. • Provides clinic-based health promotion in conjunction with regularly scheduled primary care visits. • Performs the initial entitlements assessment and collates the comprehensive plan. • Facilitates interdisciplinary conversation and planning. • Provides backup to Patient Navigators as needed. • Supervises Patient Navigator staff by chart review and face to face case discussions and performance reviews.	• BA/BS, LMSW/LCSW/ LMHC or RN/LPN degree • AND at least 2+ years of case management experience	Patient Navigators	Program Director

Patient Navigators	• Carries out tasks that are needed to execute the medical and support service plans, including the following:
	  • Accompanies patients to appointments when required.
	  • Provides coaching to patients.
	  • Delivers monthly or weekly health promotion sessions.
	  • Performs entitlements reassessment.
	  • Coordinates logistics for plan adherence – reminders, transportation and childcare arrangements.
		• High school degree or some college education.
		• Should have strong socio-cultural identification with the target population.
		• Strongly discourage the hiring of actively enrolled patients from the program or partner medical provider to protect patient confidentiality.
			None	Care Coordinator

Medical Center	• Facilitates communication about patient management	• BA/BS, LMSW/LCSW/ LMHC or RN/LPN degree	None	Medical Facility

Staff Title	Function	Recommended Minimum Credentials	Supervises:	Supervised by:
Liaison[47]	between primary care providers and Care Coordinators. • Forwards data reports (e.g., appointment dispositions, laboratory results, etc.) produced by clinical information systems to Care Coordinators. • Participates in the generation of and collates the treatment plan and forwards to Care Coordinators. • Collaborates with the clinical team to manage care coordination resources and target the neediest PLWHA for service. • May conduct selected center-based care coordination activities such as health promotion for low-intensity PLWHA as needed.	• AND at least 2+ years of case management experience • OR current satisfactory employment at the site of the medical provider as a case manager or social worker.		Decision
DOT Specialist–Health Center	• Provides clinic-based DOT.	• BSN, LPN or RN, unlicensed MD, or another staff member with medical background	None	Program Director
DOT Specialist – Field	• Responsible for field-based daily DOT. • Field based DOT includes DOT delivered in the home, CBO, work or any other location that is convenient for PLWHA.	• High school degree or some college education. • Should have strong socio-cultural identification with the target population. • Strongly discourage the hiring of actively enrolled patients from the program or partner medical provider to protect patient confidentiality.	None	Care Coordinator
Medical Provider	• Provides HIV outpatient “bridge” medical care (OBMC).	• NYS-licensed medical provider (MD, DO, NP PA,)	None	Agency Decision
Clinical Supervisor	• Provides clinical supervision to all staff providing services directly to patients. • Provides clinical or mental health guidance and the opportunity to review mental health and substance use issues as they relate to particular patients.	• Licensed mental health provider (e.g., LCSW, LMSW, LMHC, psychiatrist, psychologist)	Patient Navigators, Care Coordinators, DOT Specialists	Agency Decision

[47] This position is intended for affiliation arrangements where the medical organization could not arrange dedicated co-location of services and is not the applying agency.

APPENDIX J – Training Resources

NEW YORK CITY AND ONLINE
AIDS Community Research Initiative of America (ACRIA) 230 West 38th Street, 17th Fl. New York, NY 10018 Phone: (212) 924-3934 Website: http://www.acria.org/training/introduction
Centers For Disease Control and Prevention (CDC) Learning Connection 1600 Clifton Road, MS E-96 Atlantic, GA 30333 Phone: (808) CDC-INFO or (808) 232-4636 Email: learning@cdc.gov Website: http://www.cdc.gov/learning/?s_cid=phtnRetire
Cicatelli Associates, Inc. 505 Eighth Avenue, Suite 1600 New York, NY 10018 Phone: (212) 594-7741 Fax: (212) 629-3321 Website: http://www.cicatelli.org/
Clinical Education Initiative (CEI) Phone: (800) 233-5075 Website: http://www.ceitraining.org
Effective Interventions Phone 1: (866) 532-9565 Phone 2: (240) 645-1756 Email: interventions@danya.com Website: http://www.effectiveinterventions.org/en/TrainingCalendar.aspx
Harm Reduction Coalition 22 West 27th Street, 5th Floor New York, NY 10001 Phone: (212) 213-6376 Email: hrc@harmreduction.org Website: http://harmreduction.org/our-work/training-capacity-build/
Legal Action Center 225 Varick Street New York, NY 10014 Phone: (212) 243-1313 Toll Free: (800) 223-4044 Fax: (212) 675-0286 Email: lacinfo@lac.org Website: http://lac.org

Literacy Assistance Center (LAC) 39 Broadway, Suite 1250 New York, NY 10006 Phone: (212) 803-3300 Fax: (212) 785-3685 Website: http://lacnyc.org/
National Development and Research Institutes, Inc. (NDRI) 71 West 23rd Street, 8th Floor New York, NY 10010 Phone: (212) 845-4400 Fax: (917) 438-0894 Website: http://www.ndri.org
New York City Department of Health and Mental Hygiene, T-TAP Bureau of HIV/AIDS Prevention & Control Training and Technical Assistance Program 42-09 28th Street, CN#A-1, Floor 22 Long Island City, NY 11101 Phone: (347) 396-7701 Email: TTAP@health.nyc.gov
New York State Department of Health HIV/AIDS Education & Training Programs Phone: (518) 474-3045 Email: hivet@health.state.ny.us Website: http://www.hivtrainingny.org/
Planned Parenthood of New York City 26 Bleecker Street New York, NY 10012 Phone: (212) 965-7000 Email: choicevoice@ppnyc.org Website: http://www.plannedparenthood.org/nyc/local-education-training-15133.htm

APPENDIX K – City, State and National Resource List

NEW YORK CITY
HIV Care Coordination Phone: Call 311 Website 1: http://www.nyc.gov/html/doh/html/living/hiv-care-coord-tools.shtml Website 2: http://www.healthsolutions.org/HIVCare/?event=page.resources
NYC DOHMH HIV Services Locator Website: https://a816-healthpsi.nyc.gov/DispensingSiteLocator/mainView.do
The Positive Life Workshop Phone: (347) 396-7596 Website: http://www.healthsolutions.org/HIVCare/?event=page.resources
Public Health Solutions Website: http://healthsolutions.org
NEW YORK STATE
AIDS Drug Assistance Program for Medications (ADAP) Phone: (800) 542-2437 Website: http://www.health.state.ny.us/diseases/aids/resources/index.htm
AIDS Institute Website 1: http://www.theaidsinstitute.org/ Website 2: http://www.health.state.ny.us/diseases/aids/index.htm
Housing Opportunities for Persons with AIDS (HOPWA) Website: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing/programs
Medicaid Website: http://www.health.state.ny.us/health_care/medicaid/
Medicaid Health Homes Website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
NATIONAL
Human Resources and Services Administration, HIV/AIDS Bureau (HRSA) Website 1: http://www.hab.hrsa.gov/
Centers for Disease Control and Prevention (CDC) Phone: (800) CDC-INFO or (800) 232-4636 Website: http://www.cdc.gov/hiv/
National Institutes of Health (NIH) Website: http://www.nlm.nih.gov/medlineplus/hivaids.html

APPENDIX L – Pre-Referral to CC Program Form

PRE-REFERRAL TO CC PROGRAM FORM

Client Name: _____ **Client Record #:** _____

Complete this form with the pre-referring provider (e.g., external PCP, case manager, or other service provider) or individual based on their knowledge of the client's information. All required fields (set off by the special double border with thick outer line) should be completed at the time of pre-referral for all potentially eligible candidates, whether or not they consent to participate in the program.
PLEASE PRINT NEATLY AND RETAIN THIS FORM REGARDLESS OF CLIENT ENROLLMENT STATUS.

Type of pre-referral source:

❑ Testing Provider

❑ Outside Case Manager

❑ Self-referral

❑ Outside PCP

❑ Rikers Island Transitional Services Project

❑ Other Source (Specify:)

What is the client's primary language?	
What is the client's current home address:	
What is the client's primary telephone number?	(_____) _____ - _____
What is the client's alternate telephone number?	(_____) _____ - _____
Is client currently prescribed a regimen of ART: ❑ Yes ❑ No	
What is the reason for referral to Care Coordination? *(Check all that apply)*	
❑ Newly diagnosed	
❑ History of non-adherence	
❑ Current or recent substance use	
❑ Recent incarceration (past 12 months)	
❑ History of mental illness	
❑ First time on an ART regimen OR recent change in regimen	
❑ Possible ART resistance	
❑ Barriers to care (e.g. domestic violence, homelessness, underinsurance, loss to care)	
❑ Frequent missed appointments	
❑ Transfer of care and services from another program	
Did Program receive proof of HIV Diagnosis? ❑ Yes ❑ No	
If Yes, **What proof was given?**	❑ M11Q ❑ PCP referral/letter ❑ Other proof (Specify:_____) ❑ ADAP Card ❑ HRA referral

FOR OFFICE USE:

If Pre-Referral Source was a Testing Provider,

Was this a preliminary positive testing pre-referral? ❑ Yes ❑ No ❑ Unknown

If Yes, **Was a confirmatory test performed?** ❑ Yes ❑ No ❑ Unknown

Appointment Schedule:

Was an appointment set with PCP in Program? ❑ Yes ❑ No

If No,
Priority of Appointment Scheduling: *(Check only one)*

❑ Urgent (e.g., currently homeless, identified current threat to client, etc.)

If urgent, contact PCP within Program to set up appointment immediately, and contact necessary human services consistent with client needs.

❑ Standard

❑ De-prioritized (e.g., client ineligible, disinterested, or no longer living in the community)

❑ Other (Explain: _____)

Notes:

Program Staff Completing or Verifying Form:	Name	Signature	**Date:** m m / d d / y y
Primary Care Provider (PCP) Receiving Form:	Name	Signature	**Date:** m m / d d / y y

APPENDIX M – PCP Referral Disposition Form

PCP REFERRAL DISPOSITION FORM

Client Name: _____ **Client Record #:** _____

Primary Care Provider: Please complete this form while the client is in your office. If you approve the client for Care Coordination, then directly hand off the client and form to CC program staff at the end of the visit. If client was pre-referred from an external source, check "Yes" under Pre-Referral Status and complete this form after reaching a decision to approve or decline the Pre-Referral to the Care Coordination program.

Pre-Referral Status:

Was the client pre-referred (by an outside provider or other individual)? ❑ Yes ❑ No

If declining the Pre-Referral, skip to Notes and then add your name, signature and date to this form to complete.
If referring to Care Coordination, complete the double-bordered boxes (with thick outer line) below, and sign at bottom.

What are the reason(s) for referral? *(Check all that apply)*

- ❑ Newly Diagnosed with HIV
- ❑ Lost to Care (i.e., at least one visit in last two years, w/o a visit at that facility in past 9 months)
- ❑ Sporadic/irregular care; difficulty keeping appointments
- ❑ History of non-adherence to ART
- ❑ First time on an ART regimen OR recent change in regimen
- ❑ ART experienced with:

  Prior Tx failure and drug resistance
  -OR-
  Recurrent virologic rebound after successful suppression

CC Intervention Track recommended:

- ❑Intervention A: Non-ART Health Promotion – Quarterly
- ❑Intervention C2: Weekly (standard recommendation at enrollment for all clients currently prescribed ART)
- ❑Intervention D: DOT (highest intensity for clients currently prescribed ART)
- ❑TBD (track to be determined)

Notes:

_____

_____

_____

_____

If referring to Care Coordination,
BRING THE CLIENT AND REFERRAL DISPOSITION FORM DIRECTLY TO CC STAFF AT THE END OF VISIT.

Primary Care Provider (PCP) Completing Form:	Name	Signature	**Date:** m m / d d / y y
CC Staff Member Receiving Form:	Name	Signature	**Date:** m m / d d / y y

Client Name: _____ **Client Record #:** _____

FOR OFFICE USE *(REQUIRED FOR PROGRAM MONITORING/TA AND QUALITY ASSURANCE, BUT <u>NOT</u> FOR DATA ENTRY IN eSHARE)*:

<u>Outcome on PCP referral to Care Coordination:</u>

❑ Client enrolled

❑ Client ineligible/inappropriate referral
If Checked, **Explain why the client was ineligible or why the PCP referral was inappropriate:**

_____

_____

❑ Client Lost To Follow-Up (LTFU)
If Checked, **Explain how and when the client was determined to be lost to follow-up:**

_____

_____

❑ Client declined
If Checked, **Explain the client's reason for refusing or (if reason not known) how client refused:**

_____

_____

CC Staff Member Completing Section:	_____ Name	_____ Signature	**Date:**	/ / m m / d d / y y

APPENDIX N – Ryan White Part A Care Coordination Program Agreement (English)

RYAN WHITE PART A CARE COORDINATION PROGRAM AGREEMENT

Patient Name: _____ **Patient Record #:** _____

Before you agree to participate in this program, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You will be given a copy of this form to take with you.

What is the purpose of Care Coordination?
The mission of the Care Coordination Program is to improve the health of New Yorkers living with HIV. The Care Coordination Program will do that by helping you to obtain primary care, health education and support services. In this program, all your services will be managed under one primary care provider, the person who will be mainly responsible for your medical care. This helps to make sure that your primary care provider knows what is going on with you and can better meet your needs.

How does the Care Coordination Program work?
Staff members called Navigators and Care Coordinators or Medical Center Liaisons will help you with the activities of this program. Navigators will travel to your home or other meeting spot, while Care Coordinators or Medical Center Liaisons will stay in the office or clinic. Together, they will help you find and use resources to improve your health.

1) Your Navigator and Care Coordinator (or Medical Center Liaison) will:
   - Check if you are eligible for benefits and programs.
   - Help you find financial assistance, if needed.
   - Help you find medical insurance, if needed.
   - Help you find stable housing, if needed.
   - Make sure the care you receive is comprehensive and fits your needs.

2) Your Navigator will also offer Health Promotion. Health Promotion includes education and activities to build skills around HIV and other health issues. With new knowledge and skills, you can get more out of your appointments and medications.
   - If you do <u>not</u> have an antiretroviral (HIV) medication prescription, you will receive Health Promotion every three months.
   - If you <u>do</u> have an antiretroviral (HIV) medication prescription, you will receive treatment support as well as Health Promotion. Depending on your needs, you will receive these services every three months, every month or every week. A staff member may also visit you every day to help you take your medications.

What is expected of people who enroll in this program?
In order for you to succeed in the Care Coordination program you will be expected to:
- Go to all scheduled clinic visits or call to reschedule before your scheduled appointment if you cannot make it.
- Be available for and participate in visits with the Navigator or call to reschedule before your scheduled visit if you cannot make it.
- Work with your Navigator to learn more about HIV, your health and your care.
- Take your HIV medications to the best of your ability, if you are on them.
- Talk with your Navigator, Care Coordinator (or Medical Center Liaison) and Primary Care Provider about the things that may affect your health or your participation in the program.

You and the program staff will decide together on the medical and social services you need, and include whatever steps you agree on in a document called a care plan. The care plan will address your health-related needs and goals. To help you meet your needs and goals, the care plan will include referrals to other providers or organizations. While you are in the program, you will discuss needs with your Care Coordination team members on a regular basis. This will help them to make any necessary changes to your care plan and services.

It is important for everyone on your Care Coordination team to have up-to-date information about you. This is why information that you share with one member of your Care Coordination team may be shared with the other members. In addition to you, the team may include: your Primary Care Provider, a Medical Center Liaison, a Care Coordinator, a Navigator, and/or a peer worker to help you take your medications.

If you agree, your medications may be kept at the clinic where you receive primary care. This will help you and the Care Coordination team to keep track of your medications.

Care Coordination staff will collect information from you and from your medical charts. This information is needed to see how the program is doing and to check on the quality of services delivered. This information may include but is not limited to your medical history, dates and types of health-related appointments, services and benefits received, housing status, demographics (like race, ethnicity, gender, country of birth, schooling, and employment), risk behaviors, CD4 counts, viral loads, and medications. In addition, identifying information such as names, social security number[*], date of birth, addresses, and phone numbers will be collected so that the New York City Department of Health and Mental Hygiene (DOHMH) can connect your records and keep track of how many different individuals the program is serving. The DOHMH is the agency that applies for, receives and distributes the federal funding for Ryan White Part A in New York City.

What are the possible benefits of being in this program?

The purpose of the Care Coordination Program is to help you:

- See a Primary Care Provider on a regular basis.
- Get the medical and social services you need when you need them.
- Get healthy and stay healthy, including keeping a low viral load.
- Take medications as prescribed, if you are taking medications.
- Become able to manage your own medical and social needs.

Programs like Care Coordination have been shown to boost people's success taking HIV medications, and some have also been shown to improve signs of HIV-related health. However, there is no guarantee that you will benefit from this program or that it will affect you in the same way that it affects other people. By following the program, you will be taking advantage of one resource among many to support your health.

How will enrolling in this program affect my privacy?

Being in Care Coordination may create some intrusions into your life or routine. As part of this program, Navigators will meet you in your home or another agreed-upon meeting spot and, with your permission, will sit in on primary care visits. Also, you will be asked for

[*] Social security number is optional; you do *not* have to provide one in order to participate in this program.

contact information for yourself and for your friends and/or family, so that program staff can use the contact information you provide to re-connect with you if you fall out of touch. Staff will be careful to protect your privacy and confidentiality, especially with regard to HIV. They will never use health-related or HIV-related words in communications with your friends or family. All information about your being in this Care Coordination program is strictly confidential. You will be given a separate form to sign to permit the release or exchange of your HIV and other medical information, for the purpose of this Care Coordination program.

What if I do not want to participate, or if I want to stop after I enroll?

This program is voluntary. You may end your participation at any time. If you decide to stop, please give your Primary Care Provider and Care Coordinator or Medical Center Liaison notice in writing.

Care Coordination program staff or your Primary Care Provider can also end your participation in the program at any time. They can end your enrollment for medical, program-related or administrative reasons. For example, you might be discharged from the program if all efforts to involve you in program activities had failed. You might also be discharged if your Care Coordination team agreed that the program was not the best way of supporting your care and treatment.

Ending your participation in the Care Coordination program will not affect you getting regular medical care or treatment. The only result of ending your participation will be that you will not receive the additional support available through the program. If your participation ends, your information up to that time will still be kept and reviewed by the program, and may be included in its reports. However, the program will not collect any new information about you after the date you stop being enrolled. Any reports made on this program will group together the information from different patients, and will not identify you by name or release any other information that could identify you.

Statement of Agreement

I, (*print patient name)* _____, wish to enroll in the Care Coordination Program at (*agency)* _____.

I understand that I can end my participation and stop being in this program at any time. I understand that doing this will not affect my access to regular medical care in any way.

I understand that major activities of this program include determining my eligibility and needs; providing me with requested services; and evaluating the coordination, effectiveness and quality of services received.

I understand that no information or records associated with my case will be knowingly released to anyone or any agency without my written consent except as otherwise provided for by law. By my signature below, I give permission for personally identified (named) information about my health, needs, demographics, and care and services to be entered into a database for use by my Care Coordination team and by the New York City Department of Health and Mental Hygiene (DOHMH), which pays for this program. In addition to being used for patient care, the database can be used by authorized DOHMH staff to review the Care Coordination program for planning, quality improvement, evaluation, reporting, and research purposes. These DOHMH staff are specially trained, certified and recertified yearly by DOHMH in confidentiality procedures.

Patient Name: _____

I am signing this agreement of my own free will.

If I have any further questions, I may call _____ at (_____) _____-_____.

_____	_____/_____/_____
Patient Signature	**Date (mm/dd/yyyy)**

Care Coordination Staff administering consent:

_____	_____	_____/_____/_____
Staff Signature	**Initials**	**Date (mm/dd/yyyy)**

APPENDIX O – Ryan White Part A Care Coordination Program Agreement (Spanish)

CONFORMIDAD DEL PROGRAMA DE COORDINACIÓN DE LA CUIDADO MÉDICA RYAN WHITE PARTE A

Nombre del paciente: _____ **Nº de registro del paciente:** _____

Antes de aceptar participar en este programa, asegúrese de comprender la información que se provee a continuación. Si tiene algunas preguntas, tendremos mucho gusto en hablar con usted sobre ellas. Usted recibirá una copia de este formulario para llevarse.

¿Cuál es el propósito de la Coordinación de Cuidado Médica?
La misión del Programa de Coordinación de Cuidado Médica es mejorar la salud de los neoyorquinos que viven con el VIH. El Programa de Coordinación de la Cuidado hará eso ayudándole a obtener Atención Médica Primaria, educación sobre la salud y servicios de apoyo. En este programa, todos los servicios que reciba se administrarán a través de un solo proveedor de servicios médicos primarios, la persona que será principalmente responsable de su atención médica. Esto ayuda a garantizar que su proveedor de servicios médicos primario sepa lo que está pasando con usted y pueda satisfacer sus necesidades de una mejor manera.

¿Cómo funciona el Programa de Coordinación de Cuidado Médica?
Miembros del personal llamados Navegadores y Coordinadores de Cuidado Médica le ayudarán con las actividades de este programa. Los Navegadores viajarán hasta su casa u otro lugar de encuentro, mientras que los Coordinadores de Cuidado Médica o Enlaces con los Centros Médicos permanecerán en el consultorio o clínica. Juntos, ellos le ayudarán a encontrar y usar los recursos necesarios para mejorar su salud.

1) Su Navegador y Coordinador de Cuidado Médica hará lo siguiente:
   - Verificará si usted reúne los requisitos para recibir beneficios y programas.
   - Le ayudará a obtener asistencia financiera, si es necesario.
   - Le ayudará a obtener seguro médico, si es necesario.
   - Le ayudará a hallar alojamiento estable, si es necesario.
   - Se asegurará de que la atención médica que reciba sea integral y se ajuste a sus necesidades.

2) Su Navegador también le ofrecerá Promocion de Salud. Promocion de Salud incluye educación y actividades que incrementarán el conocimiento relacionados con el VIH y demás asuntos de la salud. Con nuevo conocimiento, usted podrá aprovechar más las citas y los medicamentos.
   - Si usted no tiene una receta médica antirretroviral (VIH), recibirá Promocion de Salud cada tres meses.
   - Si usted sí tiene una receta médica antirretroviral (VIH), recibirá apoyo para el tratamiento adicional de Promocion de Salud. Dependiendo de sus necesidades, usted recibirá estos servicios cada tres meses, cada mes o cada semana. Un miembro del personal también puede visitarlo todos los días para ayudarle a tomar sus medicamentos.

Nombre del paciente: _____

¿Qué se espera de la gente que se inscribe en este programa?
Para poder tener éxito en el Programa de Coordinación de la Cuidado Médica, se espera de usted lo siguiente:

- Que asista a todas las citas o si no puede asistir que llame con anticipación para cambiarlas.
- Que esté disponible y que participe en las visitas con el Navegador o si no puede asistir que llame con anticipación para cambiarlas.
- Que trabaje con su Navegador para aprender más sobre el VIH, su salud y su atención médica.
- Que tome sus medicamentos para el VIH de la mejor manera que pueda, si es que los está tomando.
- Que hable con su Navegador, con su Coordinador de Cuidado y con su Proveedor de Atención Médica Primaria sobre las cosas que puedan afectar su salud o su participación en el programa.

Usted y el personal del programa decidirán juntos cuáles son sus necesidades médicas y sociales, e incluirán los pasos que acuerden llevar a cabo en un documento llamado Plan de Cuidado Médica. El Plan de Cuidado Médica se ocupará de las necesidades y metas relacionadas con su salud. Para ayudarle a cumplir sus necesidades y metas, el Plan de Cuidado Médica incluirá información de otros proveedores u organizaciones. Mientras usted participe del programa, conversará sobre sus necesidades con los miembros del equipo de Coordinación de Cuidado Médica periódicamente. Esto les ayudará a ellos con los cambios que tengan que hacer en su plan de atención médica y el plan de servicios.

Es importante que todo el equipo de Coordinación de Cuidado Médica tenga la información suya actualizada. La información que usted comparta con uno de los miembros de su equipo de Coordinación de Cuidado Médica se puede compartir con otros miembros para que todos estén de acuerdo. El equipo puede incluir: su Proveedor de Atención Médica Primaria, un Enlace con el Centro Médico, un Coordinador de Cuidado Médica, un Navegador, y/o un Especialista (DOT) que le ayude a tomar sus medicamentos.

Si usted está de acuerdo, sus medicamentos se pueden guardar en la clínica donde usted recibe la Atención Médica Primaria. Esto le ayudará a usted y al equipo de Coordinación de Cuidado Médica llevar el control de sus medicamentos.

El personal de Coordinación de Cuidado Médica recopilará información de usted y de sus hojas clínicas. Esta información se necesita para ver cómo le está yendo con el programa y para controlar la calidad de los servicios proporcionados. Esta información puede incluir, aunque no se limita sólo a, su historia clínica, fechas y tipos de citas relacionadas con la salud, servicios y beneficios recibidos, estado de su vivienda, características demográficas (como raza, etnia, sexo, país de nacimiento, educación y empleo), conducta riesgosa, recuento de CD4, carga viral y medicamentos. Además, se recopilará su información personal como nombre, número de seguro social[*], fecha de nacimiento, domicilios y números de teléfono para que el Departamento de Salud y Salud Mental (DOHMH, en inglés) de la Ciudad de Nueva York pueda conectar sus registros y controlar cuántas personas diferentes están atendiendo al programa. El DOHMH es la agencia que solicita,

[*] El número de seguro social es opcional; *no* debe proporcionar uno para participar en este programa.

reciba y distribuye los fondos federales para la Parte A de Ryan White en la Ciudad de Nueva York.

¿Cuáles son los beneficios posibles de participar en este programa?
El propósito del Programa de Coordinación de la Cuidado es ayudarle a usted a:

- Ver a un Proveedor de Servicios Médicos Primario con frecuencia.
- Obtener los servicios médicos y sociales que necesite cuando los necesite.
- Estar sano y permanecer sano, lo cual incluye que se mantenga baja la carga viral
- Tomar los medicamentos según fueron recetados, si es que está tomando medicamentos.
- Volverse capaz de manejar sus propias necesidades médicas y sociales.

Los programas como la Coordinación de Cuidado Médica han demostrado que aumentan el éxito de las personas al tomar los medicamentos para el VIH, y se ha visto que algunos han mejorado las señales de salud relacionada con el VIH. Sin embargo, no hay ninguna garantía de que usted se beneficiará con este programa o de que le afectará de la misma manera que ha afectado a otras personas. Al seguir con el programa, usted aprovechará un recurso más de entre los varios que hay disponibles para mantener su salud.

¿Cómo afectará mi privacidad si me inscribo en este programa?
Al participar en el Programa de Coordinación de Cuidado Médica se pueden crear intromisiones en su vida o rutina. Como parte de este programa, los Navegadores se reunirán con usted en su casa o en otro sitio acordado por ambos y, con su permiso, estarán presentes en las visitas que tenga con el Médico de Atención Primaria. Además, se le pedirá información de contacto a usted y a sus amigos y/o familiares, para que el personal del programa pueda usar esta información que usted proporcione para ponerse en contacto con usted si usted pierde el contacto. El personal tendrá cuidado de proteger su privacidad y confidencialidad, especialmente en relación al VIH. Nunca usarán palabras relacionadas con la salud o con el VIH en comunicaciones que tengan con sus amigos o con su familia. Toda la información sobre su participación en este Programa de Coordinación de la Cuidado es estrictamente confidencial. Se le dará un formulario aparte para firmar que permitirá el acceso o intercambio de su información médica o sobre el VIH, con el objeto de este Programa de Coordinación de Cuidado Médica.

¿Qué pasa si no quiero participar o si quiero dejar de participar después de inscribirme?
Este programa es voluntario. Usted puede dejar de participar en cualquier momento. Si decide dejar de participar, entréguele una notificación por escrito a su Proveedor de Atención Médica Primaria y a su Coordinador de Cuidado Médica o Enlace con el Centro Médico.

El personal del programa de Coordinación de la Cuidado Médica o su Proveedor de Atención Médica Primaria también pueden cancelar su participación en cualquier momento. Ellos pueden cancelar su participación por razones médicas, administrativas o relacionadas con el programa. Por ejemplo, puede ser que se elija terminar el programa si todos los esfuerzos para hacerlo participar en las actividades del mismo no han dado resultado. También se le puede dar de baja si su equipo de Coordinación de Cuidado Médica concuerda que el programa no fue la mejor manera de mantener su salud y tratamiento.

Nombre del paciente: _____

Si usted decide cancelar su participación en el Programa de Coordinación de la Cuidado, no se verá afectada su atención médica normal o su tratamiento. El único resultado de que usted deje de participar será que no recibirá el apoyo adicional disponible a través del programa. Si su participación termina, el programa seguirá guardando y revisando su información obtenida hasta ese momento, y es posible que se incluya en sus informes. Sin embargo, el programa no notará ninguna nueva información sobre usted después de la fecha en que ya no está más inscripto. Cualquier informe hecho sobre este programa agrupará la información de diferentes pacientes y no lo identificará a usted por su nombre o divulgará ninguna otra información que pudiera identificarlo a usted.

Declaración de conformidad

Yo, (*nombre del paciente en letra de imprenta)* _____,

deseo inscribirme en el Programa de Coordinación de Cuidado Médica en (Organización*)*

_____

Entiendo que puedo cancelar mi participación y dejar de estar en este programa en cualquier momento. Entiendo que al hacer esto, de ninguna manera se verá afectado mi acceso a la atención médica normal.

Entiendo que las principales actividades de este programa incluyen determinar mi elegibilidad y mis necesidades; proporcionarme los servicios solicitados, y evaluar la coordinación, efectividad y la calidad de los servicios recibidos.

Entiendo que ninguna información de registros relacionados será divulgado a nadie o a ninguna organización sin mi consentimiento por escrito excepto de alguna otra manera prevista por la ley. Con mi firma abajo, autorizo a que se ingrese en una base de datos la información que me identifique (con nombre) sobre mi salud, necesidades, características demográficas, atención médica y servicios para que los use mi equipo de Coordinación de Cuidado Médica y el Departamento de Salud y Salud Mental (DOHMH, en inglés) de la Ciudad de Nueva York, quien paga por este programa. Además de usarse para la atención médica, la base de datos puede ser usada por personal autorizado del DOHMH para revisar el Programa de Coordinación de la Cuidado y planificar, mejorar la calidad, preparar informes e investigar. El personal del DOHMH está especialmente entrenado y certificado en procedimientos de confidencialidad y renuevan su certificación todos los años con el DOHMH.

Firmo esta conformidad por voluntad propia.

Si tengo más preguntas, puedo llamar a _____ al (_____) _____-_____.

_____	_____/_____/_____
Firma del paciente	**Fecha (mm/dd/aaaa)**

Personal de la Coordinación de Cuidado Médica que gestiona el consentimiento:

_____	_____	_____/_____/_____
Firma del personal	**Iniciales**	**Fecha (mm/dd/aaaa)**

APPENDIX P – HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information (English)

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two and three (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or provider disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ Both (non-HIV medical and HIV-related information)
- ☐ My non-HIV medical information **

Information in the box below must be completed. Please make sure to cross out all unused fields by marking with an "X".

Name and address of facility/provider disclosing HIV-related and/or medical information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: Information on reason(s) for referral to the program, demographics, assessments, diagnoses, laboratory tests, medications, care plans, appointment-keeping, program services received, enrollment status, and reason for end of program services.

Reason for release of information: Coordination of Care between providers on HIV care team, when the team involves more than one agency.

Time Period During Which Release of Information is Authorized:

From: _____ To: _____ **OR ☐ until case closure out of this program (*check if applicable)***

(today's date: mm/dd/yyyy) (1-3 years following today's date: mm/dd/yyyy)

Disclosures cannot be revoked once made. Additional exceptions to the right to revoke consent, if any:

The right to use the information already shared (for example, for program purposes such as to determine the quality of the services provided) cannot be revoked even if you are no longer participating in the program. Revoking consent requires notice in writing to the Care Coordinator (or Medical Liaison) and Primary Care Provider within this Care Coordination program.

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

If a Care Coordination program is carried out by two or more agencies working together under one contract, failure to consent to the sharing of HIV-related information and general medical information between the primary care and Care Coordination providers will prevent enrollment in the Care Coordination program. However, failing to consent and/or revoking your consent will not affect your access to regular medical care or treatment at this facility, and you may still receive other services at the agencies listed in this release. You may even still receive Care Coordination, through another agency or network. This form is only necessary if you want to take part in the Care Coordination program in this facility.

Please sign below only if you wish to authorize all facilities/providers listed on pages 1, 2 (and 3 and 4, if used) of this form to share information among and between themselves for the purpose of providing medical care and services.

Signature _____ Date _____

**** Human Immunodeficiency Virus that causes AIDS***

***** If releasing only non-HIV related medical information, you may use this form or another HIPAA-compliant general medical release form.***

Please Complete Information on Page 2 and/or Pages 3 and 4.

Complete information for each separate facility/provider within a Care Coordination network with which general medical and/or HIV-related information will be shared. A "separate" facility or provider is one based at an organization other than the organization of the enrolling primary care physician. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of all facilities/providers with which general medical and/or HIV-related information will be shared. General medical and/or HIV-related information will be shared by your primary care providers with the following Care Coordination network facilities/providers as necessary.

1) Name: _____ Agency: _____

Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Phone #: (_____) _____-_____

2) Name: _____ Agency: _____

Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Phone #: (_____) _____-_____

3) Name: _____ Agency: _____

Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Phone #: (_____) _____-_____

4) Name: _____ Agency: _____

Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Phone #: (_____) _____-_____

5) Name: _____ Agency: _____

Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Phone #: (_____) _____-_____

6) Name: _____ Agency: _____

Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Phone #: (_____) _____-_____

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/ provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature _____ Date_____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name_____

Client/Patient Number_____

Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information.

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general medical and/or HIV-related information.

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/ provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature _____ Date_____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name_____

Client/Patient Number_____

Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information.

_____

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general medical and/or HIV-related information.

_____

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general medical and/or HIV-related information.

_____

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

If any/all of this page is completed, please sign below:

Signature_____Date_____

Client/Patient Number_____

APPENDIX Q – HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information (Spanish)

Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Mediante este formulario se autoriza la divulgación de información médica, incluso de datos relativos al VIH. Usted puede optar por permitir la divulgación de información relacionada con el VIH únicamente, información ajena al VIH únicamente o ambos tipos. La divulgación de tal información puede estar protegida por leyes de confidencialidad federales y estatales. Se considera "información confidencial relativa al VIH" toda información que indique que una persona se ha hecho una prueba relativa al VIH, está infectada con el VIH o tiene SIDA u otra enfermedad relacionada con el VIH, y toda otra información que podría indicar que una persona ha estado potencialmente expuesta al VIH.

Según las leyes del Estado de Nueva York, sólo se puede divulgar información relativa al VIH a aquellas personas a quien usted autorice mediante la firma de un permiso escrito. También puede divulgarse a las siguientes personas y organizaciones: profesionales de la salud a cargo de su atención o la de su hijo expuesto; funcionarios de salud cuando lo exija la ley; aseguradores (para poder efectuar pagos); personas que participen en el proceso de adopción o colocación en hogares sustitutos; personal oficial correccional o afectado al proceso de libertad condicional; personal de salud o atención de emergencias que haya estado expuesto accidentalmente a su sangre; o a personas autorizadas mediante una orden judicial especial. Según lo estipulado por las leyes estatales, cualquier persona que ilegalmente revele información relacionada con el VIH puede ser sancionada con una multa de hasta $5,000 o encarcelada por un período de hasta un año. No obstante, las leyes estatales no protegen las divulgaciones repetidas de cierta información médica o relacionada con el VIH. Para obtener más información acerca de la confidencialidad de la información relativa al VIH, llame a la línea directa de confidencialidad sobre el VIH del Departamento de Salud del Estado de Nueva York al 1 800 962 5065. Si desea obtener información acerca de la protección federal de la privacidad, llame a la Oficina de Derechos Civiles al 1 800 368 1019.

Al marcar las casillas que se encuentran a continuación y firmar este formulario, se autoriza la divulgación de información médica o relativa al VIH a las personas que figuran en la página dos y tres de este formulario (o en páginas adicionales según corresponda), por las razones enumeradas. Cuando usted lo solicite, el establecimiento o el proveedor que reveló su información médica le deberá proporcionar una copia del formulario.

Autorizo la divulgación de (marque todas las opciones que correspondan):

- ☐ Mi información relativa al VIH
- ☐ Ambas (información médica tanto ajena como relativa al VIH)
- ☐ Mi información médica ajena al VIH **

Complete la información en el siguiente cuadro. El establecimiento o la persona que divulgue la información debe completar el recuadro que se encuentra a continuación:

Nombre y dirección del establecimiento/ proveedor que divulga la información médica o relativa al VIH:

_____

_____

Nombre de la persona cuya información será divulgada:_____

Nombre y dirección de la persona que firma este formulario (si difiere de la persona mencionada anteriormente):

_____

_____

Relación con la persona cuya información será divulgada: _____

_____

Describa la informacón que se ha de divulgar: La información sobre la razón o las razones por las cuales se refiere al programa, la demográfica, evaluaciones, diagnosis, exámenes de laboratorio, medicamentos, planes de cuidados, citas, los servicios del programa recibidos, estatus de matriculación, y la razón por la cual terminó los servicios del programa.

Motivo de la divulgación: Coordinación de Cuidado entre proveedores en el equipo de cuidado del VIH, cuando el equipo involucra a más de una agencia.

Período de tiempo durante el cual se autoriza la divulgación de la información:

Desde: _____ Hasta: _____ **O ☐ hasta que se cierre el caso de este programa (seleccione si aplica)**

(fecha de hoy: mm/dd/aaaa) *(1-3 años después del día de hoy: mm/dd/aaaa)*

Una vez que la información ha sido divulgada, la autorización no podrá ser revocada. Excepciones adicionales al derecho de revocar una autorización, de existirlas:

El derecho de usar la información ya compartida (por ejemplo, para propósitos del programa como para determinar la calidad de los servicios ofrecidos) no se puede revocar aunque usted ya no esté participando en el programa. Para consentir una revocación, se requiere una nota escrita y dirigida al Coordinador de Cuidado (o Enlace Médico) y al Proveedor de Cuidado Primario dentro de este programa de Cuidado Coordinado.

Descripción de las consecuencias que la prohibición de la divulgación puede traer al momento del tratamiento, el pago, la inscripción o la elegibilidad para beneficios (Observaciones: Las reglamentaciones federales sobre privacidad pueden restringir algunas consecuencias):

Si un programa de Cuidado Coordinado se leva a cabo por dos o más agencies trabajando juntas bajo un contrato, y no se obtiene consentimiento sobre la colaboración entre los proveedores de cuidado primario y los del Cuidado Coordinado sobre la información relacionada con el VIH y la información médica general, no se podrá matricular en el programa de Cuidado Coordinado. Sin embargo, si no consiente y / o si revoca su consentimiento, su acceso al cuidado medico normal o al tratamiento en esta instalación no será afectado, y todavía puede que reciba otros servicios por parte de las agencias enumeradas en esta publicación. Puede que aún todavía reciba Cuidado Coordinado a través otra agencia o red. Este formulario solo es necesario si usted desea participar en el programa de Cuidado Coordinado en esta instalación.

Todas las establecimiento/ proveedor incluidas en las páginas 1, 2 (y 3 y 4 si se la utiliza) de este formulario podrán compartir información entre sí con el propósito de prestar atención y servicios médicos. Firme a continuación para autorizar.

Firma _____ Fecha _____

*Virus de la inmunodeficiencia humana que causa el SIDA

** Si sólo se divulga información médica no relacionada con el VIH, puede utilizar este formulario u otro formulario de divulgación médica conforme a la HIPAA.

Complete la información de la página 2 y / o páginas 3 y 4.

Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Complete la información para cada establecimiento / proveedor dentro de una red de Cuidado Coordinado con la cual se compartirá la información médica general y / o la información relacionada con el VIH. Un establecimiento o proveedor "separado" es uno basado en una organización además de la organización perteneciente al médico de cuidado primario matriculado. Adjunte hojas adicionales según sea necesario. Se recomienda tachar las líneas dejadas en blanco antes de firmar.

Nombre y dirección del establecimiento/ proveedor a quien se le brindará la información médica general o relativa al VIH. La información médica general y / o la información relacionada con el VIH la compartirá sus proveedores de cuidado primario con las siguientes establecimientos / proveedores de Cuidado Coordinado a como sea necesario.

1) Nombre:_____Establecimiento:_____

Dirección:_____

Ciudad/Municipio: _____ Estado: _____ Código postal: _____

No° Teléfono: (_____) _____-_____

2) Nombre:_____Establecimiento:_____

Dirección:_____

Ciudad/Municipio: _____ Estado: _____ Código postal: _____

No° Teléfono: (_____) _____-_____

3) Nombre:_____Establecimiento:_____

Dirección:_____

Ciudad/Municipio: _____ Estado: _____ Código postal: _____

No° Teléfono: (_____) _____-_____

4) Nombre:_____Establecimiento:_____

Dirección:_____

Ciudad/Municipio: _____ Estado: _____ Código postal: _____

No° Teléfono: (_____) _____-_____

5) Nombre:_____Establecimiento:_____

Dirección:_____

Ciudad/Municipio: _____ Estado: _____ Código postal: _____

No° Teléfono: (_____) _____-_____

6) Nombre:_____Establecimiento:_____

Dirección:_____

Ciudad/Municipio: _____ Estado: _____ Código postal: _____

No° Teléfono: (_____) _____-_____

Las leyes lo protegen de la discriminación relativa al VIH en lo referente a servicios de vivienda, trabajo, atención médica, etc. Para obtener más información, llame a la División de Derechos Humanos del Estado de Nueva York, Oficina para Asuntos de Discriminación a Pacientes con SIDA al **1 800 523 2437** o al (212) 480-2522, o bien comuníquese con la Comisión de Derechos Humanos de la Ciudad de Nueva York al **(212) 306 7500**. Estas agencias son las encargados de proteger sus derechos.

He recibido respuestas a mis preguntas referidas a este formulario. Sé que no tengo la obligación de autorizar la divulgación de mi información médica o relativa al VIH y que puedo cambiar de parecer en cualquier momento y revocar mi autorización enviando una solicitud por escrito al establecimiento o profesional que corresponda. Autorizo al establecimiento o a la persona indicada en la página uno a divulgar información médica o relativa al VIH de la persona también mencionada en la página uno a las organizaciones o personas enumeradas.

Firma _____ Fecha _____
(Persona a la que se le hará la prueba o representante legal autorizado)

Si es un representante legal, indique la relación con el paciente: _____

Nombre (en letra de imprenta) _____

Número de paciente o cliente _____

Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Complete la información para cada establecimiento / persona que no sea de Cuidado Coordinado con la que se vaya a compartir información médica general y / o información relacionada con el VIH Adjunte hojas adicionales según sea necesario. Se recomienda tachar las líneas dejadas en blanco antes de firmar.

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:

_____

_____

Motivo de la divulgación, si difiere de lo indicado en la página 1:

_____

_____

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

_____

_____

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:

_____

_____

Motivo de la divulgación, si difiere de lo indicado en la página 1:

_____

_____

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

_____

_____

Las leyes lo protegen de la discriminación relativa al VIH en lo referente a servicios de vivienda, trabajo, atención médica, etc. Para obtener más información, llame a la División de Derechos Humanos del Estado de Nueva York, Oficina para Asuntos de Discriminación a Pacientes con SIDA al **1 800 523 2437** o al (212) 480-2522, o bien comuníquese con la Comisión de Derechos Humanos de la Ciudad de Nueva York al **(212) 306 7500**. Estas agencias son las encargados de proteger sus derechos.

He recibido respuestas a mis preguntas referidas a este formulario. Sé que no tengo la obligación de autorizar la divulgación de mi información médica o relativa al VIH y que puedo cambiar de parecer en cualquier momento y revocar mi autorización enviando una solicitud por escrito al establecimiento o profesional que corresponda. Autorizo al establecimiento o a la persona indicada en la página uno a divulgar información médica o relativa al VIH de la persona también mencionada en la página uno a las organizaciones o personas enumeradas.

Firma _____ Fecha _____

(Persona a la que se le hará la prueba o representante legal autorizado)

Si es un representante legal, indique la relación con el paciente: _____

Nombre (en letra de imprenta) _____

Número de paciente o cliente _____

Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Complete la información para cada establecimiento / persona que no sea de Cuidado Coordinado con la que se vaya a compartir información médica general y / o información relacionada con el VIH Adjunte hojas adicionales según sea necesario. Se recomienda tachar las líneas dejadas en blanco antes de firmar.

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:

____

____

Motivo de la divulgación, si difiere de lo indicado en la página 1:

____

____

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

____

____

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:

____

____

Motivo de la divulgación, si difiere de lo indicado en la página 1:

____

____

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

____

____

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:

____

____

Motivo de la divulgación, si difiere de lo indicado en la página 1:

____

____

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

____

____

Si alguno o todos los de esta página se completa, por favor firme abajo:

Firma ______________________________ Fecha ______________

Número de paciente o cliente ______________________________

APPENDIX R – Contact Information Form

CONTACT INFORMATION FORM

Patient Name: _____ **Patient Record #:** _____

Care Coordinator: Complete this form at baseline and any time there is a change in address or alternate contact. ***This form is to be used solely for the purpose of locating a care coordination patient if the patient falls out of contact. Do not reveal patient health, program, or HIV status information to any contact listed below. PLEASE PRINT NEATLY.***		
Current Home Address:		
Street:	**Apartment/Unit:**	
City:	**State:**	**Home ZIP Code:**
Mailing Address:	❑ Same as Current Home Address	
Street:	**Apartment/Unit:**	
City:	**State:**	**Mail ZIP Code:**
Home Visit Location:	❑ Same as Current Home Address ❑ Same as Mailing Address	
Street:	**Apartment/Unit:**	
City:	**State:**	**ZIP code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

ALTERNATIVE CONTACTS *Read to Patient:*

One of the goals of this program is to help you remain in good health. For this purpose, we may need to attempt to contact you in places other than your home. I'm going to ask you a few questions about how I may contact you in case we lose touch while you are enrolled in this program. If and when we reach out to you through these contacts, we will not reveal any information about your health.

1) Other than home, where (or with whom) do you "hang out" most often?

Contact 1 Name or Location:	**Relationship,** *if applicable*:	
Street or Intersection:		
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

2) *If applicable,* **Could we contact the person you identified as someone who is routinely involved in your care? If yes, what is their information?**

Contact 2 Name:	**Relationship:**	
Street:	**Apartment/Unit:**	
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

3) **Who would often know where you are when you are not at home?** *(This could include any parole/ probation officer)*

Contact 3 Name:	**Relationship:**	
Street:	**Apartment/Unit:**	
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

4) **Who do you expect to continue to know you and where you live/hang out, one year from now?**

Contact 4 Name:	**Relationship:**	
Street:	**Apartment/Unit:**	
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

5) **Is there anyone else who is close to you and could help us get in touch with you?**

Contact 5 Name:	**Relationship:**	
Street:	**Apartment/Unit:**	
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

Staff Member Completing Form:	_____ Name	_____ Signature	**Date**	__/__/__ m m / d d / y y

APPENDIX S – Logistics for Navigator Form

LOGISTICS FOR NAVIGATOR

Patient Name: _____ **Patient Record #:** _____

Complete this form with the patient at the time of introducing the program and conducting informed consent in your office or at the first scheduled visit. Update as needed, with any major changes affecting the logistics for Navigator encounters.
INTRO: Before you begin your work with the staff for this home-based support program, we have a few questions that will help us meet your needs for privacy and comfort as a patient.

1. **Patient will be enrolled in:** ❑ Quarterly HP (No ART) ❑ Quarterly HP ❑ Monthly HP ❑ Weekly HP ❑ DOT

2. **What days and times are best for you to meet with someone from this program?**
Check as many days as patient says he/she could meet, and fill in available times for each checked day. For patients enrolled in DOT at intake, identify time(s) for every day of the week.

Day(s) of Week:	**Time(s) of Day:**
❑ Monday	
❑ Tuesday	
❑ Wednesday	
❑ Thursday	
❑ Friday	
❑ Saturday	
❑ Sunday	
❑ Other answer (Specify: _____)	

If the patient is not enrolled in Weekly or Daily:
2a. **Which week of the month is best for your Navigator visit?**
❑ Any ❑ First ❑ Second ❑ Third ❑ Fourth ❑Last

3. **Are there any days or times when you will *not* be available for a meeting with someone from this program?**

_____

_____

4. **Where would you most like to meet for adherence support?** *Read choices:*
❑ At home
❑ At another person's home (Specify the home and relationship: _____)*
❑ Patient's PCP clinic within the Care Coordination Program
❑ Other location (Specify: _____)*
**Please specify location on the Contact Information Form*

5. **Where do you store your medications?** _____

6. **Is anyone routinely involved in your care who could support your participation in this program?**
❑ YES ❑ NO

6a. **If YES, who is that person?**** First Name: _____ Relationship to Patient: _____
***If named, please refer back to person when completing contact information form*

Patient Name: _____

If patient prefers to meet in their own or someone else's home, ask questions below. Otherwise, SKIP to QUESTION 11.

7. **In the home where you would like to meet, is there anyone who does NOT know your HIV status?**
❑ YES ❑ NO

7a. **If YES, what is their relationship to you?** _____

7b. **Should we be trying to visit you at home WITHOUT that person or those people?** ❑ YES ❑ NO

7bi. **If YES, what times and days are appropriate?**

_____

_____

8. **Where in the home do you want to do the visits?**
❑ Living Room ❑ Kitchen ❑ Other (Specify: _____)

9. **For reasons of confidentiality, how would you like the Navigator to identify him or herself, when calling you or visiting you? (For example, should they go by their first name, say they are a "friend," or say they "work with so-and-so?")**

_____

_____

10. **What else would you like us to know about how to work with you at home and protect your confidentiality?**

_____

_____

INTRO: I have a few additional questions, which will help us to tailor our work with you in a way that should fit your needs and comfort level. By giving your most honest answers, you will help us to better serve you.

11. **How comfortable are you reading English?**
❑ Not at all ❑ Somewhat ❑ Very

12. **How comfortable are you writing in English?**
❑ Not at all ❑ Somewhat ❑ Very

13. **How comfortable are you reading Spanish?**
❑ Not at all ❑ Somewhat ❑ Very

14. **How comfortable are you writing in Spanish?**
❑ Not at all ❑ Somewhat ❑ Very

NAVIGATOR ASSIGNMENT QUESTIONS:

Please ask Questions 15 and 16 only if a Navigator has not yet been assigned. Otherwise, SKIP to QUESTION 17.

15. **Do you have a preference for gender of your Navigator?**

❑ No Preference ❑ Male ❑ Female ❑ Other (Specify: _____)

16. **What language do you prefer for regular communication with your Navigator?**

❑ English ❑ Spanish ❑ Other (Specify: _____)

17. **Navigator Assigned (Name):** _____ as of _____/_____/_____
mm / dd / yy

Program Staff Completing Form: _____ (Name) _____ (Signature) **Date:** ____/____/____ (m m / d d / y y)

APPENDIX T – Common Demographics Form

COMMON DEMOGRAPHICS

Program Staff: Use current client chart and complete and/or update remaining questions via client interview.

Date: _____/_____/_____ **Client Chart/Record #:** _____

TC ID/AIRS ID #: _____ *If applicable,* **NYSID:** _____

Suffix: *(Circle one, if applicable)* Sr Jr III IV V Other (Specify: _____)

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Alias/A.K.A. Names *(Include any other first names, middle names, or last names used)*

Alias First Names	Alias Middle Names	Alias Last Names

Social Security #: _____ - _____ - _____ **Date of Birth:** _____/_____/_____ (mm/dd/yyyy)

Sex at Birth: *(Check only one)* ❑ Male ❑ Female ❑ Intersex/ambiguous

Current Self-identified Gender: *(Check only one)*
❑ Male ❑ Female ❑ Transgender (M→F) ❑ Transgender (F→M)

Currently Homeless? ❑ Yes ❑ No ❑ Declined

(If Yes to "Currently Homeless," please enter the required ZIP based on where the client spends the most time.)

CURRENT HOME ADDRESS
Street: **Apt./Unit:**
City: **State:** **ZIP:**

PERMANENT/MAILING ADDRESS ❑ Same as Current Home Address
Street: **Apt./Unit:**
City: **State:** **ZIP:**

Primary telephone number: (____) ____ - _____ **Alternate telephone number:** (____) ____ - _____
Email address:

Contact Preferences: *(Check all that apply)* ❑ Current residence address ❑ Permanent/mailing address ❑ Primary phone number ❑ Alternate phone number ❑ Email address

Race: *(Check all that apply)*
❑ Black ❑ White ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native
❑ Other (Specify: _____) ❑ Unknown ❑ Declined

(If "Asian" selected) **Asian Detail:** *(Check all that apply)*
❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Asian

(If "Native Hawaiian/Pacific Islander" selected) **Native Hawaiian/Pacific Islander Detail:** *(Check all that apply)*
❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander

Ethnicity: *(Check only one)* ❑ Hispanic ❑ Non-Hispanic ❑ Unknown ❑ Declined

(If "Hispanic" selected) **Hispanic Ethnicity Detail:** *(Check all that apply)*
❑ Mexican, Mexican-American, Chicano/a ❑ Puerto Rican ❑ Dominican ❑ Cuban
❑ Another Hispanic, Latino/a, or Spanish origin

Marital/relationship status: *(Check only one)*
❑ Single, never married ❑ Married ❑ Married, separated ❑ Partnered ❑ Divorced ❑ Widowed
❑ Other (Specify: _____)

Read question without responses, and then verify answer:
How would you identify your sexual orientation? *(Check only one)*
❑ Gay/Lesbian/Homosexual ❑ Straight/Heterosexual ❑ Bisexual ❑ Queer ❑ Questioning
❑ Other (Specify: _____) ❑ Declined

Program Staff Completing Form: _____ (Name) _____ (Signature) **Date:** ____/____/____ (mm/dd/yyyy)

APPENDIX U – Intake Assessment Form

INTAKE ASSESSMENT
(MCM, MCM-W, CMN, TCC)

Client Name: _____

[ALL] **Intake Date:** _____/_____/_____ mm / dd / yyyy

Client Record #: _____

Program Staff: Complete this form through a combination of client interview and chart review at intake. Please note that this form is used for multiple service categories. Not all data elements contained in this form are expected for each service category. To identify which questions are required for your service category, please find the data element requirement codes in the grey section header bar or to the left of individual questions.

Data Element Requirement Codes:
[1]= Required; 1= Optional
Service Category Codes:
ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

I. Clinical Information
Chart Review or Client Interview

[ALL] **Date of first known visit to this agency for any service:** _____/_____/_____ (mm/dd/yyyy)

[1] [3] **Date of first known outpatient/ambulatory care visit at this agency:**
❑ Same as above OR _____/_____/_____ (mm/dd/yyyy)

[ALL] **HIV Status:** *(Check only one)* ❑ HIV+, Not AIDS ❑ HIV+, AIDS status unknown ❑ CDC-Defined AIDS

[ALL] **HIV Diagnosis Date:** _____/_____/_____ (mm/dd/yyyy)

[ALL] *If AIDS,* **AIDS Diagnosis Date:** _____/_____/_____ (mm/dd/yyyy)

[ALL] **HIV Risk Factor:** *(Check all that apply)*
❑ MSM ❑ IDU ❑ Heterosexual ❑ Blood transfusion/components
❑ Hemophilia/coagulation disorder ❑ Perinatal ❑ Risk factor not reported or not identified

[2] [3] **Do you currently have a Primary Care Physician (PCP) / HIV primary care provider?**
❑ Yes ❑ No

[ALL] **Last PCP visit *prior* to enrollment:** _____/_____/_____ (mm/dd/yyyy) OR ❑ Unknown ❑ N/A

[1] **Initial/referral visit with PCP within this program:** _____/_____/_____ (mm/dd/yyyy)

Most recent CD4 counts and Viral Load measures from on or <u>before</u> the program enrollment date:
(Start with the most recent)

[ALL] **CD4 Records** *If none are available, check box at right:* ❑ No CD4 count on record

CD4 count	CD4 % *(optional)*	Date (mm/dd/yyyy)

[ALL] **Viral Load Records** *If none are available, check box at right:* ❑ No viral load count on record

Viral Load count	Viral Load Undetectable	Date (mm/dd/yyyy)
	❑ Yes ❑ No ❑ Unknown	
	❑ Yes ❑ No ❑ Unknown	
	❑ Yes ❑ No ❑ Unknown	

Legend:
[1]= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

ALL **Hospitalizations & ED Visits:** *(If client had any ED or inpatient care in year before enrollment, fill in table.)*				
# of Events	**Start Date (mm/dd/yyyy)**	**End Date (mm/dd/yyyy)**	**Reason/Discharge Dx**	**Facility**
# of Hospitalizations: _____ *If none, enter "0"*				
# of ED Visits: _____ *if none, enter "0"*				

ALL **Does client have any other medical conditions requiring treatment?** ❑ Yes ❑ No ❑ Unknown

ALL *If Yes,* **What condition(s)?** *(Check all that apply)*

- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease/hypertension
- ❑ Liver disease
- ❑ Other (Specify: _____)
- ❑ Kidney disease
- ❑ Hepatitis C
- ❑ Tuberculosis (TB)
- ❑ Asthma

ALL **Has client ever received a mental health diagnosis?** ❑ Yes ❑ No ❑ Unknown

ALL *If Yes,* **What diagnosis or diagnoses?** *(Check all that apply)*

- ❑ Depression
- ❑ Anxiety Disorder (Panic, GAD, etc.)
- ❑ PTSD
- ❑ Bipolar Disorder
- ❑ Psychosis (Schizophrenia, etc.)
- ❑ HIV-associated Dementia
- ❑ Other (Specify: _____)

ALL **Pregnant:** ❑ Yes ❑ No ❑ Unknown ❑ N/A (male) *If No, Unknown or N/A, go to Section II.*

ALL *If Yes,* **Date of report of client's pregnancy to program:** _____/_____/_____ (mm/dd/yyyy)

ALL **Is client enrolled in prenatal care?** ❑ Yes ❑ No ❑ Unknown

For the following questions, check "N/A" if client plans to terminate (and thus is not preparing for a live birth)

ALL *If Yes,* **When was client enrolled in prenatal care:**
❑ First trimester ❑ Second trimester ❑ Third trimester
❑ At time of delivery ❑ N/A ❑ Unknown

ALL **Estimated Due Date:** _____/_____/_____
OR select one of the following: ❑ N/A ❑ Unknown

ALL **Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?**
❑ Yes ❑ No ❑ N/A ❑ Unknown

Legend:
R= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

II. Antiretroviral Treatment (ART) Review

Chart Review or Client Interview

ALL **Is client currently prescribed ART?**

❑ Yes *If Yes, Complete regimen detail below.* ❑ No *Skip this table.*

1 2 3 HIV medication names	1 2 3 Dosage		1 2 3 # Doses	1 2 3 Frequency	1 2 3 Date Started (mm/yyyy)
	# per Dose	Dose Unit (pills, ccs, mls)			
1.				❑ Daily ❑ Weekly	_____/_____
2.				❑ Daily ❑ Weekly	_____/_____
3.				❑ Daily ❑ Weekly	_____/_____
4.				❑ Daily ❑ Weekly	_____/_____

ALL *If client is not on ART,* **Why is the client not currently prescribed ART?** *(Check only one)*

❑ Not medically indicated ❑ Not ready – by PCP determination ❑ Intolerance/side effects/toxicity

❑ Payment/insurance/cost issue ❑ Client refused ❑ Other reason ❑ Unknown

III. Client Information

Client Interview

ALL **Total number in household *(including the client)*:** _____

ALL **Current employment status:** *(Check only one)*

❑ Full-time ❑ Part-time ❑ Unemployed

❑ Unpaid volunteer/peer worker ❑ Out of workforce ❑ Other (Specify: _____)

❑ Declined

ALL **Highest level of education achieved:** *(Check only one)*

❑ No schooling ❑ 8th grade or less ❑ Some high school

❑ High School/GED or equivalent ❑ Some college ❑ Bachelors/technical degree

❑ Postgraduate ❑ Declined

ALL **Primary Language Spoken (i.e., at home):** *(Check only one)*

❑ English ❑ Spanish ❑ Other (Specify: _____) ❑ Declined

ALL *If Primary Language is not English:* **Secondary Language Spoken:** *(Check only one)*

❑ English ❑ Spanish ❑ Other (Specify: _____) ❑ Declined

ALL **Country of Birth:** *(Check only one)*

❑ USA ❑ US territory/dependency (❍ Puerto Rico ❍ Other – Specify: _____)

❑ Other country (Specify: _____) ❑ Declined

ALL *If not USA, ask:* **In what month and year did you first come to the US?** ____/_____ (mm/yyyy) ❑ Declined

IV. Insurance Information ALL

Chart Review or Client Interview

Insurance Status: ❑ Uninsured ❑ Insured *(If Insured, complete insurance details on next page. Otherwise, skip to Section V.)*

Legend:

1= Required; 1= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

Check all that apply, and complete the related details/dates on each checked insurance type:

Insurance Type	Insurance details	Effective Date (mm/dd/yyyy)	End/Expiration Date (mm/dd/yyyy)
❑ Private	*(Check only one)* ❍ Employer plan ❍ Individual plan	_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ ADAP/ADAP+	*(Check all that apply)* ❍ ADAP (Rx Coverage) ❍ ADAP Plus	_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ Medicaid or CHIP	*(Check only one plan type)* ❍ SNP (special needs plan) ❍ MCO (managed care organization) ❍ FFS (fee-for-service) ❍ Not sure which type	_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ Medicare		_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ Military, VA, Tricare		_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ IHS (Indian Health Service)		_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ Other Public Insurance		_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A

V. Financial Information ALL — *Client Interview*

What is your annual household income? $_____ per year

We will be asking you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.

- **Please answer honestly. You may refuse to answer a question; refusing will not affect your care.**
- **Please feel free to ask if you need any of the questions explained to you.**
- **If you do not want to answer a question now, please tell me and we will return to it another time.**

VI. Use of Prescriptions, Injectables and Other Substances ALL — *Client Interview*

Have you used any of the following substances? *Read the list starting with tobacco.*

Substance	…have you ever used this?	*If ever used it, ask:* In the past 3 months?	*For use in past 3 months, ask:* How often do you use?	*For use in past 3 months, ask:* How have you taken this? *(Check all that apply)*
Haven't used any	❑*	** If haven't used any substance **EVER**, skip to Section VII.*		
Tobacco	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ cigarettes smoked weekly (for other forms of tobacco, # times used weekly) *or* ❑ < weekly ❑ Declined *(reminder: 1 pack = 20 cigarettes)*	❑ Orally (chewing tobacco) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Declined (no answer)

Legend:
R= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

Substance	…have you ever used this?	*If ever used it, ask:* In the past 3 months?	*For use in past 3 months, ask:* How often do you use?	*For use in past 3 months, ask:* How have you taken this? *(Check all that apply)*
Alcohol	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ drinks weekly *or* ❑ < weekly ❑ Declined	
Marijuana	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Declined (no answer)
PCP/Hallucinogens	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Crystal Meth	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Cocaine/Crack	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Heroin	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Rx Pills to get high	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected
Hormones/steroids	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Patch ❑ Injected ❑ Declined (no answer)
Anything else: _____	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)

If client has, at this interview, reported injecting any substance in the table above, select "Yes" to the question below and select "in the past 3 months" beneath that. Ask the client directly about sharing injection equipment.

ALL **Have you ever injected any drug or substance?** *If No, go to Section VII.*
❑ Yes ❑ No ❑ Declined (no answer)

ALL *If Yes*, **When was the last time you injected any substance**?
- ❑ in the past 3 months
- ❑ between 3 and 12 months ago
- ❑ more than 12 months ago
- ❑ Declined

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

ALL *If the client reported any injection behavior in the past 3 months, ask:*
Do you currently receive clean syringes from a syringe exchange program or pharmacy?
❑ Yes ❑ No ❑ Declined

ALL **Have you ever shared needles or injection equipment with others?**
❑ Yes ❑ No ❑ Declined

ALL *If Yes*, **When was the last time you shared needles or injection equipment?**
❑ in the past 3 months
❑ between 3 and 12 months ago
❑ more than 12 months ago
❑ Declined

VII. Behavioral Risk Reduction ALL — *Client Interview*

In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?	❑ Yes	❑ No	❑ Declined *If No, skip to Section VIII.*
If Yes to the above question, please ask the following questions:			
How many sexual partners have you had in the last 12 months? _____	❑ Unknown		❑ Declined
In the past 12 months, have you had vaginal sex with a male?[A]	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had vaginal sex with a female?[B]	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had vaginal sex with a transgender person?	❑ Yes	❑ No	❑ Declined
If Yes to any vaginal sex, then ask: **In the past 12 months, have you had vaginal sex without a condom?**	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had anal sex with a male?	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had anal sex with a female?[B]	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had anal sex with a transgender person?	❑ Yes	❑ No	❑ Declined
If Yes to any anal sex, then ask: **In the past 12 months, have you had anal sex without a condom?**	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had oral sex with a male?	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had oral sex with a female?	❑ Yes	❑ No	❑ Declined
In the past 12 months, have you had oral sex with a transgender person?	❑ Yes	❑ No	❑ Declined
If Yes to any oral sex, then ask: **In the past 12 months, have you had oral sex without a condom, dental dam or other barrier?**	❑ Yes	❑ No	❑ Declined

[A] *It is optional to ask this question if the client is biologically male.*
[B] *It is optional to ask this question if the client is biologically female.*

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

VIII. General Health and Well-Being *ALL* *Client Interview*

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
❑	❑	❑	❑	❑

2. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking	❑	❑	❑
b. Climbing <u>several</u> flights of stairs	❑	❑	❑

3. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Accomplished less</u> than you would like	❑	❑	❑	❑	❑
b. Were limited in the <u>kind</u> of work or other activities	❑	❑	❑	❑	❑

4. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Accomplished less</u> than you would like	❑	❑	❑	❑	❑
b. Did work or other activities <u>less carefully than usual</u>	❑	❑	❑	❑	❑

5. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including work within and outside of your living space)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
❑	❑	❑	❑	❑

6. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u>…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	❑	❑	❑	❑	❑
b. Did you have a lot of energy?	❑	❑	❑	❑	❑
c. Have you felt downhearted and depressed?	❑	❑	❑	❑	❑

7. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
❑	❑	❑	❑	❑

Client Name: _____

IX. Disability Status [ALL] *Client Interview*

Are you deaf or do you have serious difficulty hearing? ❑ Yes ❑ No ❑ Not Asked

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)? ❑ Yes ❑ No ❑ Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ❑ Yes ❑ No ❑ Not Asked

OR ❑ **Client's age is less than 5 years old** *(If checked, skip to Living Arrangement/Housing Information)*

If the response to EITHER question 2a or 2b in Section VIII. General Health and Well-Being was "Yes, limited a lot" then select "Yes" for the next question; if the response to BOTH of those questions (2a and 2b) was "No, not limited at all" then select "No" for the next question. Under these two scenarios, the client does not need to be asked about difficulty walking or climbing stairs.

Do you have serious difficulty walking or climbing stairs? ❑ Yes ❑ No ❑ Not Asked

Do you have difficulty dressing or bathing? ❑ Yes ❑ No ❑ Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping? ❑ Yes ❑ No ❑ Not Asked

OR ❑ **Client's age is less than 15 years old**

X. Living Arrangement/Housing Information *Client Interview*

[ALL] **Are you currently enrolled in a housing assistance program?** ❑ Yes ❑ No ❑ Declined

[ALL] *If Yes,* **Agency:**_____ OR ❑ Unknown

[ALL] **What is your current living situation?** *(Check only one box at left)*

- ❑ Homeless/Place not meant for human habitation (such as a vehicle, abandoned building, or outside)
- ❑ Emergency shelter (non-SRO hotel)
- ❑ Single Room Occupancy (SRO) hotel
- ❑ Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)
- ❑ Supportive Housing Program *If checked, complete the indented detail questions below:*
  - ❍ Transitional Congregate
  - ❍ Transitional Scattered-Site
  - ❍ Permanent Congregate
  - ❍ Permanent Scattered-Site

  [ALL] **HIV housing program?** ❑ Yes ❑ No
- ❑ Room, apartment, or house that you rent (not affiliated with a supportive housing program)
- ❑ Staying or living in someone else's (family's or friend's) room, apartment, or house
- ❑ Hospital, institution, long-term care facility, or substance abuse treatment/detox center
- ❑ Jail, prison, or juvenile detention facility
- ❑ Foster care home or foster care group home
- ❑ Apartment or house that you own

[ALL] **Since what date (month and year) have you been living in your current situation?** _____/_____ (mm/yyyy)
OR select one of the following: ❑ Unknown ❑ Declined

Legend:
[1]= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

ALL **How long do you expect to be in your current living situation? If you do not know, what is your best guess?** *(Check only one)*	❑ At least 1 year	❑ 6 months - <12 months
	❑ 1 month - <6 months	❑ < 1 month
ALL **Were you ever homeless?** ❑ Yes ❑ No ❑ Declined	ALL *If Yes,* **When were you last homeless?**	_____/_____ (mm/yyyy)

1 2 3 Do not ask if client is homeless:
What are your current housing issues? *(Check all that apply)* ❑ N/A

❑ Cost	❑ Eviction or pending eviction	❑ Conflict with others in household
❑ Doubled-up in the unit	❑ Expanding household (e.g. newborn)	❑ Release from institutional setting
❑ Health or safety concerns	❑ Space/configuration (e.g. too small)	❑ Other (Specify: _____)

XI. Legal and Incarceration History ALL — *Client Interview*

Have you ever served any time in jail, prison, or juvenile detention (JD)?	❑ Yes	❑ No	❑ Declined
If Yes, **Have you served any time in the past 12 months?**	❑ Yes	❑ No	❑ Declined
Are you currently on parole/probation?	❑ Yes	❑ No	❑ Declined

If client served any time in New York State, enter the NYSID [unique identifier assigned by the New York State Division of Criminal Justice Services (DCJS)]. This is an eight-digit number followed by one-character alpha (letter). Note: if the client has an old NYSID (with only 7 digits plus the letter at the end), insert a zero (0) at the start to reach 8 digits.

NYSID: _____ *Entered via eSHARE Common Demographics screen*

XII. Current Enrollments and Needed Referrals ALL — *Client Interview*

Check current enrollments and any immediate referrals needed. Provide detail on referrals in Care Plan.

Currently Enrolled?	Referral Needed?	Service Category:
❑	❑	ADHC
❑	❑	SNP
❑	❑	Medicaid Health Home
❑	❑	Other Medicaid Case Management
❑	❑	HASA
❑	❑	Outpatient Bridge Medical Care
❑	❑	No to all of the above

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

Client Name: _____

1 ***For program staff:***
During the induction period, every client should be seen weekly in this program, unless the client is otherwise indicated for Intervention D: DOT at enrollment. If a client is indicated for Intervention D: DOT, the client will receive weekly health promotion and daily or near-daily DOT. Clients who are not prescribed ART should be assigned to Intervention A: Non-ARV HP-Quarterly, but receive weekly health promotion throughout the induction period. eSHARE will permit tracking of service frequency during induction.

BASELINE CARE COORDINATION PROGRAM TRACK

Client is enrolling in:

- ❑ **Intervention A: Non-ARV HP – Quarterly**
- ❑ Intervention B: ARV HP – Quarterly
- ❑ Intervention C1: Monthly
- ❑ **Intervention C2: Weekly**
- ❑ **Intervention D: DOT**

Notes:

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ALL **Staff Member Completing Form:** Name	Signature	ALL **Date** m m / d d / yyyy

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W/CMN

APPENDIX V – SF-12v2™ General Health and Wellbeing Survey (Spanish)

Su Salud y Bienestar

Esta encuesta le pide sus opiniones acerca de su salud. Esta información permitirá saber cómo se siente y qué tan bien puede hacer usted sus actividades normales. *¡Gracias por contestar estas preguntas!*

Para cada una de las siguientes preguntas, por favor marque con una ☒ la casilla que mejor describa su respuesta.

1. En general, ¿diría que su salud es:

Excelente	Muy buena	Buena	Pasable	Mala
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. Las siguientes preguntas se refieren a actividades que usted podría hacer durante un día típico. ¿Su estado de salud actual lo/la limita para hacer estas actividades? Si es así, ¿cuánto?

	Sí, me limita mucho	Sí, me limita un poco	No, no me limita en absoluto
a Actividades moderadas, como moviendo una mesa, empujando la aspiradora, barriendo el piso o caminando	☐ 1	☐ 2	☐ 3
b Subir varios pisos por la escalera	☐ 1	☐ 2	☐ 3

3. Durante las últimas 4 semanas, ¿cuánto tiempo ha tenido usted alguno de los siguientes problemas con el trabajo u otras actividades diarias regulares a causa de su salud física?

	Siempre	Casi siempre	Algunas veces	Casi nunca	Nunca
a Ha logrado hacer menos de lo que le hubiera gustado	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Ha tenido limitaciones en cuanto al tipo de trabajo u otras actividades	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

(IQOLA SF-12v2 Standard, United States (Spanish))

4. Durante las <u>últimas 4 semanas</u>, ¿cuánto tiempo ha tenido usted alguno de los siguientes problemas con el trabajo u otras actividades diarias regulares <u>a causa de algún problema emocional</u> (como sentirse deprimido/a o ansioso/a)?

	Siempre	Casi siempre	Algunas veces	Casi nunca	Nunca
b Ha logrado hacer menos de lo que le hubiera gustado	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Ha hecho el trabajo u otras actividades con menos cuidado de lo usual	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. Durante <u>las últimas 4 semanas</u>, ¿cuánto ha interferido <u>el dolor</u> con su trabajo normal (incluyendo el trabajo adentro y afuera del lugar donde usted vive)?

Nada en absoluto	Un poco	Medianamente	Bastante	Extremadamente
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. Estas preguntas se refieren a cómo se siente usted y a cómo le han ido las cosas <u>durante las últimas 4 semanas</u>. Para cada pregunta, por favor dé la respuesta que más se acerca a la manera como se ha sentido usted. ¿Cuánto tiempo <u>durante las últimas 4 semanas</u>…

	Siempre	Casi siempre	Algunas veces	Casi nunca	Nunca
a se ha sentido tranquilo/a y sosegado/a?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b ha tenido mucha energía?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c se ha sentido desanimado/a y deprimido/a?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. Durante <u>las últimas 4 semanas</u>, ¿cuánto tiempo ha interferido <u>su salud física o sus problemas emocionales</u> con sus actividades sociales (como visitas con amigos, parientes, familia, etc.)?

Siempre	Casi siempre	Algunas veces	Casi nunca	Nunca
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

(IQOLA SF-12v2 Standard, United States (Spanish))

APPENDIX W – Adherence Assessment (ART Daily Regimens Only)

ADHERENCE ASSESSMENT (ART DAILY REGIMENS ONLY)

Client Name: _____ **Client Record #:** _____

Adherence Assessment Self-Report Date: _____ / _____ / _____ (mm/dd/yyyy)

NYC-MCM Only: **Client is enrolled in:** ❑ B: Quarterly HP ❑ C1: Monthly HP ❑ C2: Weekly HP ❑ D: DOT

NOTE: THIS INTERVIEW SHOULD ONLY BE CONDUCTED WITH CLIENTS WHO ARE CURRENTLY ON ART.

INTRO: The purpose of this form is to learn about pill-taking and the issues that affect pill-taking, or adherence.

- ***Please answer all questions honestly; you will not be "judged" based on your responses.***
- ***Please feel free to ask if you need any of the questions explained to you.***

The answers you give in this interview will be used to plan ways to help other people who must take pills on a difficult schedule. Many people find it hard to always remember their pills:

- ***Some people get busy and forget to carry their pills with them.***
- ***Some people find it hard to take their pills according to all the instructions, such as "with meals," "on an empty stomach," or "with plenty of fluids."***
- ***Some people decide to skip pills to avoid side effects or to just not be taking pills that day.***

We need to understand how people with HIV are really managing their pills. Please tell us what you are actually doing. Don't worry about telling us that you don't take all your pills. We need to know what is really happening, not what you think we "want to hear."

Complete this page with your client. Be prepared to help the client remember and name medications in his/her regimen, as needed. Please refer to separate list for names and pictures of all HIV medications.

1. Please indicate the name of the daily HIV medications you take, the number of pills in each dose, number of doses each day, and any doses that you may have missed.
Include only daily ART prescriptions here; special calculations are required for less-than-daily ARTs.

MEDICATION REGIMEN			HOW MANY DOSES DID YOU MISS …				
Step 1. Names of your HIV drugs (eg. Kaletra)	# Pills/dose	**Step 2.** # Dose/day	Yesterday?	Day before yesterday?	3 days ago?	4 days ago?	**Step 3.** Total Doses Missed
1.							
2.							
3.							
4.							
Total doses/day, across ART medications:			*For each row (each HIV drug), add up the missed doses and place # in far right column. Then enter column total (the sum across ART drugs) in the outlined box at right.⇒*				

For program staff: **(Adherence Assessment Form)** *ONLY COUNT ART ADHERENCE*

A. Number of ART drugs in regimen (count the rows completed in Step 1 above)	B. Prescribed # ART doses in 4-day period *Multiply*: 4 x total in outlined box from Step 2 =	C. Total doses missed (total in outlined box from Step 3 above)	D. 4-Day Adherence Percentage (%) [(b-c)/b)] x 100 =
a	b	c	d %
	(Verified by Supervisor ❑)	(Verified by Supervisor ❑)	(Verified by Supervisor ❑)

Client Name: _____ **Client Record #:** _____

2. When was the last time you missed any of your HIV medications? *Check only one*

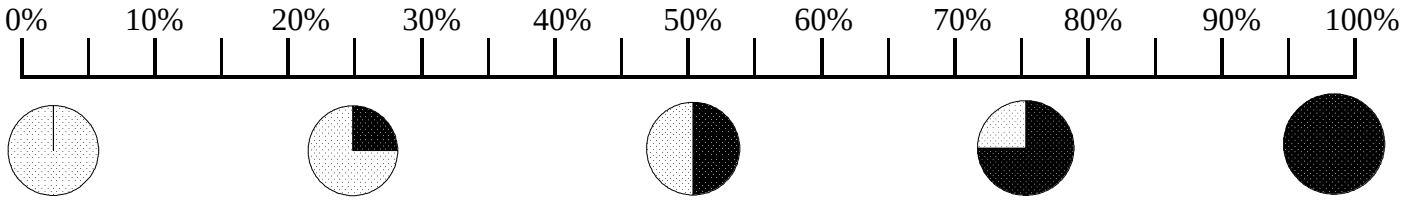
❑5	Within the past week
❑4	1-2 weeks ago
❑3	2-4 weeks ago
❑2	1-3 months ago
❑1	More than 3 months ago
❑0	Never skip medications

3. People may miss taking their medications for various reasons. Here is a list of possible reasons why you may miss taking your medications. Have you missed taking your HIV medications because you:
(Read choices aloud, and check as many as apply.)

Reasons for non-adherence:

❑Yes	❑ No	Simply forgot	❑Yes	❑ No	Felt depressed/overwhelmed
❑Yes	❑ No	Were away from home	❑Yes	❑ No	Felt there were too many pills
❑Yes	❑ No	Were busy with other things	❑Yes	❑ No	Did not want others to notice you taking pills
❑Yes	❑ No	Had change in daily routine	❑Yes	❑ No	Felt like the drug was toxic/harmful
❑Yes	❑ No	Fell asleep/slept through dose time	❑Yes	❑ No	Ran out of pills
❑Yes	❑ No	Felt ill or sick	❑Yes	❑ No	Felt good
❑Yes	❑ No	Wanted to avoid side effects	❑Yes	❑ No	Other (Specify:_____)

4. Self-assessed Adherence Visual Analog Scale (VAS): *(Show VAS to client during and after question.)*
In general over the past 4 weeks, how much of the time did you take all of your HIV medication as prescribed by your doctor? Put an "X" on the line below at the point that shows about how much of the medication you have taken. 0% means you have taken none. 50% means you have taken about half of the prescribed amount of HIV medications. 100% means you have taken every single prescribed dose of your medications.



For program staff:

4a. Best estimate based on VAS: ☐ %

5. What adherence support tools or reminders is this client using now?

❑ Pillbox/organizer ❑ Pharmacy support (e.g., delivery and/or automatic refill) ❑ DOT ❑ Electronic reminder (e.g., text/email/calendar alerts, PillStation, alarm, or MEMS caps)
❑ Other: _____ ❑ None

5a. *If one of the tools listed above was used as another adherence measurement at this visit,*
What is the result (as a percentage)? _____ **%**

6. Adherence Problem Identified: ❑Yes ❑ No (*If Yes,* PCP Notified: ❑ Care Coordinator Notified: ❑)

6a. *If Yes,* **Was Adherence Section in Client Care Plan updated?** ❑Yes ❑ No *If Yes,* Date: ____/____/_____

Staff Member Completing Form: _____ Name _____ Signature **Date:** ____ / ____ / ____ (m m / d d / y y)

APPENDIX X – Adherence Assessment (ART Non-Daily Regiments Only)

ADHERENCE ASSESSMENT (ART NON-DAILY REGIMENS ONLY)

Client Name: _____ **Client Record #:** _____

Adherence Assessment Self-Report Date: _____ / _____ / _____ (mm/dd/yyyy)

NYC-MCM Only: **Client is enrolled in:** ❑ B: Quarterly HP ❑ C1: Monthly HP ❑ C2: Weekly HP ❑ D: DOT

NOTE: THIS INTERVIEW SHOULD ONLY BE CONDUCTED WITH CLIENTS WHO ARE CURRENTLY ON ART.

INTRO: The purpose of this form is to learn about pill-taking and the issues that affect pill-taking, or adherence. This form is used if any of the medications in the regimen is prescribed for less-than-daily use.

- ***Please answer all questions honestly; you will not be "judged" based on your responses.***
- ***Please feel free to ask if you need any of the questions explained to you.***

The answers you give in this interview will be used to plan ways to help other people who must take pills on a difficult schedule. Many people find it hard to always remember their pills:

- ***Some people get busy and forget to carry their pills with them.***
- ***Some people find it hard to take their pills according to all the instructions, such as "with meals," "on an empty stomach," or "with plenty of fluids."***
- ***Some people decide to skip pills to avoid side effects or to just not be taking pills that day.***

We need to understand how people with HIV are really managing their pills. Please tell us what you are actually doing. Don't worry about telling us that you don't take all your pills. We need to know what is really happening, not what you think we "want to hear."

Complete this page with your client. Be prepared to help the client remember and name medications in his/her regimen, as needed. Please refer to separate list for names and pictures of all HIV medications.

1. Please indicate the name of the daily HIV medications you take, the number of pills in each dose, number of doses each day, and any doses that you may have <u>missed</u>.

MEDICATION REGIMEN			**HOW MANY DOSES DID YOU MISS …**				
<u>Step 1.</u> Names of your HIV drugs (eg. Kaletra)	**# Pills/dose**	**# Dose/day**	**Yesterday?**	**Day before yesterday?**	**3 days ago?**	**4 days ago?**	**<u>Step 3.</u> Total Doses Missed**
1.							
2.							
3.							
4.							
			For each row (each HIV drug), add up the missed doses and place # in far right column. Then enter column total (the sum across ART drugs) in the outlined box at right.⇒				c
<u>Step 2 (non-daily)</u>: Prescribed Doses Across ART Medications *(ONLY use and sum this row if the patient has an ART regimen in which the number of doses per day varies)*							Total Rx'd doses b

***For program staff:* (Adherence Assessment Form)** *ONLY COUNT ART ADHERENCE*

A. Number of ART drugs in regimen (count the rows completed in Step 1 above)	**B. Prescribed # ART doses in 4-day period (Total Rx'd doses from Step 2 above)**	**C. Total doses missed (total in outlined box from Step 3 above)**	**D. 4-Day Adherence Percentage (%) [(b-c)/b)] x 100 =**
a	b	c	d %
	(Verified by Supervisor ❑)	**(Verified by Supervisor ❑)**	**(Verified by Supervisor ❑)**

Client Name: _____ **Client Record #:** _____

2. When was the last time you missed any of your HIV medications? *Check only one*

❑5	Within the past week
❑4	1-2 weeks ago
❑3	2-4 weeks ago
❑2	1-3 months ago
❑1	More than 3 months ago
❑0	Never skip medications

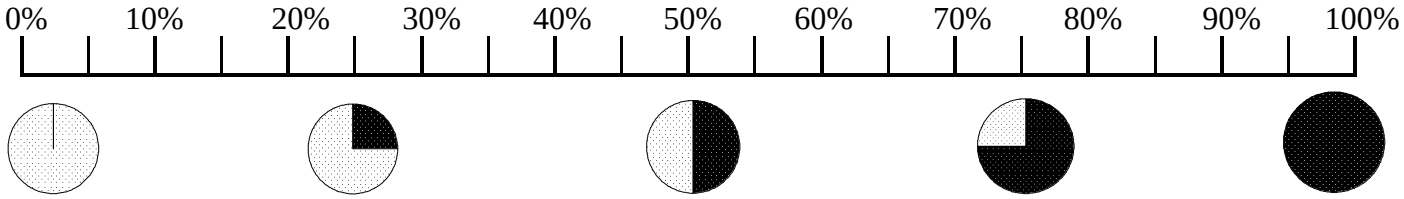
3. People may miss taking their medications for various reasons. Here is a list of possible reasons why you may miss taking your medications. Have you missed taking your HIV medications because you:

(Read choices aloud, and check as many as apply.)

Reasons for non-adherence:

❑Yes	❑ No	Simply forgot	❑Yes	❑ No	Felt depressed/overwhelmed
❑Yes	❑ No	Were away from home	❑Yes	❑ No	Felt there were too many pills
❑Yes	❑ No	Were busy with other things	❑Yes	❑ No	Did not want others to notice you taking pills
❑Yes	❑ No	Had change in daily routine	❑Yes	❑ No	Felt like the drug was toxic/harmful
❑Yes	❑ No	Fell asleep/slept through dose time	❑Yes	❑ No	Ran out of pills
❑Yes	❑ No	Felt ill or sick	❑Yes	❑ No	Felt good
❑Yes	❑ No	Wanted to avoid side effects	❑Yes	❑ No	Other (Specify:_____)

4. Self-assessed Adherence Visual Analog Scale (VAS): *(Show VAS to client during and after question.)*
In general over the past 4 weeks, how much of the time did you take all of your HIV medication as prescribed by your doctor? Put an "X" on the line below at the point that shows about how much of the medication you have taken. 0% means you have taken none. 50% means you have taken about half of the prescribed amount of HIV medications. 100% means you have taken every single prescribed dose of your medications.



For program staff:

4a. Best estimate based on VAS: ☐ %

5. What adherence support tools or reminders is this client using now?

❑ Pillbox/organizer ❑ Pharmacy support (e.g., delivery and/or automatic refill) ❑ DOT ❑ Electronic reminder (e.g., text/email/calendar alerts, PillStation, alarm, or MEMS caps)
❑ Other: _____ ❑ None

5a. *If one of the tools listed above was used as another adherence measurement at this visit,*

What is the result (as a percentage)? _____ **%**

6. Adherence Problem Identified: ❑Yes ❑ No (*If Yes,* PCP Notified: ❑ Care Coordinator Notified: ❑)

6a. *If Yes,* **Was Adherence Section in Client Care Plan updated?** ❑Yes ❑ No *If Yes,* Date: ____/____/_____

Staff Member Completing Form: _____ Name _____ Signature **Date:** ____ / ____ / ____ (m m / d d / y y)

APPENDIX Y – Comprehensive Care Plan

COMPREHENSIVE CARE PLAN

DATE CREATED: ____/____/_____

☐ **Initial or New**
☐ **Update**

REVIEW PERIOD: ___/____/___ - ___/____/___
(START DATE- END DATE)

Client Name: _____ **Client Record #:** _____

Current Track (Frequency of Service): ❑ Quarterly A ❑ Quarterly B ❑ Monthly C1 ❑ Weekly C2 ❑ Daily D

Program Staff: **DEVELOP AN INITIAL PLAN** within two (2) weeks of enrollment. **UPDATE** this form when there are minor changes/updates. **CREATE A NEW PLAN** to replace the last form at least every six (6) months or if there are significant changes/updates to the goals. Use **S.M.A.R.T** (Specific, Measureable, Attainable, Realistic and Time-bound) goals and objectives for each area of concern identified. **NOTE:** For all goals, please ensure that all relevant health promotion topics are identified to be addressed as an objective/action step and are listed in Section 2.

SECTION 1: MEDICAL, PROGRAM OR SOCIAL SERVICES GOALS

1a: PRIMARY CARE PROVIDER VISIT ATTENDANCE GOAL:

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

1b: OTHER MEDICAL, PROGRAM OR SOCIAL SERVICE GOAL:

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

1c: OTHER MEDICAL, PROGRAM OR SOCIAL SERVICE GOAL:

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

SECTION 2: HEALTH PROMOTION CURRICULUM

2a: HEALTH PROMOTION GOAL #1:

Date Goal Resolved: ____/____/____

_____

Objectives/Action Steps **(Make sure objectives/action steps are also S.M.A.R.T.)**	**Responsible Party**	**Target End Date** **(Date objectives/action steps are expected to be accomplished)**	**Outcome (Were the objectives/action steps accomplished?)**	**Outcome Date (Date objectives/actions step were accomplished)**
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

2b: HEALTH PROMOTION GOAL #2 :

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

2c: HEALTH PROMOTION GOAL #3:

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

2d. CURRICULUM TOPICS TO BE COVERED	**Target End Date**
Please list the topic number and topic name to be completed	
	____/____/_____
	____/____/_____
	____/____/_____
	____/____/_____
	____/____/_____

Client Name: _____

SECTION 3: ADHERENCE TO PRESCRIBED MEDICATIONS

Please complete Adherence section only if the Client is currently prescribed either an ART regimen and/or the following non-ART medications: psychotropic, opportunistic infections, and/or Hepatitis C.

3a. ADHERENCE ISSUE/GOAL 1:

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

3b. ADHERENCE ISSUE/GOAL 2:

Date Goal Resolved: ____/____/____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

SECTION 4: OTHER NEEDS AND GOALS

In this section, please identify any additional and/or emerging issues or goals.

4a. OTHER ISSUE/GOAL 1:

Date Goal Resolved: ____/____/____

_____

Objectives/Action Steps **(Make sure objectives/action steps are also S.M.A.R.T.)**	**Responsible Party**	**Target End Date** **(Date objectives/action steps are expected to be accomplished)**	**Outcome** (**Were the objectives/action steps accomplished?**)	**Outcome Date** (**Date objectives/actions step were accomplished**)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

4b. OTHER ISSUE/GOAL 2:

Date Goal Resolved: ____/____/____

_____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

4c. OTHER ISSUE/GOAL 3:

Date Goal Resolved: ____/____/____

_____

Objectives/Action Steps (Make sure objectives/action steps are also S.M.A.R.T.)	**Responsible Party**	**Target End Date** (Date objectives/action steps are expected to be accomplished)	**Outcome** (Were the objectives/action steps accomplished?)	**Outcome Date** (Date objectives/actions step were accomplished)
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____
	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Client Name: _____

	❑ Primary Care Provider ❑ Care Coordinator ❑ Patient Navigator ❑ Client ❑ Other: _____	____/____/_____	❑ Yes ❑ No	____/____/_____

Notes:_____

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Client:	_____ **Name (Print)**	_____ **Signature**	**Date:** _____ **m m / d d / y y**
Care Coordination Staff:	_____ **Name (Print)**	_____ **Signature**	**Date:** **/ /** **m m / d d / y y**
Primary Care Provider:	_____ **Name (Print)**	_____ **Signature**	**Date:** **/ /** **m m / d d / y y**

APPENDIX Z – Referrals/Appointments Tracking Log

REFERRALS/APPOINTMENTS TRACKING LOG
P. 1: INTERNAL PCP APPOINTMENTS

Client Name: _____ **Client Record #:** _____

This form facilitates tracking of referrals to and appointments with internal and external service providers. Appointment details entered in eSHARE will feed into the Services/Forms Scheduling Report, which can serve as a reminder and help to prioritize clients for follow-up. Please record internal (within agency or within formal network) PCP appointments on Page 1. Page 2 should be used for referrals to external primary care, as well as for referrals to internal or external services of other kinds (non-primary care). Please note that eSHARE will offer an option to associate the referral or PCP appointment with an entered service in the system (for example, "Assistance with health care"). This option to link the referral or appointment to an already-entered service is reflected in the second column of the tables below. Not all referrals/appointments need to be linked.

PCP Appointment?	Associate with Entered Service	Worker(s) Who Made Appointment	PCP Appointment Information	Resources Needed	Appt. Disposition	Date Completed
Client has or had appointment scheduled with PCP: ❑ Yes ❑ No *If Yes,* date appt. made: ____/____/_____	Service Type: _____ Service Date: ____/____/_____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	Last Name: _____ First Name: _____ **Date of the Appt.:** ____/____/_____	❑ Reminder call/message ❑ Transport – Car/Taxi/Van ❑ Transport – MetroCard ❑ Childcare – in field ❑ Childcare – service site ❑ Accompany from field ❑ Accompany at service site ❑ Appointment preparation ❑ Interpreting services ❑ Other (_____) ❑ N/A (none required)	❑ Completed ❑ Rescheduled ❑ Client missed ❑ Client showed, but appt incomplete ❑ Other (*Specify:* _____)	____/____/_____ mm/dd/yyyy
Client has or had appointment scheduled with PCP: ❑ Yes ❑ No *If Yes,* date appt. made: ____/____/_____	Service Type: _____ Service Date: ____/____/_____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	Last Name: _____ First Name: _____ **Date of the Appt.:** ____/____/_____	❑ Reminder call/message ❑ Transport – Car/Taxi/Van ❑ Transport – MetroCard ❑ Childcare – in field ❑ Childcare – service site ❑ Accompany from field ❑ Accompany at service site ❑ Appointment preparation ❑ Interpreting services ❑ Other (_____) ❑ N/A (none required)	❑ Completed ❑ Rescheduled ❑ Client missed ❑ Client showed, but appt incomplete ❑ Other (*Specify:* _____)	____/____/_____ mm/dd/yyyy

Program Staff Completing Form: _____ (Name) _____ (Signature) **Date:** ____/____/____ (mm/dd/yy)

REFERRALS/APPOINTMENTS TRACKING LOG
P. 2: REFERRALS (EXTERNAL PRIMARY CARE OR OTHER SERVICES – INTERNAL OR EXTERNAL)

Client Name: _____ **Client Record #:** _____

Referral for Services?	Associate with Entered Service	Worker(s) Who Made Referral	Other Service Referral and Appointment Information	Resources Needed	Appt. Disposition	Date Completed
Client has or had a referral for other services: ❑ Yes ❑ No *If Yes,* date referral made: ____/____/_____	Service Type: _____ Service Date: ____/____/_____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	Service Type: _____ Agency: _____ Appt. set: ❑ Yes ❑ No *If Yes, fill in details:* Last Name: _____ First Name: _____ **Date of the Appt.:** ____/____/_____	❑ Reminder call/message ❑ Transport – Car/Taxi/Van ❑ Transport – MetroCard ❑ Childcare – in field ❑ Childcare – service site ❑ Accompany from field ❑ Accompany at service site ❑ Appointment preparation ❑ Interpreting services ❑ Other (_____) ❑ N/A (none required)	❑ Completed ❑ Rescheduled ❑ Agency refused ❑ Client missed ❑ Client showed, but appt incomplete ❑ Other (*Specify:* _____)	____/____/_____ mm/dd/yyyy
Client has or had appointment scheduled to receive other services: ❑ Yes ❑ No *If Yes,* date referral made: ____/____/_____	Service Type: _____ Service Date: ____/____/_____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	Service Type: _____ Agency: _____ Appt. set: ❑ Yes ❑ No *If Yes, fill in details:* Last Name: _____ First Name: _____ **Date of the Appt.:** ____/____/_____	❑ Reminder call/message ❑ Transport – Car/Taxi/Van ❑ Transport – MetroCard ❑ Childcare – in field ❑ Childcare – service site ❑ Accompany from field ❑ Accompany at service site ❑ Appointment preparation ❑ Interpreting services ❑ Other (_____) ❑ N/A (none required)	❑ Completed ❑ Rescheduled ❑ Agency refused ❑ Client missed ❑ Client showed, but appt incomplete ❑ Other (*Specify:* _____)	____/____/_____ mm/dd/yyyy

Program Staff Completing Form: _____ (Name) _____ (Signature) **Date:** ____/____/____ (m m / d d / y y)

APPENDIX AA – PCSM Update

PCSM UPDATE

Client Name:	_____	Client Record #:	_____

Program (Part A Service Category) Performing Update:

I. Primary Care *(Required for all service categories)*

Do you currently have a Primary Care Physician (PCP) / HIV primary care provider? ❑ Yes ❑ No

PCP visits since last update: _____/_____/_____ (mm/dd/yyyy) OR ❑ N/A (no new primary care visit)

_____/_____/_____ (mm/dd/yyyy) _____/_____/_____ (mm/dd/yyyy) _____/_____/_____ (mm/dd/yyyy)

II. Clinical Information – Labs *(Required for all service categories except ADV, LGL, HOA and TRN)*

CD4 tests since last update *If none are available, check box at right:* ❑ No new CD4 count on record

CD4 count	CD4 % *(optional)*	Date (mm/dd/yyyy)

Viral Load tests since last update *If none are available, check box at right:* ❑ No new VL on record

Viral Load count	Viral Load Undetectable	Date (mm/dd/yyyy)
	❑ Yes ❑ No ❑ Unknown	
	❑ Yes ❑ No ❑ Unknown	
	❑ Yes ❑ No ❑ Unknown	

III. Antiretroviral Treatment (ART) Review *(Required for all service categories except ADV, LGL, HOA and TRN)*

Has client had any change in ART status or ART regimen (e.g., started or stopped any antiretroviral medication) since the last assessment? ❑ Yes ❑ No *If No, skip to Section IV.*

If yes, **Is client currently prescribed ART?** ❑ Yes ❑ No

If client is not on ART, **Why is the client not currently prescribed ART?** *(Check only one)*

❑ Not medically indicated ❑ Not ready – by PCP determination ❑ Intolerance/side effects/toxicity

❑ Payment/insurance/cost issue ❑ Client refused ❑ Other reason ❑ Unknown

(Required for MCM and OMC only) If currently prescribed ART, please complete the table below:

HIV medication names	Dosage		# Doses	Frequency	Date Started (mm/yyyy)
	# per Dose	Dose Unit (pills, ccs, mls)			
1.				❍Daily ❍Weekly	_____/_____
2.				❍Daily ❍Weekly	_____/_____
3.				❍Daily ❍Weekly	_____/_____
4.				❍Daily ❍Weekly	_____/_____

IV. HIV/AIDS Status Information *(Required for all service categories)*

Most Recent HIV Status: *(Check only one)*

❑ HIV+, Not AIDS ❑ HIV+, AIDS status unknown ❑ CDC-Defined AIDS

If AIDS, **AIDS Diagnosis Date:** _____/_____/_____ (mm/dd/yyyy) *Optional for ADV, LGL, OHC, TRN*

Client Name:	_____	Client Record #:	_____

Notes:

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Staff Member Completing Form: _____ Name	_____ Signature	Date ___/___/___ m m / d d / y y

APPENDIX BB – Curriculum Coverage Log

CURRICULUM COVERAGE LOG

Client Name: _____ **Client Record #:** _____

Complete the Curriculum Coverage Log whenever a topic is discussed with the client. Please use the Care Plan to guide curriculum activities. Write in the dates of the visits that included curriculum material, for each topic taught. When a topic is completed as expected in two visits, just write in the "Date Started" and "Date Completed." However, if a topic is not completed in the second (or even third) teaching session on that topic, write in the date of that session under "Date Continued," and then write in the final session date for "Date Completed." At the right, note any areas that took or will take more time and practice, reasons for doing topics out of order, next steps, etc.

TOPICS	DATE STARTED (mm/dd/yy)	DATE(S) CONTINUED (mm/dd/yy)	DATE COMPLETED (mm/dd/yy)	NOTES (challenges, needs, order changes, or next steps)
Topic 1: Introduction to Health Promotion (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 2: Me & HIV (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 3: Using a Pillbox (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 4: Handling Your ART Medications (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 5: What is Adherence? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 6: Side Effects (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 7: What is HIV and how does it affect my body? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 8: Identifying and Building Social Support Networks (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	

TOPICS	DATE STARTED (mm/dd/yy)	DATE(S) CONTINUED (mm/dd/yy)	DATE COMPLETED (mm/dd/yy)	NOTES (challenges, needs, order changes, or next steps)
Topic 9: Adherence Strengths and Difficulties (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 10: Medical Appointments and Providers (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 11: Health Maintenance (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 12: Harm Reduction: Sexual Behavior (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 13: Harm Reduction: Substance Use (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 14: Harm Reduction: Safety in Relationships (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 15: Healthy Living – Diet and Exercise (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 16: Wrap-up	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 17: Harm Reduction: Tobacco Use (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Topic 18: Me and Hepatitis C (discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	

Staff Member Completing Form: _____ (Name) _____ (Signature) **Date:** ___ / ___ / ___ (m m / d d / y y)

APPENDIX CC – Group Services Tracking Log

GROUP SERVICES TRACKING LOG

Program Staff: Please complete this form at the time group services are held. This form will be used by multiple service categories. Sections, questions and/or answer options for specific service categories are identified by their 3-letter category code. If the word 'ALL' appears before a question or a section, it can be completed by all service categories, and if 'ALL' appears as ALL, it is required for all service categories using this form. Data Element Requirement Codes:

ALL= Required; ALL= Optional

ALL **DATE:** ____/____/_____ mm/dd/yyyy	ALL **START TIME:** __ __ : __ __ am/pm	ALL **END TIME:** __ __ : __ __ am/pm
ALL **WORKERS PROVIDING SERVICE:** a) _____ b) _____ c) _____		d) _____ e) _____ f) _____
ALL **SITE OF SERVICE:** *except HRR* ❑ Program site (*Specify:* _____) ❑ Client home		❑ Other field site (*Specify:* _____) ❑ Phone

ALL **Service Type**	ALL **Service Details** *Check only one option, unless otherwise specified*	
OHY, SCG/SCI, MSV, MHN, HRR, HOM, STH ❑ Counseling	❑ Supportive *(auto-populated for SCG/SCI)* ❑ AOD (Substance Use) ❑ Mental Health ❑ Treatment Adherence ❑ Readiness for Care *(auto-populated for OHY)*	*MSV, MHN* *If Treatment Adherence counseling,* **Select type(s) of treatment discussed in the adherence counseling session:** *Check all that apply* ❑ ARVs ❑ Other Medications (*Specify*_____) *MSV, HRR* *If AOD counseling,* **Specify whether smoking and tobacco use was covered during the counseling session:** ❑ Yes ❑ No
FNS, FBM, HRR, MCM ❑ Health Education/Promotion	*FNS, FBM* ❑ Nutritional Education *HRR* ❑ Seeking Safety *MCM* ❑ Health Promotion Curriculum	MCM **Detail on health education/promotion topic coverage:** *Check all that apply* ❑ Topic 1: Introduction to Health Promotion ❑ Topic 2: Me & HIV ❑ Topic 3: Using a Pillbox ❑ Topic 4: Handling your ART Medications ❑ Topic 5: What is Adherence? ❑ Topic 6: Side Effects ❑ Topic 7: What is HIV and how does it affect my body? ❑ Topic 8: Identifying and Building Social Support Networks ❑ Topic 9: Adherence Strengths and Difficulties ❑ Topic 10: Medical Appointments and Providers ❑ Topic 11: Health Maintenance ❑ Topic 12: Harm Reduction: Sexual Behavior ❑ Topic 13: Harm Reduction: Substance Use ❑ Topic 14: Harm Reduction: Safety in Relationships ❑ Topic 15: Healthy Living - Diet and Exercise ❑ Topic 16: Wrap-up ❑ Topic 17: Harm Reduction: Tobacco Use ❑ Topic 18: Me & Hepatitis C ❑ Other health education/promotion topic(s) (*Specify:* _____) HRR **Detail on Seeking Safety health education conversations:** *Check all that apply* ❑ Asking for Help ❑ Honesty ❑ Setting Boundaries in Relationships ❑ Healthy Relationships ❑ Community Resources ❑ Healing from Anger ❑ Getting Others to Support Your Recovery ❑ Detaching from Emotional Pain: Grounding ❑ Taking Good Care of Yourself ❑ Red and Green Flags ❑ Commitment ❑ Coping with Triggers ❑ Respecting Your Time ❑ Self-Nurturing ❑ PTSD: Taking Back Your Power ❑ Compassion ❑ When Substances Control You ❑ Recovery Thinking ❑ Integrating the Split Self ❑ Creating Meaning ❑ Discovery ❑ Introduction to Treatment/Case Management ❑ Safety ❑ The Life Choices Game (review) ❑ Termination
MCM-W, HRR, STH ❑ Other Supportive Activities	ALL **Type of Other Supportive Activities:**	❑ Life Skills Training *(auto-populated for STH)* ❑ Support Group *(auto-populated for MCM-W)* ❑ Low Threshold AOD ❑ Overdose Prevention ❑ Recreational Therapy/Structured Socialization
FNS ❑ Congregate Meals	FNS **Type of meal provided:** ❑ Breakfast ❑ Lunch ❑ Dinner	

Group Service Details:

ALL **Cycle number or ID for this group session, if applicable:** _____

ALL **Agency-specific group name:** _____

MSV, HRR **Number of group attendees: _____**

ALL **Clients attended:**

1.	16.
2.	17.
3.	18.
4.	19.
5.	20.
6.	21.
7.	22.
8.	23.
9.	24.
10.	25.
11.	26.
12.	27.
13.	28.
14.	29.
15.	30.

Collaterals attended: *Complete for Congregate Meals (FNS), Other Supportive Activities (HRR, STH) & Counseling (SCG/SCI, STH)*

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

MCM ALL **Other Group Service Details:** *Required for MCM, optional for all other service categories*

Number of HIV information/education materials distributed:
Number of referral/resource lists distributed:
Number of program/agency promotional materials distributed:
Number of male condoms distributed:
Number of female condoms distributed:
Number of other materials distributed:
Write in description of other materials distributed:

Notes:

_____

_____

_____

Program Staff Completing Form: _____ (Name) _____ (Signature) **Date Completed:** ___/___/___ (m m / d d / y y)

APPENDIX DD – Pill Box Log (ART Only) – For Daily Regimens

PILL BOX LOG (ART ONLY)- FOR DAILY REGIMENS

Client Name: _____ **Client Record #:** _____

Program Track: ❑ B: Quarterly HP ❑ C1: Monthly HP ❑ C2: Weekly HP

THIS FORM SHOULD ONLY BE COMPLETED FOR CLIENTS WHO ARE CURRENTLY ON ART BUT HAVE NOT BEEN RECEIVING DOT IN THIS REVIEW PERIOD.
Program Staff: Add to the Monthly Pill Box Log at each weekly, monthly or quarterly visit. Include every pill box available for review since the previous review, going back at most 4 weeks. In the space below, identify the medications currently prescribed, the number of pills prescribed per day per medication, and the number of pills taken per day per medication. If a pillbox review cannot be completed, put an X in the spaces for "Sum of Total Pills Taken" and "Total Pills Prescribed." After a weekly review, sum the number of pills taken per ARV in the first gray-shaded column and complete the weekly totals. A 4-week summary is on Page 2. If the regimen changes mid-week, start a new week on the first day of the new regimen.

Week: ____/____/_____ to ____/____/_____		Number of Pills Taken							Weekly Totals					
Medication ***List antiretrovirals (ARVs) and the # of prescribed pills/day for each***	# pills/ day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs)		Total Pills Prescribed (a1 x days in period)		% Adherence [(b1/c1) x 100]
										b1	÷	c1	x100=	%
Daily pills prescribed (across ARVs)=	a1								b1	**b1=Total weekly pills taken across ARVs**				

Week: ____/____/_____ to ____/____/_____		Number of Pills Taken							Weekly Totals					
Medication ***List antiretrovirals (ARVs) and the # of prescribed pills/day for each***	# pills/ day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs)		Total Pills Prescribed (a2 x days in period)		% Adherence [(b2/c2) x 100]
										b2	÷	c2	x100=	%
Daily pills prescribed (across ARVs)=	a2								b2	**b2=Total weekly pills taken across ARVs**				

Cells shaded in gray may be calculated by the Adherence Form Assistance Tool

Week: ____/____/_____ to ____/____/_____		Number of Pills Taken							Weekly Totals					
Medication ***List antiretrovirals (ARVs) and the # of prescribed pills/day for each***	# pills/ day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs)		Total Pills Prescribed (a3 x days in period)		% Adherence [(b3/c3) x 100]
										b3		c3		
											÷		x100=	%
Daily pills prescribed (across ARVs)=	a3								b3	**b3=Total weekly pills taken across ARVs**				

Week: ____/____/_____ to ____/____/_____		Number of Pills Taken							Weekly Totals					
Medication ***List antiretrovirals (ARVs) and the # of prescribed pills/day for each***	# pills/ day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs)		Total Pills Prescribed (a4 x days in period)		% Adherence [(b4/c4) x 100]
										b4		c4		
											÷		x100=	%
Daily pills prescribed (across ARVs)=	a4								b4	**b4=Total weekly pills taken across ARVs**				

Cells shaded in gray may be calculated by the Adherence Form Assistance Tool

Symptom review by self-report over 4 weeks:

- ❑ Diarrhea
- ❑ Nausea
- ❑ Sleep disturbance
- ❑ Fatigue
- ❑ Muscle pain
- ❑ Nerve pain
- ❑ Abdominal pain
- ❑ Headache
- ❑ Dizziness or fainting
- ❑ Rash
- ❑ Other (Specify:_____)

4-week Adherence Summary: **Date of Pill Box report: _____/_____/_____**

[(b1+b2+b3+b4) ÷ (c1+c2+c3+c4)] X 100 = % Adherence by Pill Box count

Total Taken	÷	Total Prescribed	X	100	=	

Staff Member Completing Form:	Name	Signature	**Date:**	m m / d d / y y
Verified By:	Name	Signature	**Date:**	m m / d d / y y

APPENDIX EE – Pill Box Log (ART Only) – For Non-Daily Regimens

PILL BOX LOG (ART ONLY)- FOR NON-DAILY REGIMENS

Client Name: _____ **Client Record #:** _____

Program Track: ❑ B: Quarterly HP ❑ C1: Monthly HP ❑ C2: Weekly HP

THIS FORM SHOULD ONLY BE COMPLETED FOR CLIENTS WHO ARE CURRENTLY ON ART BUT HAVE NOT BEEN RECEIVING DOT IN THIS REVIEW PERIOD. IN ADDITION, THIS VERSION IS INTENDED FOR CLIENTS WHO HAVE SOME ARVs PRESCRIBED FOR LESS-THAN-DAILY USE.
*Program Staff: Add to the Monthly Pill Box Log at each weekly, monthly or quarterly visit. Include every pill box available for review since the previous review, going back at most 4 weeks. In the space below, identify the medications currently prescribed, the number of pills **prescribed** per day per medication, and the number of pills **taken** per day per medication. If a pillbox review cannot be completed, put an X in the spaces for "Sum of Total Pills Taken" and "Total Pills Prescribed." After a weekly review, sum the number of pills taken per ARV in the first gray-shaded column and complete the weekly totals. A 4-week summary is on Page 2. If the regimen changes mid-week, start a new week on the first day of the new regimen.*

Week: ____/____/_____ to ____/____/_____

Medication *List antiretrovirals (ARVs)*	**Prescribed Pills and Frequency** *(# pills/day, # days/week)*	Number of Pills Taken: Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Weekly Totals: Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs) b1	÷	Total Pills Prescribed (a1) a1	x100=	% Adherence [(b1/a1) x 100]
											÷		x100=	%
Pills prescribed (across ARVs) for each day:									a1	**a1=Total weekly pills prescribed (Rx'd)**				

Week: ____/____/_____ to ____/____/_____

Medication *List antiretrovirals (ARVs)*	**Prescribed Pills and Frequency** *(# pills/day, # days/week)*	Number of Pills Taken: Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Weekly Totals: Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs) b2	÷	Total Pills Prescribed (a2) a2	x100=	% Adherence [(b2/a2) x 100]
											÷		x100=	%
Pills prescribed (across ARVs) for each day:									a2	**a2=Total weekly pills prescribed (Rx'd)**				

Cells shaded in gray may be calculated by the Adherence Form Assistance Tool

Week: ____/____/_____ to ____/____/_____		Number of Pills Taken							Weekly Totals					
Medication *List antiretrovirals (ARVs)*	**Prescribed Pills and Frequency** *(# pills/day, # days/week)*	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs) b3		Total Pills Prescribed (a3) a3		% Adherence [(b3/a3) x 100]
											÷		x100=	%
Pills prescribed (across ARVs) for each day:									a3	**a3=Total weekly pills prescribed (Rx'd)**				

Week: ____/____/_____ to ____/____/_____		Number of Pills Taken							Weekly Totals					
Medication *List antiretrovirals (ARVs)*	**Prescribed Pills and Frequency** *(# pills/day, # days/week)*	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total Pills Taken per ARV	Sum of Total Pills Taken (all ARVs) b4		Total Pills Prescribed (a4) a4		% Adherence [(b4/a4) x 100]
											÷		x100=	%
Pills prescribed (across ARVs) for each day:									a4	**a4=Total weekly pills prescribed (Rx'd)**				

Cells shaded in gray may be calculated by the Adherence Form Assistance Tool

Symptom review by self-report over 4 weeks:

- ❑ Diarrhea
- ❑ Nausea
- ❑ Sleep disturbance
- ❑ Fatigue
- ❑ Muscle pain
- ❑ Nerve pain
- ❑ Abdominal pain
- ❑ Headache
- ❑ Dizziness or fainting
- ❑ Rash
- ❑ Other (Specify:_____)

4-week Adherence Summary: **Date of Pill Box report: _____/_____/_____**

[(b1+b2+b3+b4) ÷ (a1+a2+a3+a4)] X 100 = % Adherence by Pill Box

Total Taken	÷	Total Prescribed	X	100	=	

Staff Member Completing Form:	Name	Signature	**Date:** m m / d d / y y
Verified By:	Name	Signature	**Date:** m m / d d / y y

APPENDIX FF – Monthly DOT Log (ART Only)

MONTHLY DOT LOG (ART ONLY)

Month _____ Year _____

Client Name: _____ **Client Record #:** _____

DOT Specialist or Navigator: Document pills taken at each DOT visit in Section 1. The number at the top of each column refers to the day of the month. Please write the month of the review at the top of the form. For each medication, place the number of observed pills taken at the DOT visit above the dotted line, and place the number of unobserved pills taken below the dotted line, in the shaded area. NOTE: If regimen changes mid-month, create a new DOT log starting on the first day of the new regimen. (Example: if a new regimen starts on day 15, begin client a new DOT log leaving days 1-14 blank, with first entry on day 15.)

Section 1: Daily Tracking		**Pills Taken**																														
Medication *List ARVs, with #pills/day prescribed for each*	#	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total

Total pills Rx'd per day =	a	**Monthly total pills taken (observed only)=**	b
		Monthly total pills taken (observed and unobserved) =	c

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Pills Rx'd for each day *Use this row only for ART regimens with varying pills Rx'd per day.*																																d*
Days without DOT *At right, mark an 'X' for any day without any DOT {no dose(s) observed}.*																																†

Symptom Review by client self-report:

- ❑ Diarrhea
- ❑ Nausea
- ❑ Sleep disturbance
- ❑ Fatigue
- ❑ Muscle pain
- ❑ Nerve pain
- ❑ Abdominal pain
- ❑ Headache
- ❑ Dizziness or fainting
- ❑ Rash
- ❑ Other (Specify: _____)

*In 'd' write Total pills Rx'd for the month (for a non-daily regimen)

†Days in DOT month without an observation

Monthly DOT Log Month _____ Year _____

Client Name: _____ **Client Record #:** _____

Section 2: Monthly Adherence Summary – For program use only

At the end of the month, please complete boxes a, b, c, and d (if applicable) in Section 1, and the monthly summary in Section 2 for all pills prescribed and taken for the month. Include both an overall adherence measure and the strict adherence measure that counts observed pills only.

Date of DOT report:_____/_____/_____

ARV Medication ***(Transcribe from Section 1 on pg. 1)***

Item 1. **Days in period**	e	**Item 2.** **TOTAL number of pills prescribed (Rx'd) in period** *(Multiply Total pills Rx'd per day by Days in period: a x e) OR (Insert Total pills Rx'd from box 'd' on page 1)*	(a x e) OR d **Verified** ❑	**Item 3.** **TOTAL pills taken in period (c on p.1)**	c **Verified** ❑	**Item 5.** **Report of adherence by DOT count for a month (Item 3/Item 2) x 100 =**	% **Verified** ❑
				Item 4. **TOTAL pills observed taken in period (b on p.1)**	b **Verified** ❑	**Item 6.** **Report of directly observed adherence by DOT for a month (Item 4/Item 2) x 100 =**	% **Verified** ❑

❑ **Directly observed adherence not available (N/A)**

Notes:

_____

_____

_____

_____

_____

_____

_____

Staff Member Completing Form:	Name	Signature	**Date:**	m m / d d / y y
Verified By:	Name	Signature	**Date:**	m m / d d / y y

APPENDIX GG – Care Coordination Case Conference Form

CARE COORDINATION CASE CONFERENCE

Client Name: _____ **Client Record #:** _____ **Enroll Date:** _____/_____/_____

Navigator: _____ **Last PCP Visit Date:** _____/_____/_____

Note: For clients in non-ART track (A), skip ART Regimen Review (bottom of P. 1) and Adherence Review (top of P. 2).
Care Coordinator or Navigator: Please discuss the client with the PCP and use this form to guide discussion at least once quarterly, throughout the client's program enrollment.

Is this a formal/scheduled ongoing case review? ❑ Yes ❑ No *If No, only field required for eSHARE is Date of Case Conference.*

Date of Case Conference: ____/____/_____

Current Track (Check One): ❑ A: Quarterly (No ART) ❑ B: Quarterly (ART) ❑ C1:Monthly ❑ C2:Weekly ❑ D:DOT

Previous Conference (Date: ____/____/_____)*

	#	Date
Previous CD4:		
Previous VL:		

Missed PCP appointments reported at last Conference: _____ ❑ N/A (no prior Conference)

*Refer to intake, if this is first Conference.

Current Conference

From EMR and CC records

	#	Date(s)
Most Recent CD4:		
Most Recent VL:		
Hospitalizations since last Case Conference*:		
ED visits since last Case Conference*:		

PCP appointments missed since last completed appointment: _____

Topics covered since last Conference*: _____

Total # of topics covered to this point: _____

Progress Notes (include progress with enrollment in services, topics covered, adherence barriers, risk behaviors, disclosure issues, social issues or services, and any other developments relevant to care plan):

_____

_____

_____

_____

_____

ART Regimen Review

Currently prescribed ART: ❑ Yes ❑ No *If No, skip to Notes on Page 2*

Check the appropriate option

- ❑ Regimen unchanged since last conference *If checked, skip to Page 2*
- ❑ Regimen changed since last conference *If checked, indicate reason for regimen change below*

Reason for regimen change

- ❑ Treatment failure/ Viral resistance
- ❑ Intolerance/ Side effects (Specify: _____)
- ❑ Change in guidance/regimen simplification
- ❑ Other (Specify: _____)

Current ART Medications:	Pills/dose	Dose Frequency	Continued or New?	If New, Start Date:
			❑ Continuing ❑ New	_____/_____/_____
			❑ Continuing ❑ New	_____/_____/_____
			❑ Continuing ❑ New	_____/_____/_____
			❑ Continuing ❑ New	_____/_____/_____

Client Name: _____ **Client Record #:** _____

Adherence Review *Complete only if client is prescribed ART. Leave left side blank if this is the first Conference.*

Record DOT or pillbox adherence assessment

From previous conference:

DOT or Pillbox at **PREVIOUS** Conf. (Measure:_____)
Value as % from 0-100

Date	Value
____/____/____	

For current conference:

Most recent DOT or Pillbox* **SINCE LAST** Conf. (Measure:_____)
Value as % from 0-100
*Summary of up to 4 weekly pillbox checks or 1 month of DOT

Date	Value
____/____/____	

Record self-report adherence assessment

From previous conference:

Date of last self-report Adherence Assessment at previous conf.	Date	____/____/____
4-day self-report adherence value *Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 1, Box D*	Value	
Last missed dose score *Value from 0-5, Adherence Assessment P. 2, Question 2*	Value	
VAS adherence value *Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 2, Question 4a*	Value	

For current conference:

Date of most recent available self-report Adherence Assessment	Date	____/____/____
4-day self-report adherence value *Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 1, Box D*	Value	
Last missed dose score *Value from 0-5, Adherence Assessment P. 2, Question 2*	Value	
VAS adherence value *Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 2, Question 4a*	Value	

Notes on Current Needs: *Include adherence barriers, risk behaviors, disclosure issues, housing issues, social issues, and any other behavioral, clinical, or psychosocial concerns that need to be addressed*

Notes on Case Conference Discussion:

Does care plan need to be updated? ❑ Yes ❑ No *If Yes,* Date Updated: _____/_____/_____

Client Disposition Summary

Check the appropriate option

- ❑ Continue current Program/Track
- ❑ Change in Program/Track *(Update Client Status Change form)*
  Change to: ❑ A: Quarterly (No ART) ❑ B: Quarterly (ART) ❑ C1: Monthly ❑ C2: Weekly ❑ D: DOT
- ❑ Discharge from program *(Update Client Status Change form)*

	Name	Signature	Date
Physician/PA/NP			___/___/_____
Care Coordinator			___/___/_____

APPENDIX HH – Reassessment Form

REASSESSMENT
(MCM, MCM-W, TCC)

Client Name: _____

ALL **Reassessment Date:** _____/_____/_____ mm / dd / yyyy

Client Record #: _____

Program Staff: Re-assess clients at least every six months. When completing this interview/chart review, you should have the intake or previous assessment available for reference. Clients may need to be reminded of responses on the previous assessment, in order to report accurately on what has changed. For items collected via client interview, mention the date of the last assessment, and explain that, except where otherwise specified, you will be asking about any changes since that date.

Please note that this form is used for multiple service categories. Not all data elements contained in this form are expected for each service category. To identify which questions are required for your service category, please find the data element requirement codes in the grey section header bar or to the left of individual questions.

Data Element Requirement Codes:
1= Required; 1= Optional
Service Category Codes:
ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

I. Clinical Information
Chart Review or Client Interview

ALL **Hospitalizations and ED Visits since last assessment:**

# of Events	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Reason/Discharge Dx	Facility
# of Hospitalizations: _____ *If none, enter "0"*				
# of ED Visits: _____ *if none, enter "0"*				

ALL **Has client received or newly reported any other medical conditions requiring treatment since last assessment?** ❑ Yes ❑ No ❑ Unknown

ALL *If Yes,* **What condition(s)?** *(Check all that apply)*

- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease/hypertension
- ❑ Liver disease
- ❑ Other (Specify: _____)
- ❑ Kidney disease
- ❑ Hepatitis C
- ❑ Tuberculosis (TB)
- ❑ Asthma

ALL **Has client received or newly reported a mental health diagnosis since last assessment?**
❑ Yes ❑ No ❑ Unknown

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

Client Name: _____

ALL *If Yes,* **What diagnosis or diagnoses?** *(Check all that apply)*

- ❑ Depression
- ❑ Anxiety Disorder (Panic, GAD, etc.)
- ❑ PTSD
- ❑ Bipolar Disorder
- ❑ Psychosis (Schizophrenia, etc.)
- ❑ HIV-associated Dementia
- ❑ Other (Specify: _____)

ALL **Pregnant:** ❑ Yes ❑ No ❑ Unknown ❑ N/A (male) *If No, Unknown or N/A, go to Section II.*

ALL *If Yes,* **Date of report of client's pregnancy to program:** _____/_____/_____ (mm/dd/yyyy)

ALL **Is client enrolled in prenatal care?** ❑ Yes ❑ No ❑ Unknown

For the following questions, check "N/A" if client plans to terminate (and thus is not preparing for a live birth)

ALL *If Yes,* **When was client enrolled in prenatal care:**

❑ First trimester ❑ Second trimester ❑ Third trimester
❑ At time of delivery ❑ N/A ❑ Unknown

ALL **Estimated Due Date:** _____/_____/_____

OR select one of the following: ❑ N/A ❑ Unknown

ALL **Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?**

❑ Yes ❑ No ❑ N/A ❑ Unknown

II. Client Information ALL — *Client Interview*

Has your employment status changed since the last assessment? ❑ Yes ❑ No
If Yes, please complete the following: *If No, go to Section III.*

Current employment status: *(Check only one)*

❑ Full-time ❑ Part-time ❑ Unemployed
❑ Unpaid volunteer/peer worker ❑ Out of workforce ❑ Other (Specify: _____)
❑ Declined

III. Insurance Information ALL — *Chart Review or Client Interview*

Has your insurance status changed since the last assessment? ❑ Yes ❑ No *If No, go to Section IV.*
If Yes, **Insurance Status**: ❑ Uninsured ❑ Insured
(If Insured, complete insurance details below. Otherwise, skip to Section IV.)

Check all that apply, and complete the related details/dates on each checked insurance type:

Insurance Type	Insurance details	Effective Date (mm/dd/yyyy)	End/Expiration Date (mm/dd/yyyy)
❑ Private	*(Check only one)* ❍ Employer plan ❍ Individual plan	____/____/_____	____/____/_____ ❑ Unknown ❑ N/A
❑ ADAP/ADAP+	*(Check all that apply)* ❍ ADAP (Rx Coverage) ❍ ADAP Plus	____/____/_____	____/____/_____ ❑ Unknown ❑ N/A
❑ Medicaid or CHIP	*(Check only one plan type)* ❍ SNP (special needs plan) ❍ MCO (managed care organization) ❍ FFS (fee-for-service) ❍ Not sure which type	____/____/_____	____/____/_____ ❑ Unknown ❑ N/A

Legend:
1 = Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

Client Name: _____

Insurance Type	Insurance details	Effective Date (mm/dd/yyyy)	End/Expiration Date (mm/dd/yyyy)
❑ Medicare		____/____/_____	____/____/_____ ❑ Unknown ❑ N/A
❑ Military, VA, Tricare		____/____/_____	____/____/_____ ❑ Unknown ❑ N/A
❑ IHS (Indian Health Service)		____/____/_____	____/____/_____ ❑ Unknown ❑ N/A
❑ Other public insurance		____/____/_____	____/____/_____ ❑ Unknown ❑ N/A

IV. Financial Information ALL — *Client Interview*

What is your annual household income? $_____ per year

We will be asking you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.

- **Please answer honestly. You may refuse to answer a question; refusing will not affect your care.**
- **Please feel free to ask if you need any of the questions explained to you.**
- **If you do not want to answer a question now, please tell me and we will return to it another time.**

V. Use of Prescriptions, Injectables and Other Substances ALL — *Client Interview*

Substance	Used in the past 3 months?	How often do you use?	How have you taken this? *(Check all that apply)*
Haven't used any	❑*	** If haven't used any substance **IN PAST 3 MONTHS**, skip to Section VI.*	
Tobacco	❑ Yes ❑ No ❑ Declined	___ cigarettes smoked weekly (for other forms of tobacco, # times used weekly) *or* ❑ < weekly ❑ Declined *(reminder: 1 pack = 20 cigarettes)*	❑ Orally (chewing tobacco) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Declined (no answer)
Alcohol	❑ Yes ❑ No ❑ Declined	___ drinks weekly *or* ❑ < weekly ❑ Declined	
Marijuana	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Declined (no answer)
PCP/Hallucinogens	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

Client Name: _____

Substance	Used in the past 3 months?	How often do you use?	How have you taken this? *(Check all that apply)*
Crystal Meth	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Cocaine/Crack	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Heroin	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Rx Pills to get high	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Hormones/steroids	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Patch ❑ Injected ❑ Declined (no answer)
Anything else: _____	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)

If client has, at this interview, reported injecting any substance in the table above, select "Yes" to the question below and select "in the past 3 months" beneath that. Ask the client directly about sharing injection equipment.

ALL **Have you ever injected any drug or substance?** *If No, go to Section VI.*
❑ Yes ❑ No ❑ Declined (no answer)

ALL *If Yes*, **When was the last time you injected any substance**?
- ❑ in the past 3 months
- ❑ between 3 and 12 months ago
- ❑ more than 12 months ago
- ❑ Declined

ALL *If the client reported any injection behavior in the past 3 months, ask:*
Do you currently receive clean syringes from a syringe exchange program or pharmacy?
❑ Yes ❑ No ❑ Declined

ALL **Have you ever shared needles or injection equipment with others?**
❑ Yes ❑ No ❑ Declined

ALL *If Yes*, **When was the last time you shared needles or injection equipment?**
- ❑ in the past 3 months
- ❑ between 3 and 12 months ago
- ❑ more than 12 months ago
- ❑ Declined

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

Client Name: _____

VI. Behavioral Risk Reduction [ALL] *Client Interview*

In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?	❑ Yes ❑ No ❑ Declined *If No, skip to Section VII.*
If Yes to the above question, please ask the following questions:	
How many sexual partners have you had in the last 12 months? _____	❑ Unknown ❑ Declined
In the past 12 months, have you had vaginal sex with a male?[A]	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had vaginal sex with a female?[B]	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had vaginal sex with a transgender person?	❑ Yes ❑ No ❑ Declined
If Yes to any vaginal sex, then ask: **In the past 12 months, have you had vaginal sex without a condom?**	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had anal sex with a male?	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had anal sex with a female?[B]	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had anal sex with a transgender person?	❑ Yes ❑ No ❑ Declined
If Yes to any anal sex, then ask: **In the past 12 months, have you had anal sex without a condom?**	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had oral sex with a male?	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had oral sex with a female?	❑ Yes ❑ No ❑ Declined
In the past 12 months, have you had oral sex with a transgender person?	❑ Yes ❑ No ❑ Declined
If Yes to any oral sex, then ask: **In the past 12 months, have you had oral sex without a condom, dental dam or other barrier?**	❑ Yes ❑ No ❑ Declined

[A] *It is optional to ask this question if the client is biologically male.*
[B] *It is optional to ask this question if the client is biologically female.*

VII. Gender and Sexual Identity [ALL] *Client Interview*

Since the last assessment, have you changed how you identify in terms of gender or sexual orientation?
❑ Yes ❑ No *If No, go to Section VIII.*

If Yes, please complete the below questions and update on Common Demographics form in eSHARE

What is your current self-identified gender: *(Check only one)*
❑ Male ❑ Female ❑ Transgender (M→F) ❑ Transgender (F→M)

Read question without responses, and then verify answer: **How would you identify your sexual orientation?** *(Check only one)*
❑ Gay/Lesbian/Homosexual ❑ Straight/Heterosexual ❑ Bisexual ❑ Queer ❑ Questioning
❑ Other (Specify: _____) ❑ Declined

Legend:
[1]= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

Client Name: _____

VIII. General Health and Well-Being ALL *Client Interview*

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
❑	❑	❑	❑	❑

2. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking……..	❑	❑	❑
b. Climbing <u>several</u> flights of stairs……..	❑	❑	❑

3. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Accomplished less</u> than you would like……	❑	❑	❑	❑	❑
b. Were limited in the <u>kind</u> of work or other activities..……..	❑	❑	❑	❑	❑

4. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Accomplished less</u> than you would like……	❑	❑	❑	❑	❑
b. Did work or other activities <u>less carefully than usual</u>……	❑	❑	❑	❑	❑

5. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including work within and outside of your living space)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
❑	❑	❑	❑	❑

6. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u>…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?.....	❑	❑	❑	❑	❑
b. Did you have a lot of energy?.....	❑	❑	❑	❑	❑
c. Have you felt downhearted and depressed?.....	❑	❑	❑	❑	❑

7. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
❑	❑	❑	❑	❑

Client Name: _____

IX. Disability Status [ALL] *Client Interview*

Are you deaf or do you have serious difficulty hearing? ❑ Yes ❑ No ❑ Not Asked

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)? ❑ Yes ❑ No ❑ Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ❑ Yes ❑ No ❑ Not Asked

OR ❑ **Client's age is less than 5 years old** *(If checked, skip to Living Arrangement/Housing Information)*

If the response to EITHER question 2a or 2b in Section VIII. General Health and Well-Being was "Yes, limited a lot" then select "Yes" for the next question; if the response to BOTH of those questions (2a and 2b) was "No, not limited at all" then select "No" for the next question. Under these two scenarios, the client does not need to be asked about difficulty walking or climbing stairs.

Do you have serious difficulty walking or climbing stairs? ❑ Yes ❑ No ❑ Not Asked

Do you have difficulty dressing or bathing? ❑ Yes ❑ No ❑ Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping? ❑ Yes ❑ No ❑ Not Asked

OR ❑ **Client's age is less than 15 years old**

X. Living Arrangement/Housing Information *Client Interview*

[ALL] **Has your housing situation changed since last assessment?** ❑ Yes ❑ No
If No, go to P.8 Household Composition questions

If Yes, please complete the following questions:

[ALL] **Are you currently enrolled in a housing assistance program?** ❑ Yes ❑ No ❑ Declined	[ALL] *If Yes,* **Agency:**_____ OR ❑ Unknown

[ALL] **What is your current living situation?** *(Check only one box at left)*

- ❑ Homeless/Place not meant for human habitation (such as a vehicle, abandoned building, or outside)
- ❑ Emergency shelter (non-SRO hotel)
- ❑ Single Room Occupancy (SRO) hotel
- ❑ Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)
- ❑ Supportive Housing Program *If checked, complete the indented detail questions below:*
  - ❍ Transitional Congregate
  - ❍ Transitional Scattered-Site
  - ❍ Permanent Congregate
  - ❍ Permanent Scattered-Site

  [ALL] **HIV housing program?** ❑ Yes ❑ No
- ❑ Room, apartment, or house that you rent (not affiliated with a supportive housing program)
- ❑ Staying or living in someone else's (family's or friend's) room, apartment, or house
- ❑ Hospital, institution, long-term care facility, or substance abuse treatment/detox center
- ❑ Jail, prison, or juvenile detention facility
- ❑ Foster care home or foster care group home
- ❑ Apartment or house that you own

[ALL] **Since what date (month and year) have you been living in your current situation?**	_____/_____ (mm/yyyy) OR select one of the following: ❑ Unknown ❑ Declined
[ALL] **How long do you expect to be in your current living situation? If you do not know, what is your best guess?** *(Check only one)*	❑ at least 1 year ❑ 6 months - <12 months ❑ 1 month - <6 months ❑ < 1 month

Legend:
[1]= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

Client Name: _____

ALL **Have you been homeless any time since your last assessment?**	❑ Yes ❑ No ❑ Declined	ALL *If Yes,* **When were you last homeless?**	_____/_____ (mm/yyyy)

1 2 3 Do not ask if client is homeless:

What are your current housing issues? *(Check all that apply)* ❑ N/A

❑ Cost	❑ Eviction or pending eviction	❑ Conflict with others in household
❑ Doubled-up in the unit	❑ Expanding household (e.g. newborn)	❑ Release from institutional setting
❑ Health or safety concerns	❑ Space/configuration (e.g. too small)	❑ Other (Specify: _____)

HOUSEHOLD COMPOSITION

ALL **Has there been any change in who lives with you (any change in your household)?** ❑ Yes ❑ No

If No, go to Section XI. If Yes, continue: ALL **Total number in Household *(including the client)*:** _____

XI. Legal and Incarceration History ALL — *Client Interview*

In the past 3 months, have you served any time in jail, prison, or juvenile detention (JD)?	❑ Yes	❑ No	❑ Declined
If No, **Have you served any time in the past 12 months?**	❑ Yes	❑ No	❑ Declined
Are you currently on parole/probation?	❑ Yes	❑ No	❑ Declined

If client served any time in New York State, enter the NYSID [unique identifier assigned by the New York State Division of Criminal Justice Services (DCJS)]. This is an eight-digit number followed by one-character alpha (letter). Note: if the client has an old NYSID (with only 7 digits plus the letter at the end), insert a zero (0) at the start to reach 8 digits.

NYSID: _____ *Entered on eSHARE Common Demographics form*

XII. Current Enrollments and Needed Referrals ALL — *Client Interview*

Check current enrollments and any immediate referrals needed. Provide detail on referrals in Care Plan.

Currently Enrolled?	Referral Needed?	Service Category:
❑	❑	ADHC
❑	❑	SNP
❑	❑	Medicaid Health Home
❑	❑	Other Medicaid Case Management
❑	❑	HASA
❑	❑	Outpatient Bridge Medical Care
❑	❑	No to all of the above

Notes:

_____

_____

_____

_____

_____

_____

ALL **Staff Member Completing Form:**	Name	Signature	ALL **Date** / / m m / d d / yyyy

Legend:

1= Required; 1= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

APPENDIX II –Status Change Information Form (Track and Treatment Status)

STATUS CHANGE INFORMATION FORM
(TRACK AND TREATMENT STATUS)

Client Name: _____ **Client Record #:** _____

Care Coordinator: Please complete the below information for clients continuing active enrollment but with a change in program track or treatment status. If a client's program enrollment is closed or their service activity is temporarily suspended or is resumed after a suspension, please complete the Status Change for Case Closure/Suspension.

1. Date of update (mm/dd/yyyy):			/			/					
2. Last encounter date (mm/dd/yyyy):			/			/					

3. Event prompting or indicating the change in client status (What initiated this status change?)**:**

- ❑ **Case conference** *Specify one type:* ❍ Emergency/unscheduled conference ❍ Formal/scheduled review
- ❑ **Separate notification by member of the care team**
- ❑ **Notification by client's friend/family member/acquaintance**
- ❑ **Direct notification by client**
- ❑ **Receipt of information through another agency**
- ❑ **Other communication** *Specify:*

4. Indicate status change while continuing in program: *(Check all that apply, from **bold** checkbox options at left)*

- ❑ **Change in track, to:** ❍ A: Quarterly (no ART) ❍ B: Quarterly ❍ C1: Monthly ❍ C2: Weekly ❍ D: DOT

  Reason: *(Check only one option)*

  - ❍ Refusal to continue in higher-intensity track (despite need)
  - ❍ Reduced acuity of need (graduation to a lower-intensity track)
  - ❍ Agreement to try a track recommended previously
  - ❍ Difficulty keeping primary medical care appointments
  - ❍ First time on ART regimen or recent change in regimen
  - ❍ Recent non-adherence
  - ❍ Recent treatment failure
  - ❍ Other reason *Specify:*

  Date new track started (mm/dd/yyyy): _____/_____/_____

  Date prior track ended (mm/dd/yyyy): _____/_____/_____

- ❑ **Change in treatment (ART) status:**
  - ❍ Drug holiday or discontinued treatment
  - ❍ Started/resumed treatment
  - ❍ Regimen change
- ❑ **Change of residence or housing status within NYC**
- ❑ **Any other change or correction to contact information**
- ❑ **Change in household composition or disclosure status within household**
- ❑ **Change in transportation needs**
- ❑ **Other status change** *Specify:*

Notes:

_____

_____

_____

_____

Care Coordinator Completing Form:	Name	Signature	**Date:**	/ / m m / d d / y y

APPENDIX JJ –Status Change Information Form (Case Closure/Suspension)

STATUS CHANGE INFORMATION FORM
(CASE CLOSURE/SUSPENSION)

Client Name: _____ **Client Record #:** _____

Program Staff: Please complete the following information at the time of a client case closure, and enter into the enrollment details screen in eSHARE.

1. Date of update (mm/dd/yyyy):			/			/				
2. Last encounter date (mm/dd/yyyy):			/			/				

3. Enrollment status

- ❑ **Case Closed** {Date of Closure (mm/dd/yyyy): _____/_____/_____} *(go to #5)*
- ❑ **Case Suspended** {Date of Suspension (mm/dd/yyyy): _____/_____/_____} *(go to #4)*
- ❑ **Case Resumed after Suspension** {Date Resumed (mm/dd/yyyy): _____/_____/_____} *(skip to end)*

4. Please indicate the reason for client suspension from the program: *(Check only one **bold** option)*

- ❑ **Arrest with jail/prison time – not expected/known to be long-term**
- ❑ **Hospital/institutional admission – not expected to be long-term**
- ❑ **Other reason** *Specify reason:*

5. Please indicate the reason for closing this client's case: *(Check only one **bold** option)*

- ❑ **Completed program/graduated**
- ❑ **Moved/relocated**
- ❑ **Discharged due to a violation of program rules or requirements:** *(Check only one discharge reason)*
  - ❍ Refusal to continue (and no transfer to another program for comparable services)
  - ❍ Under-participation (participation below level needed to implement intervention according to model)
  - ❍ Ongoing active substance abuse (*if* this violates program rules or prevents constructive participation)
  - ❍ Discontinuation/deferral of ART (*if* enrolled for ART Adherence services only)
  - ❍ Inappropriate conduct
  - ❍ Concern for safety of field staff assigned to client
  - ❍ Ineligibility
  - ❍ Other *Specify:* _____
- ❑ **Lost to follow-up**
- ❑ **Transferred:** *(Check only one transfer detail)*
  - ❍ Incarcerated *Specify facility:* _____
  - ❍ Hospitalized *Specify facility:* _____
  - ❍ In residential treatment *Specify facility:* _____
  - ❍ Otherwise institutionalized *Specify facility:* _____
  - ❍ Receiving care elsewhere *Specify facility:* _____
  - ❍ Other transfer situation *Specify situation:* _____
- ❑ **Deceased** {Date of Death (mm/dd/yyyy): _____/_____/_____}
- ❑ **Program funding ended**
- ❑ **Mistaken enrollment**

Notes:

_____

_____

_____

_____

_____

_____

Program Staff Completing Form: _____ (Name) _____ (Signature) **Date:** ___/___/___ (m m / d d / y y)

APPENDIX KK – Services Tracking Log

SERVICES TRACKING LOG
(MCM/TCC/CMN)

Client Name: _____ **Client Record #:** _____

Program Staff: Use this form to log services provided for an individual client, across days or weeks. Fill in the date of the service, start time, staff providing the service, location, service type, and service details. Not all services on this form are required for each client or at a certain interval. Start a new form when the space provided for an individual service type has been filled and you are ready to log another service of that type. Note: Travel time and End time (in grey shading) are optional. Except for Accompaniment, please keep Travel time out of service Start time and End time entries. Permissible service types are identified by the below service category codes.

Service Category Codes:

ALL=All Categories, 1=MCM-NYC; 2=TCC; 3=MCM-W/CMN (Tri-County)

Service Date (mm/dd/yyyy)	Service Start Time/End Time	Worker(s)	Site of service delivery *(Select only one)*	Service Type	Service Details	
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Intake assessment** *ALL*		
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Other assessment/ reassessment** *ALL*	*(Select all that apply)* ❑ Re-Assessment (clinical, psychosocial, general health/well-being, housing, etc.) ❑ Adherence assessment - self-report ❑ Adherence assessment - pill count ❑ Adherence assessment - DOT ❑ Adherence assessment - other measure ❑ Logistical assessment or reassessment ❑ Health assessment ❑ Client risk assessment ❑ Mental health ❑ Harm reduction ❑ Case management ❑ Nutritional assessment ❑ 90 day follow up ❑ Other non-medical assessment/reassessment (Specify: _____)	
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Care plan/ service plan** *ALL*	*(Select only one)* ❑ Development of initial plan with this enrollment ❑ Update to plan ❑ Start of new plan (replacing last care/service plan) ❑ Housing services plan ❑ Discharge plan ❑ Other (Specify: _____)	
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Accompaniment** *ALL*	**Accompaniment to:** *(Select only one)* ❑ Primary care ❑ Other healthcare service ❑ Social service	**Accompaniment from:** *(Select only one)* ❑ Client's home or other field (non-provider) location ❑ One provider to another - different street address ❑ One provider to another - same street address ❑ Jail/prison

Service Date (mm/dd/yyyy)	Service Start Time/End Time	Worker(s)	Site of service delivery *(Select only one)*	Service Type	Service Details
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Assistance with health care** *ALL*	*Required ONLY for MCM-NYC (Select all that apply)* ❑ Help with filling out forms ❑ Eligibility assessment ❑ Reminder call/message ❑ Referral/ Appointment-making ❑ Arrangement for transportation ❑ Arrangement for childcare or eldercare ❑ Arrangement for interpreting services ❑ Appointment preparation ❑ Other (Specify: _____)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Assistance with entitlements and benefits** *1 2*	*Required ONLY for MCM-NYC (Select all that apply)* ❑ Help with filling out forms ❑ Eligibility assessment ❑ Reminder call/message ❑ Referral/ Appointment-making ❑ Arrangement for transportation ❑ Arrangement for childcare or eldercare ❑ Arrangement for interpreting services ❑ Appointment preparation ❑ Other (Specify: _____)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Assistance with social services** *1 2*	*Required ONLY for MCM-NYC (Select all that apply)* ❑ Help with filling out forms ❑ Eligibility assessment ❑ Reminder call/message ❑ Referral/ Appointment-making ❑ Arrangement for transportation ❑ Arrangement for childcare or eldercare ❑ Arrangement for interpreting services ❑ Appointment preparation ❑ Other (Specify: _____)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Assistance with housing** *1 2*	*Required ONLY for MCM-NYC (Select all that apply)* ❑ Help with filling out forms ❑ Eligibility assessment ❑ Reminder call/message ❑ Referral/Appointment-making ❑ Arrangement for transportation ❑ Arrangement for childcare or eldercare ❑ Arrangement for interpreting services ❑ Appointment preparation ❑ Other (Specify: _____)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Outreach for patient re-engagement** *ALL*	*Required* ❑ Phone call ❑ Letter ❑ E-mail or text message ❑ Home visit ❑ Search in other locations ❑ Made contact with patient ❑ Returned patient to care/program ❑ Other (Specify: _____)

Service Date (mm/dd/yyyy)	Service Start Time/End Time	Worker(s)	Site of service delivery *(Select only one)*	Service Type	Service Details
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Health education/ promotion** *ALL*	Topic #: _____ OR Non-Care Coordination Conversation #:_____ ❑ Other topic (Specify: _____) *(Select only one) Note: Optional for TCC* ❑ Started topic, but did not complete ❑ Continued topic, but did not complete ❑ Completed topic
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Case finding** *1 3*	*(Select all that apply)* ❑ Case identification/search of medical records ❑ Case outreach ❑ Case located ❑ Case interviewed ❑ Returned to care ❑ Enrolled in OBMC ❑ Other disposition **Total estimated time spent on case-finding activities:** ___ ___ : ___ ___ (Hours) (Minutes)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Case conference** *1 3*	*(Select only one)* ❑ Initial case conference (at or before enrollment) ❑ Informal/unscheduled ongoing conference ❑ Formal/scheduled ongoing case review *If Formal/scheduled ongoing case review:* Formal Case Conference form date: __/__/____
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Medical assessment/ reassessment** *1*	*(Select all that apply)* ❑ Review of laboratory test values ❑ Review of symptoms and/or side effects ❑ Risk behavior (PWP) assessment/discussion ❑ Other review/discussion (Specify: _____)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **DOT** *1*	**Dose directly observed?** ❑ Yes ❑ No **Type of meds:** *(Select all that apply)* ❑ ART ❑ Psychotropic and/or opportunistic infection Medications ❑ HCV medications
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Coordination with service providers** *2*	**Service providers involved:** *(Select only one)* ❑ Primary care ❑ Other healthcare services ❑ Social services ❑ HASA ❑ Housing services **Coordination activity:** *(Select only one)* ❑ Case conference ❑ Appointment making ❑ Verification ❑ Interpretation services ❑ Other (Specify:_____)
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Referral for HIV testing** *2*	Referral/Appointment Tracking form date: __/__/____ OR ❑ No Match

Notes:

Program Staff Completing Form:	Name	Signature	**Date: Completed** m m / d d / y y

APPENDIX LL –Care Coordination eSHARE Mapping

e·share
Electronic System for HIV/AIDS Reporting & Evaluation

Updated 3/5/2015

Mapping of Contract Activities and eSHARE Service Types

Service Category: Care Coordination (MCM/MCC)

This mapping details all activities contracted across the service categories listed and is intended to guide data reporting in eSHARE. Individual activities may not apply to every contract within the service category; please refer to your contract scope of services or your contractual service requirements. For details on payment rules and processing, please refer to the *Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions* , available on the PHS website.

	PMPD Thresholds	eSHARE Service Type	Information required in service details	eSHARE Service Site	Payment Point?
1	Ryan White Only Clients	Accompaniment	ANY service detail	ANY service site EXCEPT "Phone"	N/A
		Assistance with entitlements and benefits	ANY service detail EXCEPT "Reminder call/message" or "Court Advocacy"		
		Assistance with health care			
		Assistance with housing			
		Assistance with social services			
		Care plan/service plan	ANY service detail EXCEPT "Housing services plan" or "Discharge plan"		
		Case conference	ANY service detail		
		Case finding	ANY service detail *Service type "Case finding" is meant to capture all case finding activity done PRIOR to enrollment and is entered no more than once per enrollment with a Service date equal to the enrollment date. All time spent on case finding activities for the client is aggregated and included in this one Service type entry.*		
		Health education/promotion	ANY service detail EXCEPT "Non-Care Coordination health education conversations"		
		Health education/promotion (Health Promotion Group via Group Services Tracking Log)	Service detail must specify "Health Promotion Curriculum". Select ANY conversation under "Detail on Health Promotion Curriculum"		
		Intake Assessment	Not applicable		
		Medical assessment/reassessment	ANY service detail		
		Other assessment/reassessment	ANY service detail EXCEPT "Health assessment", "Client risk assessment", "Mental health", "Harm reduction", "Case management", "Nutritional assessment", or "90 day follow up"		
		Outreach for client re-engagement[1] *To achieve seven (7) days of payability*	Service detail must specify "Home Visit" or "Search in other Location"	Service site must specify "Client Home" or "Other Field Site"	
		Outreach for client re-engagement[1] *To achieve three (3) days of payability*	Service detail may specify "Letter", "Phone call", and/or "E-mail or text message"	ANY service site	

e·share
Electronic System for HIV/AIDS Reporting & Evaluation

Updated 3/5/2015

Mapping of Contract Activities and eSHARE Service Types

Service Category: Care Coordination (MCM/MCC)

This mapping details all activities contracted across the service categories listed and is intended to guide data reporting in eSHARE. Individual activities may not apply to every contract within the service category; please refer to your contract scope of services or your contractual service requirements. For details on payment rules and processing, please refer to the *Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions* , available on the PHS website.

	PMPD Thresholds	eSHARE Service Type	Information required in service details	eSHARE Service Site	Payment Point?
2	Ryan White - Health Home Dually Enrolled Clients	Care plan/service plan	ANY service detail EXCEPT "Housing services plan" or "Discharge plan"	ANY service site EXCEPT "Phone"	N/A
		Case conference	ANY service detail		
		Health education/promotion	ANY service detail EXCEPT "Non-Care Coordination health education conversations"		
		Health education/promotion (Health Promotion Group via Group Services Tracking Log)	Service detail must specify "Health Promotion Curriculum". Select ANY conversation under "Detail on Health Promotion Curriculum"		
		Intake Assessment	Not applicable		
		Medical assessment/reassessment	ANY service detail		
		Other assessment/reassessment	ANY service detail EXCEPT "Adherence assessment - other measure", "Health assessment", "Client risk assessment", "Mental health", "Harm reduction", "Case management", "Nutritional assessment", or "90 day follow up"		
3	DOT Encounter (ART & Non-ART)	DOT	ANY service detail	ANY service site EXCEPT "Phone"	YES

[1]NOTE: Outreach for client re-engagement is recognized for clients in Tracks C1, C2, or D only. Different combinations of service sites and service details are recognized to maintain clients in a payable status.

Refer to the Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions.

APPENDIX MM – Guide to Care Coordination Forms

Appendix MM – Guide to Care Coordination Forms

Important Points

- Use the most recently revised Care Coordination Program forms. Refer to the Resources list below.
- Review instructions in the grey section header bar of each form. The instructions provide helpful and necessary guidance on completing the forms.
- Items in double-bolded boxes are required for entry into eSHARE.
- Forms are shared by non-Care Coordination service categories.
  - Care Coordination should complete items with the *Service Category Code 1* (MCM) and *Service Category Code ALL*.
- To identify which questions are required for Care Coordination, find the data element requirement codes in the grey section header bar or to the left of individual questions.
  - Data Element Requirement Codes: *1*= *Required; 1*= *Optional*

Key to Guide

NAME OF FORM	
Usage	• Describes whether the form is either REQUIRED or OPTIONAL • **REQUIRED** means the form must be used as provided • **OPTIONAL** means the form itself may be modified, however, the modified form must still contain the required elements in double-bolded boxes.
Key Points	• Describes highlights and important points
Definitions	• Defines terms related to the form
Frequency	• Describes when the form should be completed
Staff Responsible	• Describes which Care Coordination program staff is/are responsible for completing the form
eSHARE Reporting	• Describes the reporting requirements and how to enter the form/service into eSHARE
Alternative Use	• For the Adherence Forms only: Describes how the form may be used in other ways
Payment Methodology	• For the Services Tracking Log Form only: Describes which services count toward meeting the PMPD threshold

Resources

The current versions of the Care Coordination Forms can be downloaded from:

- eSHARE's Resources section (PDF)
- PHS, Contractor Resources website (EXCEL Adherence Assessment Forms Assistance Tool; WORD Services Tracking Log): http://www.healthsolutions.org/hivcare/?event=page.resources

PRE-REFERRAL FORM	
Usage	• This form is **OPTIONAL** and is not expected for every patient.
Key Points	• Use this form when the patient is referred to Care Coordination from a source other than the affiliated PCP.
Definitions	• Referral sources other than the affiliated PC could include: Patient self-referral, HIV Testing program, social work department, in-patient and emergency departments, etc.
Frequency	• One (1) time, prior to the initial PCP visit, pre-enrollment into Care Coordination.
Staff	• Any CC staff may complete the form.
eSHARE Reporting	• Form must be entered into eSHARE. o Pre-Referral Form • No service corresponds to this form.

PCP REFERRAL DISPOSITION FORM	
Usage	• This form is **REQUIRED**.
Key Points	• PCP uses this form to document referral reason(s) and recommended track. • PCP completes this form *after*: o Assessing the patient's eligibility for enrollment in Care Coordination o Obtaining verbal consent from the patient to enroll • If the patient is referred to Care Coordination, then PCP hands-off this form and introduces the patient to CC staff (e.g. Care Coordinator or Medical Center Liaison).
Frequency	• One (1) time, during the initial PCP visit, pre-enrollment into Care Coordination.
Staff Responsible	• PCP completes the form and hands-off to CC staff. • CC staff receives and signs the form and documents the outcome of the referral.
eSHARE Reporting	• Form must be entered into eSHARE. o PCP Referral Disposition Form • No service corresponds to this form.

RYAN WHITE PART A CARE COORDINATION PROGRAM AGREEMENT	
Usage	• This form is **REQUIRED**.
Key Points	• Completion of this form with the patient's signature is needed to begin providing services to the patient. • Review the agreement verbally with the patient.
Frequency	• One (1) time at referral and/or enrollment, or within five (5) business days of PCP referral and patient hand-off.
Staff Responsible	• Patient signature required. • Any CC staff may complete the form: o Primary: Care Coordinator or Medical Center Liaison o Secondary: Patient Navigator
eSHARE Reporting	• Form must be entered into eSHARE. o Enrollment details screen: check the box for Program Agreement and enter the date of the signed form. • No service corresponds to this form.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND CONFIDENTIAL HIV RELATED INFORMATION FORM	
Usage	• This form is **REQUIRED** for patients receiving services at multi-agency programs where the Care Coordination program is not part of the same agency as the medical provider.
Key Points	• Must be completed *prior* to receiving and/or providing medical information amongst programs that are not part of the same organization. • Authorizes release of medical information including HIV-related information. • Includes information that is specific to Care Coordination Programs.
Frequency	• Initial completion at time of referral and/or enrollment, or within five (5) business days of PCP referral and patient hand-off. • Complete a new form **at least** annually or whenever changes occur.
Staff Responsible	• Patient signature required. • Any CC staff may complete the form: o Primary: Care Coordinator or Medical Center Liaison o Secondary: Patient Navigator
eSHARE Reporting	• Form must be entered into eSHARE. o Enrollment details screen: enter the start date and end date. • No service corresponds to this form.

CONTACT INFORMATION FORM	
Usage	• This form is **OPTIONAL**. You may document contact information using your agency's form.
Key Points	• Ideally, collect contact information at the first meeting with the patient. • Ask about "alternative contacts" and get as much information as possible. This will help your outreach efforts in case the patient does not return. • Ask patient about whether you may disclose who you are or why you are calling to those listed as contacts. Ensure that person is authorized on the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information.
Frequency	• One (1) time at referral, enrollment or first meeting with CC staff. • Update when contact information changes.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator or Medical Center Liaison o Secondary: Patient Navigator
eSHARE Reporting	• Form is not reported in eSHARE. • No service corresponds to this form.

LOGISTICS FOR NAVIGATOR FORM	
Usage	• This form is **OPTIONAL**. You may document logistics using your agency's form.
Key Points	• Ideally, collect contact information at the first meeting with the patient. • Ask patient about their preferences in when and where to meet, medication storage, caregivers, confidentiality concerns, literacy level, etc. • Aids in assigning a Patient Navigator to the patient.
Frequency	• One (1) time at enrollment or first meeting with CC staff. • Update when logistical information changes.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator (except for the section on navigator assignment)
eSHARE Reporting	• Form is not reported in eSHARE. • No service corresponds to this form.

COMMON DEMOGRAPHICS FORM	
Usage	• This form is **REQUIRED**.
Key Points	• Report the patient's legal name in the bolded boxes. • Report other names including preferred names under "Alias". • Demographics must be entered into eSHARE before you are able to add the Care Coordination program enrollment and all other forms and services.
Frequency	• One (1) time within the first two (2) weeks of enrollment. • Update when demographic information changes.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form must be entered into eSHARE. o Demographic Data screen: add or edit demographics • No service corresponds to this form.

INTAKE ASSESSMENT FORM	
Usage	• This form is **REQUIRED**.
Key Points	• Required questions preceded by Service Category code 1 or ALL • The start date on the first page is the day you began the intake. • The completed date on the last page is the day you completed all sections and signed the form. • Complete the form using chart review and patient interview. • PCP visit dates, CD4 and VL values that occurred **BEFORE** enrollment are reported on this form. • **Questions in Section VIII "General Health and Well-Being" must be asked exactly as they are written**. • To identify a patient dually-enrolled in CC *and* Health Homes, check the appropriate box in Section XI "Current Enrollments and Needed Referrals."
Frequency	• One time (1) within the first two (2) weeks of enrollment.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form *and* Service must be entered into eSHARE. o Intake Assessment Form: *After* this is entered in eSHARE, you may enter back-dated Forms/Services that occurred between Enrollment and Intake. o Services Delivered Form o **Service Type**: "Intake Assessment" o **Service Detail**: None o **Service Site**: Should NOT be "Phone"

COMPREHENSIVE CARE PLAN FORM	
Usage	This form is **OPTIONAL.** You may document the care plan using your agency's form. Reminder: OPTIONAL means the form itself may be modified, however, the modified form must still contain the fourteen (14) required documentation elements
Key Points	• Requires in-person participation from the patient and the PCP to create the initial, updated and new care plans. • Records the patient's goals (medical, social, other). • Update the outcome dates and dispositions for each goal. • UPDATE the Care Plan if there are minor changes/updates • Create a NEW Care Plan if there are significant changes/updates
Definitions	• The fourteen (14) required elements are: 1. Client Name 2. Date Created 3. Review Period 4. S.M.A.R.T Goals/Objective - (Specific, Measurable, Attainable, Realistic, Time-bound) 5. Target Dates 6. Outcome (Completed: Yes, No) 7. Outcome Date 8. Frequency of Services 9. Client Signature 10. Client Signature Date 11. Staff Signature 12. Staff Signature Date 13. Primary Care Physician's (PCP) Signature 14. Primary Care Physician's Signature Date
Frequency	• Develop an INITIAL plan within the first two (2) weeks of enrollment. • Ongoing, at least once (1) every six (6) months.
Staff Responsible	• Care Coordination staff, PCP and client signatures and signature dates are required. • Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form is not reported in eSHARE. • Service must be entered into eSHARE. o Services Delivered Form o **Service Type**: "Care Plan/Service Plan" o **Service Detail:** "Development of initial plan with this enrollment" for the first care plan, OR "Update to plan" for updating an existing plan, OR "Start of new plan (replacing last care/service plan)" for replacing the last care plan. o **Service Site**: "Program site," "Patient home," "Other field site," and "Phone."

REFERRALS/APPOINTMENTS TRACKING LOG FORM	
Usage	• This form is **OPTIONAL.** You may document referrals using your agency's form.
Key Points	• Used to track referrals or appointments to PCP or external services providers (e.g. social services, mental health, etc.)
Frequency	• As needed.
Staff Responsible	• Any CC staff may complete the form.
eSHARE Reporting	• Form may be entered in eSHARE and may be linked with a Service. o Referral/Appointment Tracking Form: enter the referral/appointment details. o To link the Form to a Service: Choose from a list of services entered in the last six (6) months. A referral can only be associated with one (1) service.

PCSM UPDATE FORM	
Usage	• This form is **REQUIRED**.
Key Points	• Collects information on PCP visits, CD4 count, VL, ART status, HIV and AIDS status. • This form **must** still be completed even if there are no new data to report. • If there are no new lab values, PCP visits or status changes to report, then select "N/A" for each section.
Frequency	• Ongoing, at least once (1) every 90 days. eSHARE Services Delivered lockout occurs after 120 days. Refer to August 23, 2011 communication from DOHMH on PCSM Reporting for Ryan White Part A Contracts.
Staff Responsible	• Any CC staff may complete the form.
eSHARE Reporting	• Form must be entered into eSHARE. o PCSM Form (located under PCSM Patient Search) • If you discuss PCSM updates with the patient, then a Service may be entered. o Services Delivered Form o **Service Type**: "Medical Assessment/Reassessment" o **Service Detail**: "Review of laboratory test values" o **Service Site**: "Program site," "Patient home," "Other field site," or "Phone"

CURRICULUM COVERAGE LOG FORM	
Usage	• This form is **OPTIONAL**. You may track health promotion discussions using your agency's form.
Key Points	• Tracks the status of health promotion curriculum topics that are started, continued, or completed.
Frequency	• As needed.
Staff Responsible	• Any CC staff may complete the form: o Primary: Patient Navigator o Secondary: Care Coordinator
eSHARE Reporting	• Form is not reported in eSHARE. o No service corresponds to this form.

ADHERENCE ASSESSMENT FORM (Self-Report)	
Usage	• This form is **REQUIRED** for patients currently on prescribed ART. o Tracks B, C1, C2, and D
Key Points	• Documents patient's **self-report** adherence assessments. • ART includes pills, liquids, and injectable medications. • Used in preparation for a formal case conference. • Used in addition *to* the Pill Box Log or Monthly DOT Log.
Frequency	• One time within the first two (2) weeks of enrollment. • Ongoing, at least once (1) every three (3) months.
Staff Responsible	• Any CC staff may complete the form.
eSHARE Reporting	• Form *and* Service must be entered into eSHARE. o Adherence Assessment Form **(ART only)** o Services Delivered Form **(ART only)** ▪ **Service Type:** "Other assessment/reassessment" ▪ **Service Detail:** "Adherence Assessment – self-report" ▪ **Service Site**: "Program site," "Patient home," "Other field site," or "Phone"
Daily vs. Non-Daily	• Applies to all three (3) adherence assessment forms: o Adherence Assessment Form o Pill Box Log Form o Monthly DOT Log Form • Use only ONE (1) form (daily or non-daily) per adherence assessment per patient. • **ART Daily Regimens Only:** This form is used for patients who are prescribed the same number of ART pills each day of the week. • **ART Non-Daily Regimens Only:** This form is used for patients who are prescribed a different number of ART pills on different days in the week. o **NOTE:** If the patient is taking at least one (1) Non-Daily ART in their regimen, then *use the Non-Daily form to document the entire regimen of daily and non-daily ARTs*.
Alternative Use (for non-Pill Box usage)	• May be used for patients in Tracks B, C1, and C2 who **do not** use a pill box or blister pack. • If used to replace the Pill Box Log, then the paper form and eSHARE entry must be completed at the frequency below: o **Track B:** At every Quarterly visit o **Track C1:** At every Monthly visit o **Track C2:** Once (1) per month at one (1) of the Weekly visits
Alternative Use (for non-ART)	• To document **non-ART** (i.e. psychotropic, and opportunistic infection and/or Hepatitis C medications) adherence assessments for patients in any Track, it is optional to use this paper form. • In eSHARE: **DO NOT enter the Form for adherence % results. The eSHARE Form is *only* for ART adherence.**

PILL BOX LOG FORM	
Usage	• This form is **REQUIRED** for patients on prescribed ART who are NOT receiving DOT. o Tracks B, C1, and C2
Key Points	• Used to document pill box counts **conducted by CC staff**. • **Do NOT** use to document patient self-reported adherence status. • ART includes pills, liquids, and injectable medications. • Records pill box counts going back no more than four (4) weeks regardless of patient track. • Blister packs may be used to measure adherence on Pill Box Log. o Empty packs must be reviewed to verify number of pills taken each day against number of pill prescribed each day.
Frequency	• **Track B**: At every Quarterly visit, review available pill boxes going back no more than four (4) weeks. • **Track C1**: At every Monthly visit, review available pill boxes going back no more than four (4) weeks. • **Track C2**: At every Weekly visit, review the pill box for the past week. o For Track C2, enter the adherence percentages calculated from the completed paper form into eSHARE only once (1) per month.
Staff Responsible	• Any CC staff may complete the form: o Primary: Patient Navigator o Secondary: Care Coordinator
eSHARE Reporting	• Form *and* Service must be entered into eSHARE. o Pill Box Log Form **(ART only)** o Services Delivered Form **(ART only)** ▪ **Service Type**: "Other assessment/reassessment" ▪ **Service Detail**: "Adherence Assessment – pill count" ▪ **Service Site** should NOT be "Phone" ▪ **NOTE**: This service summarizes the last four (4) weeks of pill box counts. This is NOT meant to capture each Weekly pill box count.
Daily vs. Non-Daily	• Refer to the ADHERENCE ASSESSMENT FORM section on "Daily vs. Non-Daily."
Alternative Use	• To document **non-ART** (i.e. psychotropic, opportunistic infection, and/or Hepatitis C medications) pill counts for patients in any Track, it is optional to use this paper form. • In eSHARE: **DO NOT enter the Form for adherence % results. The eSHARE Form is ONLY for ART adherence.**

MONTHLY DOT LOG FORM	
Usage	• This form is **REQUIRED** for patients on ART who are receiving modified Directly Observed Therapy (DOT). o Track D only
Key Points	• Used at **each DOT visit.** • Documents direct or indirect observation **by CC staff** of pills taken. • **Do NOT** use to document patient self-reported adherence status.
Definitions	• **Direct observation:** *CC staff member visually observes* the patient take the medication dose. • **Indirect observation**: *CC staff member does NOT visually observe* the patient take the medication dose but DOES visually observe that the medication dose is "gone" by conducting a pill count. o Indirect observation includes unobserved doses or days that occur when CC staff members are not present (e.g. weekends).
Frequency	• Update the form at every DOT visit. • Complete the calculations for both adherence percentages at the end of each calendar month.
Staff Responsible	• Any CC staff may complete the form: o Primary: Patient Navigator or DOT Specialist o Secondary: Care Coordinator
eSHARE Reporting	**At every DOT visit:** • Only if there is face-to-face contact with the patient. o Services Delivered Form **(Prescribed ART and Non-ART)** ▪ **Service Type**: "DOT" ▪ **Service Detail 1**: Dose Directly Observed? "Yes" for directly observed doses OR "No" for indirectly observed doses ▪ **Service Detail 2**: Type of Meds: (Select all that apply): o ART o Psychotropic and/or opportunistic infection o HCV Medications ▪ **Service Site** should **NOT** be "Phone" **Once (1) per month:** • Form *and* Service must be entered into eSHARE. o DOT Log Form **Prescribed ART and Non-)** o Services Delivered Form **Prescribed ART and Non-ART)** ▪ **Service Type**: "Other assessment/reassessment" ▪ **Service Detail**: "Adherence Assessment – DOT" ▪ **Service Site** should NOT be "Phone" ▪ **NOTE**: This service summarizes the last calendar month of DOT sessions. Enter this service ONCE (1) per month.
Daily vs. Non-Daily	• Refer to the ADHERENCE ASSESSMENT FORM section on "Daily vs. Non-Daily."

Alternative Use	• To document **non-ART** DOT (i.e. psychotropic, opportunistic infection, and/or Hepatitis C medications), it is optional to use this paper form. • In eSHARE: **DO NOT enter the Form for adherence % results. The eSHARE Form is ONLY for ART adherence.** DOT for non-ART Services should be entered using Service Type: "Other assessment/reassessment", Service Detail: "Adherence Assessment – other measure", Service Site should NOT be "Phone".

CARE COORDINATION CASE CONFERENCE FORM	
Usage	• This form is **REQUIRED**.
Key Points	• Used to document **formal** case conferences. • CC staff prepares for case conference with PCP by gathering information from most recent adherence assessments, PCSM, and patient's current issues. • Case conferences may result in Track changes. • Track changes should be discussed during case conferences with the PCP and CC staff.
Definitions	• **Formal case conference** occurs when all elements included on the form are completed with the required attendees present, and does not need to be scheduled. o Required attendees include: ▪ Program Staff (CC and/or PN and/or MCL) ▪ Clinician (MD/DO/NP/PA) o Optional attendees include: ▪ Patient
Frequency	• Ongoing, at least once every three (3) months.
Staff Responsible	• PCP signature is required. • Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form *and* Service must be entered into eSHARE. o Formal Case Conference Form o Services Delivered Form ▪ **Service Type**: "Case Conference" ▪ **Service Detail**: "Formal/scheduled ongoing case review" ▪ **Service Site**: "Program site," "Patient home," "Other field site," or "Phone"

REASSESSMENT FORM	
Usage	• This form is **REQUIRED**.
Key Points	• Required questions preceded by Service Category Code 1 or ALL • The start date on the first page is the day you began the intake. • The completed date on the last page is the day you completed all sections and signed the form. • Complete the form using chart review or patient interview. • **Questions in Section VIII "General Health and Well-Being" must be asked exactly as they are written.** • To identify a patient dually enrolled in CC *and* Health Homes, check the appropriate box in Section XI "Current Enrollments and Needed Referrals."
Frequency	• Ongoing, at least once (1) every six (6) months. • OR, any time Health Homes enrollment status changes.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form *and* Service must be entered into eSHARE. o Re-Assessment Form o Services Delivered Form o **Service Type:** "Other assessment/reassessment" o **Service Detail:** "Re-Assessment (clinical, psychosocial, general health/well-being, housing, enrollments, etc.)" o **Service Site:** Should NOT be "Phone"

STATUS CHANGE INFORMATION FORM (TRACK AND TREATMENT STATUS)	
Usage	• This form is **REQUIRED**.
Key Points	• Used for patients continuing active enrollment. • Documents changes in program track, treatment status, housing status, contact information, household composition or disclosure status, transportation needs, and other. • Decisions that result in changes in track and treatment status **MUST** have supporting documentation in the patient chart. • "Date of update" is the date CC staff learns of the change. • Change in Track: o Should occur **after** a formal Case Conference o **Must** select one (1) reason for change o Consecutive dates **must** be used for "Date new track started" and "Date prior track ended" o If "Date prior track ended" is 3/6/2015, then the "Date new track started" is 3/7/2015, even though 3/7/2015 falls on a weekend.
Frequency	• As needed.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form must be entered into eSHARE. o Patient Status Change Form • No service corresponds to this form.

STATUS CHANGE INFORMATION FORM (CASE CLOSURE/SUSPENSION)	
Usage	• This form is **REQUIRED**.
Key Points	• Used when you close a case, suspend a case, resume a suspended case. • Must select one (1) reason for closing or suspending a case. • "Mistaken enrollment" is a case closure reason to identify patients who should not be counted in your enrollment list. When this reason is selected, the patient will no longer appear on any eSHARE reports for open or closed patients. • "Enrollment Closed Date" **must** be one (1) day **after** the last service was provided.
Frequency	• As needed.
Staff Responsible	• Any CC staff may complete the form: o Primary: Care Coordinator o Secondary: Patient Navigator
eSHARE Reporting	• Form must be entered into eSHARE. o Enrollment Details screen: change Enrollment Status to "Closed" and add date of closure. • No service corresponds to this form.

GROUP SERVICES TRACKING LOG FORM	
Usage	• This form is **OPTIONAL.** Use this form only if a health promotion curriculum group session was conducted.
Key Points	• Required questions are preceded by Service Category ALL or MCM • Must include the "Start Time" and the "End Time" • Include the names of all patients who attended • At the bottom of Page 1, 'Group Service Details' may be used for internal tracking purposes, but can be left blank.
Frequency	• Complete the form each time a group service occurs. • This form should be entered into eSHARE at least once (1) per month
Staff Responsible	• CC staff who conducted the service.
eSHARE Reporting	• Service must be entered into eSHARE. o Under "Clients and Services" access "Group Services"
Definitions	• Worker(s) Providing – List all CC staff involved in facilitating the group session • Service Start Time and End Time – Document the group's Start Time and End Time
Service Date	• Date should match the date of the actual group session
Site of Service Delivery	• Group sessions should **only** be conducted at the "Program Site."
Service Type	• The only service type for MCM is "Health education/promotion".
Service Details	• First, select MCM service detail "Health Promotion Curriculum" • Second, select MCM detail on health education/promotion topic coverage: o "Topic #" which may be 1-18, or "Other (please specify)".

SERVICES TRACKING LOG FORM	
Usage	• This form is **OPTIONAL.** You may document services using your agency's form. Reminder: OPTIONAL means the form itself may be modified, however, the modified form must still contain the six (6) required elements.
Key Points	• Document and report **ALL** services performed each day. Patient activities documented in progress notes should match the services reported on this form and in eSHARE. • Each patient encounter may result in multiple Services. • This form is available in Microsoft Word, and may be tailored for each Program and/or patient. • Some CC Forms have a corresponding Service on the Services Tracking Log. • Use one (1) form until you run out of space.
Definitions	• The six (6) required elements are: **1. Service Date** o Date must match date of actual service or patient encounter o If Service corresponds to a Form, then date should match the Completed Date on the Form o Travel time is optional **2. Service Start Time/End Time** o The same Start Time may be used for multiple services that occur during one encounter o End Time is optional **3. Worker(s) Providing** o List all CC staff and medical providers involved in each service **4. Site of Service Delivery** o Definitions apply to all services except when indicated otherwise in the Service Type descriptions. o Program Site: CC Staff and Patient are together at the CC office or the PCP office o Client Home: CC Staff and Patient are together at patient home o Other Field Site: CC Staff and Patient are together at field site o Phone: CC Staff and Patient may not be in the same location. CC Staff is calling the patient or calling another provider on behalf of the patient and CC Staff is located at Program Site. **5. Service Type** o CC service types are identified by Service Category Code 1 o Refer to the Service Type descriptions. **6. Service Details** o Read the instructions highlighted in grey in each box o Refer to the Service Type descriptions.
Frequency	• Complete the form on each day a service occurs. • This form should be entered into eSHARE at least once (1) per month for patients in any Track.
Staff Responsible	• CC staff who conducted the service.

eSHARE Reporting	• Service must be entered into eSHARE. o Services Delivered Form o Refer to the Service Type descriptions
Payment Methodology	• Refer to Public Health Solutions' Guide to Requirements for Service Payability and Data Reporting (February 2015) and communications on November 3, 2011 and June 1, 2012 for full details. Access the Payability Guide here: http://www.healthsolutions.org/hivcare/documents/RequirementsGuide.pdf • For patients enrolled in **Ryan White only**, the following service types count as Face-to-Face as long as the Service Site is not "Phone," and for the four (4) "Assistance with…" services types, as long as the Service Detail is not "Reminder call/message": o Case Finding o Intake Assessment o Medical Assessment/Reassessment o Other Assessment/Reassessment o Care Plan/Service Plan o Case Conference o Accompaniment o Assistance with Entitlements and Benefits o Assistance with Health Care o Assistance with Housing o Assistance with Social Services o Health Education/Promotion (Individual and Group) • For patients dually enrolled in **Ryan White and Health Homes**, the following service types count as Face-to-Face: o Health Education/Promotion (Individual and Group) o Intake Assessment o Care Plan/Service Plan o Case Conference o Medical Assessment/Reassessment o Other Assessment/Reassessment

INTAKE ASSESSMENT SERVICE	
Definition	• Corresponds with completion of the Intake Assessment Form. • Must be completed no more than fourteen (14) days after Enrollment Date.
Service Date	• Service Date = Intake Form Completed Date.
Site of Service	• Should NOT be "Phone".
Service Details	• None.
OTHER ASSESSMENT/REASSESSMENT SERVICE	
Definition	• This Service corresponds to the completion of the appropriate Form specified in the Service Details section.
Service Date	• Service Date = Form Completed Date.
Site of Service	• Should NOT be "Phone".

Service Details	• Select all that apply from the service details available to CC: o "Re-Assessment (clinical, psychosocial, general health/well-being, housing, enrollments, etc.)" corresponds to the Reassessment Form. o "Adherence assessment - self-report" corresponds to the Adherence Assessment Form. o "Adherence assessment - pill count" corresponds to the Pill Box Log Form. o "Adherence assessment - DOT" corresponds to the Monthly DOT Log Form. o "Adherence assessment - other measure" is used for other adherence assessment measures. o "Logistical assessment or reassessment" corresponds to the Logistics for Navigator Form. o "Other non-medical assessment/reassessment" does not correspond to a Form, may be used for other types of assessments.
CARE PLAN/SERVICE PLAN SERVICE	
Definition	• This Service corresponds to the completion of the Comprehensive Care Plan Form.
Service Date	• Service Date = Form Completed Date on updated plan or new plan.
Site of Service Delivery	• "Program site," "Patient home," "Other field site," or "Phone."
Service Details	• Select only **one (1)** from the following service details available to CC: o "Development of initial plan with this enrollment" corresponds with the Care Plan Form developed during the first two (2) weeks of enrollment. o "Update to plan" for updating an existing Care Plan Form. o "Start of new plan (replacing last care/service plan)" for a new Care Plan Form that replaces the last Form.
ACCOMPANIMENT SERVICE	
Definition	• Escort (travel with patient at least one (1) way) AND/OR Accompany (stay with patient during appointment).
Service Date	• Service Date = Date that accompaniment activity occurred.
Site of Service Delivery	• Site = Location where you START the service. • Should NOT be "Phone."

Service Details	• First, select only ONE (1) from the **Accompaniment TO** service details: o "Primary care" o "Other healthcare" o "Social service" • Second, select only ONE (1) from the **Accompaniment FROM** service details: o "Patient's home or other field (non-provider) location" o "One provider to another - different street address" o "One provider to another - same address" o "Jail/prison"
ASSISTANCE WITH HEALTH CARE SERVICE	
Definition	• Examples include PCP visits, other medical appointments, mental health care. • DO NOT USE for escorts to or accompaniments during a medical visit. • USE when you assist a patient **before** or **after** a medical visit. • These activities may involve encounters with the patient or with other service providers on behalf of the patient.
Service Date	• Service Date = Date that assistance activity occurred.
Site of Service Delivery	• "Program site," "Patient home," "Other field site," or "Phone."
Service Details	• Select all that apply <u>EXCEPT for "Court Advocacy"</u> from the following service details: o "Help with filling out forms" o "Eligibility assessment" o "Reminder call/message" o "Referral/Appointment-making" o "Arrangement for transportation" o "Arrangement for childcare or eldercare" o "Arrangement for interpreting services" o "Appointment preparation" o "Other (Specify:)"
ASSISTANCE WITH ENTITLEMENTS AND BENEFITS SERVICE	
Definition	• Examples include SSI, SSDI, food stamps, public assistance, health insurance or coverage (i.e. ADAP, Medicaid). • These activities may involve encounters with the patient or with other service providers on behalf of the patient.
Service Date	• Service Date = Date that assistance activity occurred.
Site of Service Delivery	• "Program site," "Patient home," "Other field site," or "Phone."

Service Details	• Select all that apply EXCEPT for "Court Advocacy" from the following service details: o "Help with filling out forms" o "Eligibility assessment" o "Reminder call/message" o "Referral/Appointment-making" o "Arrangement for transportation" o "Arrangement for childcare or eldercare" o "Arrangement for interpreting services" o "Appointment preparation" o "Other (Specify:)"
ASSISTANCE WITH SOCIAL SERVICES SERVICE	
Definition	• Examples include social work, case management, food and nutrition services, legal services, other supportive services. • These activities may involve encounters with the patient or with other service providers on behalf of the patient.
Service Date	• Service Date = Date that assistance activity occurred.
Site of Service Delivery	• "Program site," "Patient home," "Other field site," or "Phone."
Service Details	• Select all that apply EXCEPT for "Court Advocacy" from the following service details: o "Help with filling out forms" o "Eligibility assessment" o "Reminder call/message" o "Referral/Appointment-making" o "Arrangement for transportation" o "Arrangement for childcare or eldercare" o "Arrangement for interpreting services" o "Appointment preparation" o "Other (Specify:)"
ASSISTANCE WITH HOUSING SERVICE	
Definition	• Examples include HASA, housing placement, rental assistance. • These activities may involve encounters with the patient or with other service providers on behalf of the patient.
Service Date	• Service Date = Date that assistance activity occurred.
Site of Service	• "Program site," "Patient home," "Other field site," or "Phone."

Service Details	• Select all that apply <u>EXCEPT for "Court Advocacy"</u> from the following service details: o "Help with filling out forms" o "Eligibility assessment" o "Reminder call/message" o "Referral/Appointment-making" o "Arrangement for transportation" o "Arrangement for childcare or eldercare" o "Arrangement for interpreting services" o "Appointment preparation" o "Other (Specify:)"
OUTREACH FOR PATIENT RE-ENGAGEMENT SERVICE	
Definition	• Used for "Missed Appointment" procedure outreach activities. • Document all outreach activities once an enrolled patient misses an appointment (e.g. scheduled home visit, medical visit, etc.) • May use for outreach activities that resulted in either making or not making contact with patient.
Service Date	• Service Date = Date that outreach activity occurred.
Site of Service Delivery	• "Program Site:" CC Staff is conducting outreach activities at the CC office or the PCP office. • "Client Home:" CC Staff is searching for the patient at the patient's home (e.g. knocking on door, speaking to roommate, calling patient while standing outside house, etc.). • "Other Field Site:" CC Staff is searching for the patient at a field site (e.g. park, café, patient's work location, methadone clinic, calling patient while in field location, etc.). • "Phone:" CC Staff is at the Program Site and is calling the patient.
Service Details	• Select all that apply. • If "Made contact with patient" is selected, then you should report a second service type that matches what you discussed with the patient. For example, if an outreach activity resulted in having a health promotion discussion with the patient, then report a second service type of "Health education/promotion."

HEALTH EDUCATION/PROMOTION SERVICE	
Definition	• Topic # o Use only CC HIV curriculum topic numbers (1-18). o For discussions that do not follow the curriculum guide, use the topic number that most closely represents your discussion. o For other topics not captured in 1-18, use "Other topic (please specify)." o DO NOT USE Non-Care Coordination Conversation #. • Started, Continued, Completed o You may cover a topic as many times as needed. o You may start and stop a topic as needed, i.e. take more than one (1) encounter to complete one (1)topic. o After a topic is completed, may start again or continue as many times as needed.
Service Date	• Service Date = Date that health promotion session occurred.
Site of Service	• "Program site," "Patient home," "Other field site," or "Phone."
Service Details	• First, select the "Topic #" which may be 1-18, or select "Other topic (please specify)." • Second, select only ONE (1) of the following service details. o "Started topic , but did not complete" o "Continued topic, but did not complete" o "Completed topic"
MEDICAL ASSESSMENT/REASSESSMENT SERVICE	
Definition	• You may choose to use "medical assessment/reassessment" alone OR combine with "health education/promotion."
Service Date	• Service Date = Date that medical assessment occurred.
Site of Service	• "Program site," "Patient home," "Other field site," or "Phone."
Service Details	• Select all that apply: o "Review of laboratory test values" documents the "service" for PCSM Update form only if there are new laboratory values (CD4 count, VL) to report, AND/OR supplements Health Promotion discussions with review of laboratory values. o "Review of symptoms and/or side effects" supplements Health Promotion discussions on ART adherence with review of symptoms and side effects. o "Risk behavior (PWP) assessment/discussion" supplements Health Promotion conversations with review of risk behaviors. o "Other Review/discussion" for other medical assessment/reassessment activity.

CASE FINDING SERVICE	
Definition	• Case Finding = "Return to Care" activities o Re-engage those who meet the definition of "out of care" (i.e. patient was seen at the agency within two (2) years but not during the last nine (9) months) AND are not enrolled in CC. • Used to document the pre-enrollment case finding activities *after* the patient is enrolled. • Used once to sum the total amount of time spent on pre-enrollment case finding activities.
Service Date	• Service Date = Enrollment Date.
Site of Service	• "Program site"
Service Details	• Select all that apply. • Sum the total amount of time spent on case finding.
CASE CONFERENCE SERVICE	

Definition	• **Initial case conference** is a brief face-to-face meeting between the PCP and CC staff that occurs during the initial hand-off of the patient at the time of PCP referral.
	  o Required attendees include:
	  o Program Staff (CC/PN or MCL)
	  o Clinician (MD/DO/NP/PA)
	  o Patient
	• **Informal case conference** occurs as frequently as needed - scheduled or unscheduled - and does not require completion of the Case Conference Form, and may be a stand-alone Service.
	  o Required attendees include:
	  o Program Staff (CC and/or PN and/or MCL)
	  o Non-Program Staff (Clinician, Social Worker, Mental Health Provider, Nutritionist, etc.)
	  o Optional attendees include: Patient
	• **Formal case conference** occurs when all elements included on the Case Conference Form are completed with the required attendees present, and may be scheduled or unscheduled.
	  o Required attendees include:
	  o Program Staff (CC and/or PN and/or MCL)
	  o Clinician (MD/DO/NP/PA)
	  o Optional attendees include: Patient

Service Date	• Service Date of **Initial case conference** = Date of patient "hand-off" from PCP. If this occurs before the patient is enrolled, then Service Date = Enrollment Date. • Service Date of **Informal case conference** = Date that informal case conference occurred. • Service Date of **Formal case conference** = Case Conference Form Completed Date.

Site of Service Delivery	• **Initial case conference**: should NOT be "Phone." • **Informal case conference**: "Program site," "Patient home," "Other field site," or "Phone." • **Formal case conference**: should NOT be "Phone."
Service Details	• Select only ONE (1) of the following service details: o "Initial case conference (at or before enrollment)" corresponds to the definition of **Initial case conference.** o Informal/unscheduled ongoing conference" corresponds to the definition of **Informal case conference**. o "Formal/scheduled ongoing case review" corresponds to the definition of **Formal case conference** AND to the Date of Completed Case Conference Form.
DOT SERVICE	
Definition	• Patients receiving DOT for ART must be enrolled in Track D. • Patients receiving DOT for non-ART may be enrolled in any Track. • MUST be Face-to-Face contact with the patient. o If not, then log only on the Monthly DOT Log Form. • CC DOT is a modified type of DOT, which is typically scheduled for one (1) dose per business day (i.e. five (5) days per week). • **Field-based DOT** occurs at the patient's home or another mutually agreed-upon field-based location.. o Patients are responsible for the storage of medications. o DOT may be conducted by non-clinical Program Staff (e.g. DOT Specialist, Patient Navigator, etc.) • **Clinic-based DOT*** occurs at the Program location and/or the primary medical care site: o Medication dispensed and/or distributed on-site: o Dispensing and/or distributing prescribed medications on-site is neither a programmatic requirement, nor an expectation o Agencies that dispense and/or distribute prescribed medications must have proper medication storage facilities o Agencies must review their dispensing and/or distributing processes with their own agency's legal department to ensure that it is compliant with all Federal, State, and Local laws and regulations. o Medication neither dispensed nor distributed on-site –Patients may bring their prescribed medications to the site for DOT, which may be conducted by either clinical or non-clinical Program Staff (e.g. DOT Specialist, Patient Navigator, etc.). *Any deviations from this definition **must** be approved by NYC DOHMH
Service Date	• Service Date = Date of face-to-face DOT encounter.
Site of Service Delivery	• "Program site" indicates clinic-based DOT. • "Patient home" or "Other field site" indicate field-based DOT. • Should **NOT** be "Phone."

Service Details	• First, select only ONE (1) answer to **Dose Directly Observed?** o "YES," directly observed dose; CC staff observes the patient self-administer a prescribed dose. o "NO," indirectly observed dose; CC staff uses pill box, blister packs or other means to verify that the patient self-administered a prescribed dose. • Second, select all that apply to **Type Of Meds:** o "ART" o "Psychotropic and/or opportunistic infection medications o HCV medications"