TRANSITIONAL CARE COORDINATION FOR HOMELESS AND UNSTABLY HOUSED PEOPLE WITH HIV

PROGRAM MANUAL

Version 3.0

Issued by:

New York City Department of Health and Mental Hygiene
Bureau of HIV/AIDS Prevention and Control
Care & Treatment Program

Released March 2014

NYC Health

TRANSITIONAL CARE COORDINATION (TCC) FOR HOMELESS AND UNSABLY HOUSED PEOPLE WITH HIV PROGRAM MANUAL Version 3.0

TRANSITIONAL CARE COORDINATION (TCC) FOR HOMELESS AND UNSABLY HOUSED PEOPLE WITH HIV PROGRAM MANUAL Version 3.0

ORIGINAL EFFECTIVE DATE: **March 2011**
REVISION DATE: **February 2014**

POLICIES

- All people with HIV, in NYC should have access to[1]:
  - Comprehensive and holistic healthcare situated in a medical home as defined by the American College of Physicians;
  - Health promotion to promote self-sufficiency, optimal health and risk reduction; and
  - Needed social support services to help maintain linkage to primary care.

- As needed, people with HIV should receive assistance:
  - Navigating the healthcare and social services systems;
  - Coordinating logistics such as transportation, interpretation 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 people with HIV can expect that critical health information is available to providers when they need it, and that adequate security measures are in place to safeguard its confidentiality.

BACKGROUND

In the United States, more than 1 million (1,144,500) persons aged 13 years and older are living with HIV infection in the United States today.[2] New York City continues to be at the epicenter of the U.S. epidemic, with 114,926 New Yorkers reported to be living with HIV/AIDS as of the end of 2012.[3] While advances in medical care for people with HIV have been significant, disparities exist in access to health care and health outcomes for this population. Factors associated with poorer health outcomes include being unstably housed or homeless, being an injection drug user, having a mental illness, and having a lower

[1] Refer to the Definitions section (Appendix A) for definitions referenced throughout the manual.
[2] Centers for Disease Control and Prevention. HIV in the United States: At A Glance. http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf. Accessed January 9, 2014.
[3] New York City Department of Health and Mental Hygiene. HIV Surveillance Annual Report, 2012. http://www.nyc.gov/html/doh/downloads/pdf/dires/surveillance-report-dec-2013.pdf. Accessed January 9, 2014.

socioeconomic status. Many of these factors disproportionately impact persons belonging to racial/ethnic minority groups in NYC, and increase the likelihood that they will be out of care and access care later in their disease. The association between these social and environmental factors with poor clinical outcomes among people with HIV makes facilitating access to and maintenance in HIV primary care as well as integrating medical care with social support a high priority.

In December 2005, DOHMH and Department of Homeless Services (DHS) reported that of the 88,014 New Yorkers who were known to be living with HIV/AIDS from 2001 through 2003, 3,108 (about 4%) used the homeless shelter system for at least one night during the study period[4]. The report also found that the prevalence of HIV/AIDS among users of the single adult shelter system was more than twice as high as the prevalence in the NYC adult population. Additionally, a study published by the CDC found that compared to the stably housed, homeless people with HIV were more likely to be uninsured, to have visited an emergency department, and to have been admitted to a hospital. Moreover, homeless PLWHA persons had lower CD4 counts, were less likely to have taken HIV anti-retroviral medications, and were less adherent to their medication regimen[5].

To respond to these needs, the NYC DOHMH has allocated funds for a **Critical Time Intervention (CTI)**[6] model which provides case management services and care coordination services for the homeless and unstably housed to address issues and challenges specific to this population. With significant support from the National Institute of Mental Health and the New York State Office of Mental Health, CTI was originally developed and tested by researchers and clinicians at Columbia University and New York State Psychiatric Institute. The model is listed in the National Registry of Evidence-Based Programs and Practices and is currently being applied and tested in the US (including programs in NYC) and abroad. CTI has been successfully used to support and stabilize persons with mental health disorders and homelessness. As such the model is suitable for adaptation to serve PLWHA persons experiencing homelessness.

CTI is an empirically supported, time-limited case management model originally designed to reduce homelessness among persons with severe mental health disorders by bridging the gap between services for the homeless and community services. DOHMH has adopted the evidence-based model to a broader population (not restricted to severely mental ill). This adaptation has resulted in the **Transitional Care Coordination Program (TCC)**. The five phases of this intervention are: Outreach, Transition, Try-Out, and Transfer of Care, and Follow-up. Clients are identified and enrolled in TCC through targeted case finding and self-referral during the Outreach phase. In Transition, the client and Transitional Care Coordinator formulate a treatment plan, focusing on areas identified as crucial in facilitating

[4] Kerker B, Bainbridge J, Li W, et al. The Health of Homeless Adults in New York City: A report from the New York City Departments of Health and Mental Hygiene and Homeless Services, 2005. http://www.nyc.gov/html/dhs/downloads/pdf/homeless_adults_health.pdf
[5] Kidder DP, Wolitski RJ, Campsmith ML, Nakamura GV. Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. *American Journal of Public Health*. 2007; 97(12): 2238-2245.
[6] Critical Time Intervention Web Site. http://www.criticaltime.org. Accessed January 17, 2014.

the client's stability and utilization of community-based care. During the Try-Out phase, the client and Transitional Care Coordinator test and adjust the systems of support that have been established in the community during the Transition phase. In the Transfer of Care phase, smaller adjustments in the network of support are made and linkage to a supportive housing or appropriate case management program will provide longer-term care coordination support is completed. Finally, in the Follow-up phase, the Transitional Care Coordinator contacts community linkages to verify client engagement and retention. Additionally, in each phase, the TCC team assesses concrete needs (i.e., medication compliance, money management, substance abuse management, housing crisis management, and family interventions). Health promotion activities and accompaniment services are provided during Transition, Try-out, and Transfer of Care phases. The TCC team also links clients to appropriate resources, and avoids providing direct, assertive care.

PURPOSE

This Program Manual is intended to:

- Be a requirement for Ryan White (Part A) TCC Programs per the terms of the contract (solicited through the TCC Request for Proposals and updated via contract modification).
- Be a reference for Transitional Care Coordination providers for the purpose of delivering transitional case management for people with HIV.

GOALS OF TRANSITIONAL CARE COORDINATION

The goals of TCC are to improve care for people with HIV who are homeless or unstably housed[7] by:

1) Ensuring entry into and continuity of HIV primary medical care; and
2) Providing linkage to housing services and other support social services; and
3) Decreasing unnecessary Emergency Room and hospitalization visits.

[7] The term **"homeless"** is used to define individuals who: lack a regular and/or adequate nighttime residence; have a primary nighttime residence that is a public or private shelter or dwelling designed to provide temporary living accommodations, including SROs; live in an institution that provides temporary residence for individuals intended to be institutionalized; or live in a public or private place not intended or ordinarily used as a regular sleeping accommodation for human beings. The term **"unstably housed"** expands on the definition of "homeless" to also include individuals who frequently move between housing situations, individuals who are facing eviction, and/or individuals who are temporarily living with family or friends.

ELEMENTS OF THE MANUAL

1.0 Practice Standards

1.1 The TCC team ensures the execution of the Comprehensive Care Plan.
1.2 Screen all clients for eligibility in the Program and coordinate with similar programs so clients receive streamlined, unduplicated services.
1.3 Address urgent needs and schedule follow-up medical care during intake.
1.4 Program staff should encourage clients to speak with their primary care provider about starting anti-retroviral therapy (ART) and inquire about barriers and challenges to initiating ART (e.g., substance use or unstable housing).
1.5 Maintain up-to-date contact information for clients.
1.6 Perform a detailed assessment of housing and social services and benefits and logistical needs in order to guide the client's care plan development.
1.7 Provide health promotion to all TCC clients using core curriculum developed by PACT and DOHMH.
1.8 Assist people with HIV to attain self-sufficiency and successfully graduate to either supportive housing, Ryan White Part A Care Coordination, Medicaid Health Home, or other case management program (depending on client needs).
1.9 In order to ensure that confidentiality law or related institutional policies do not preclude ready transfer of sensitive personal health information, the Program must ensure that a valid client consent to release HIV information is always on file.
1.10 Develop monitoring guidance and quality management activities.
1.11 Report relevant program service and client data to DOHMH.
1.12 Contractors are required to have a written emergency preparedness plan.

2.0 Components of Transitional Care Coordination

2.1 Full Range of TCC Program Services

2.1.1 How does TCC work?

2.1.1.1 TCC provides emotional and practical support during the critical time of transition to community care.

2.1.1.2 TCC connects people with formal services (e.g. primary care, case management) and informal community supports (i.e. friends, family, clergy) in the critical period.

2.1.1.3 TCC is a time-limited intervention, divided into five (5) specific Phases with decreasing service intensity over time.

2.1.1.4 TCC focuses on six (6) treatment areas that promote client stability through a range of program activities.

Six Areas of Focus	Main Goal
Medical	Linkage to a primary care provider
Health	Delivering Health Promotion guide topics
Housing	Linkage to a housing placement provider

Case Management Services	Linkage to a supportive housing, Ryan White Part A Care Coordination, Medicaid Health Home, or other case management program (depending on client need)
Benefits/Entitlements Assistance	Providing access to entitlements
Building Support Network	Developing diverse social supports

2.1.2 The Spirit of TCC

2.1.2.1 An intrinsic belief in the possibility of wellness for people with HIV and other special needs

2.1.2.2 The relationship between staff and client is one of collaboration

2.1.2.3 The best approach to working with clients is one that is person-centered and strength-based

2.1.2.4 The client is the expert on his/her own need, and has the right to the best possible services

2.1.2.5 Works with gradual change (harm-reduction and motivational interviewing approach to behavior change)

2.1.2.6 Continues to maintain work with a client despite changes in client location or circumstance (no drop-out policy)

2.2 Phase 0: Outreach

2.2.1 This pre-program phase focuses on targeted case finding and referral to and coordination of HIV testing. Once clients are engaged, confirmed HIV-positive and referred to the program, they will move to Phase 1.

2.3 Phase 1: Transition to Transitional Care Coordination Program Phase

2.3.1 Occurs months 1-3

2.3.2 Referrals to the TCC program may come from the Outreach Specialist or other service providers. The referring party should provide key information about the client's social service(s) and housing status. The client may also self-refer.

2.3.3 During the enrollment process clients should be assessed for eligibility and needed benefits, and clients should provide informed consent to participate in TCC.

2.3.4 An initial assessment should screen for unmet needs including, but not limited to, housing, food, medical provider, substance use, mental illness and case management services. In accordance with the payer of last resort regulations, clients must be assessed for eligibility for other programs providing similar services (i.e., Medicaid, Medicare, HASA, etc.). A detailed description of how to conduct program intake assessment can be found in Section 6.0.

2.3.5 Staff conducting intake should provide client with an overview of TCC, ensuring that a conversation on staff roles/expectations throughout the different program phases takes place.

2.3.6 Health promotion conversations may be utilized in the assessment process. For example, Conversation K: Understanding Social Support and Conversation L: Disclosure and Networks of Social support may be used to assess for client's current informal supports.

2.3.7 It is important to establish a trusting and solid relationship during this Phase. Therefore, cultural and linguistic competencies are essential.

2.3.8 Phase 1 focuses on providing intensive support and assessing existing or potential client's resources.

2.3.9 TCC staff members are expected to support clients through phone calls, face-to-face meetings, and home visits to engage the clients and support progress on the care plan. Contact during this Phase, particularly early on, is expected to be frequent, intensive and supportive.

2.3.9.1 At least one (1) call or meeting with either a formal support (community-based service provider) or informal support (friend, family, and clergy) is expected to take place during the first month of enrollment.

2.3.9.2 At least three (3) in-person community-based meetings with the client are expected during Phase 1.

2.3.9.3 At least two (2) calls or meetings with either a formal support (community-based service provider) or informal support (friend, family, and clergy) is expected to take place during the first month of enrollment.

2.3.10 The Transitional Care Coordinator has thirty (30) days from the point of enrollment to develop a Comprehensive Care Plan (*Appendix J*) in collaboration with the client that addresses the client's presenting needs.

2.3.10.1 Only one (1) to three (3) areas of focus should be selected per care/plan.

2.3.10.2 Each area of focus chosen in the care plan should be accompanied in the care plan by a reason/rationale.

2.3.10.3 General actions steps should be recorded for each area

2.3.10.4 The full plan must include the signature of both the client and Transitional Care Coordinator.

2.3.11 Development of primary care and housing goals should begin in this Phase as these are seen as high priorities of the program.

2.3.12 Outreach Specialists are expected to offer and accompany clients to HIV primary care visits and supportive service appointments (as needed).

2.3.13 Reassessments (*Appendix P*, Comprehensive Care Plans, and the required PCSM updates *(Appendix Q)* should occur every 90-120 days as a client transitions from one Phase to the next. On the Comprehensive Care Plan, only ongoing service goals should carry over to the next Plan, noting that only one to three areas of focus will be included.

2.4 Phase 2: Try Out Phase

2.4.1 Occurs months 4-6

2.4.2 Phase 2 is devoted to testing and adjusting the systems of support that were developed in Phase 1. The role of TCC staff should also change during this Phase. In-person contact with the client should begin to decrease and staff should play a more supportive role monitoring the efforts of community resources and other service providers. During this Phase, staff should be prepared to provide mediation between the client and their support network and/or providers. They should also be aware that clients may need to change providers before finding one with whom they are comfortable.

2.4.3 Contact and introductions should be made with either supportive housing, Ryan White Part A Care Coordination program, Medicaid Health Home, or other case management program (depending on client's needs) to begin discussion of the client's transition and to introduce the client to the selected provider(s). As linkages with providers and support networks increase, contact with TCC team members decreases as appropriate.

2.4.4 TCC team should reinforce staff roles and expectations, reminding client and service providers that face-to-face contact will steadily decrease in Phase 2. However, the worker will remain supportive of the client by testing the strength of linkages created.

2.4.5 Through coordination with other service providers and support contacts, staff should document the specific ways in which linkages to formal and informal supports are (or are not) working in progress notes.

2.4.6 The Comprehensive Care Plan, Reassessment and PCSM update must be updated every 90-120 days at a minimum. Ongoing service goals should carry over to the next Plan, noting that only one to three areas of focus will be included.

2.4.7 Since ongoing primary care and housing instability are key issues, efforts should continue to concentrate on linking/retaining clients in care and finding permanent housing.

2.4.8 Accompaniment and Health Promotion activities continue as needed and appropriate during this Phase.

2.5 Phase 3: Graduation and Transfer to Supportive Housing or Case Management Program Phase

2.5.1 Occurs months 7-9

2.5.2 Phase 3 focuses on completing the transfer of care to a supportive housing or appropriate case management program that will provide longer-term care coordination support to the client. Entry into and continuity of primary HIV medical care, housing placement and access/enrollment in a case management or supportive housing program are key outcomes of the TCC program. Nine (9) months of continuous enrollment (without disenrollment/reenrollment) is required for graduation.

2.5.2.1 Linkage to a Primary Care Provider – Selection of a PCP should be done with the transfer activity in mind.

2.5.2.2 Linkage to Housing Placement Provider – Depending upon client need, the program should focus on finding supportive housing or placing the client in an appropriate level of assistance for independent housing. If the client is eligible for supportive housing, then case management services should be provided by the supportive housing provider.

2.5.2.3 Transfer to Case Management Program – Clients who successfully complete the TCC program must be transferred to supportive housing, Ryan White Part A Care Coordination, Medicaid Health Home, or other case management program (depending on client need) by the end of Phase 3. Program staff must facilitate the transfer.

2.5.3 TCC team should reinforce staff roles and expectations, reminding client and service providers that face-to-face contact will dramatically decrease in Phase 3. However, the worker will remain supportive of the client by testing the strength of linkages created.

2.5.3.1 Program staff should try to limit communication with clients to no more than once every 3 weeks during this period.

2.5.4 Through coordination with other services providers and support contacts, staff should document the specific ways in which linkages to formal and informal supports are (or are not) working.

2.5.5 Accompaniment and Health Promotion activities continue as needed and appropriate during this Phase. A minimum of six (6) unique Health Promotion sessions must be completed during Phases 1-3 as a graduation requirement.

2.5.6 The Program Director and Transitional Care Coordinator should meet regularly to discuss the plans for transition with the TCC team, other service providers, and any existing informal community supports.

2.5.7 A final joint transfer-of-care meeting or phone call with client and primary linkages should be convened.

2.5.7.1 TCC staff should solicit feedback from client on experience with the intervention and progress that was made.

2.5.7.2 TCC staff may utilize the TCC Transfer of Care Coordination Form *(Appendix W)* to facilitate transfer of releases of information, compile provider contact information and the associated follow-up care plans.

2.5.7.3 A prognosis for client's long-term continuity of care and housing stability should be made in the client's progress note *(Appendix T)*.

2.5.8 The Comprehensive Care Plan, Reassessment and PCSM update must be updated every 90-120 days at a minimum. Ongoing service goals should carry over to the next Plan, noting that only one to three areas of focus will be included.

2.6 Phase 4: Follow-up Phase

2.6.1 Occurs month 12 (3 months after graduation)

2.6.2 Phase 4 provides follow-up with the client and/or assigned Case Manager three (3) months after the transition takes place.

2.6.2.1 During the third month after the client is graduated from the TCC program and transferred to a case management program, housing provider, and primary care provider, the Transitional Care Coordinator should follow-up with the appropriate assigned program staff to ensure that the relationship between the client and program is working well.

2.6.2.2 Follow-up conversations with the client and coordination of care with the provider should be documented in the client charts.

2.6.2.3 A prognosis for client's long-term continuity of care and housing stability should be made in the client's closing progress note.

2.6.3 If the client was successfully referred to a housing provider, engaged in the case management program and keeps his/her PCP appointments, the case can be closed and the client will graduate.

2.6.4 If the client is found to be out of care and/or no longer engaged in case management and/or housing services, re-assess and place into the TCC Phase that best corresponds with the client's needs.

2.7 Limited Services

2.7.1 If at any time, an existing TCC client is receiving active services with a Health Home/comprehensive case management program, the client is eligible to receive temporary "limited services" in the TCC program.

- **"Active services"** – defined as having received three (3) face-to-face services from a Health Home or a comprehensive case management program within the previous three months.
- **"Temporary"** – defined as up to 6 months (or until the end of the 12 month enrollment period).
- **"Limited services"** – defined as services that are not provided by a Health Home and/or are essential to client's successful transition, including:
  - Health Promotion (a.k.a. HIV Self-Management Support);
  - Linkage to Housing Services;
  - Comprehensive Care Plan and Reassessment & Updates;
  - Coordination with Service Providers; and
  - Post-transfer follow-up.

3.0 Transitional Care Coordination Service Types

3.1 Section Overview: The program is funded to provide the following services. Descriptions of the service types and the manner in which they are reported to DOHMH/HIVCS are given below. For details on mapping services, please refer to the TCC eSHARE mapping (*Appendix Y)* or access the most recent document in the "Resources" tab in eSHARE.

3.2 Targeted Case Finding & Outreach Events

3.2.1 The Outreach Specialist conducts targeted case finding via event-based outreach venues where homeless and unstably-housed individuals reside or congregate, including, but not limited to:

- Single Room Occupancy (SRO) hotels that house a high proportion of people with HIV;
- Food pantries, soup kitchens, or religious institutions that serve homeless individuals;
- Homeless and domestic violence shelters;
- Syringe exchange programs
- Drop-in centers and other service centers

3.2.2 The Outreach Specialist(s) conducting a targeted case finding event must make at least 10 contacts **OR** 3 engagements with potential clients.

3.2.2.1 **Contacts** are defined as interactions that take place individually or in groups in an attempt to engage potential clients.

3.2.2.2 **Engagement** is defined as a one-on-one interaction with potential clients in a setting that ensures client privacy and confidentiality, where contact information is shared and referrals for program enrollment are made.

3.2.2.3 Targeted case finding services should include a minimum of two hours per event, and allow an additional three hours for travel/setup time and documentation.

Example 1: While conducting a targeted case finding at an SRO, the Outreach Specialist from Agency A knocks on 15 residents' doors. Of those 15 attempts, 10 residents open their doors (10 contacts).

Example 2: The Outreach Specialist is able to fully describe the TCC program and gather enough information to refer 5 interested clients for enrollment (5 engagements).

Example 3: Outreach Specialists from Agency B go out to conduct targeted case finding on a street corner determined to yield many potential TCC clients. However, after the first hour of yielding only 5 contacts, the outreach team decides to move to a location further down the street where there is slightly heavier foot traffic. The move results in 7 more contacts over

the course of the next hour. In cases similar to this, the Outreach Specialist may record the street outreach in two (or more) separate locations as a single targeted case finding event by aggregating the number of contacts and engagements on one form.

3.2.3 *Documentation:* In order to report a completed targeted case finding activity, documentation should contain all required elements from the Anonymous Events Services eSHARE Form (*Appendix H*) including the total number of contacts and engagements.

3.2.3.1 TCC staff should keep a record of both successful (meeting the 10 contact or 3 engagement threshold) AND unsuccessful targeted case finding activities for purposes of review and quality assurance activities.

3.2.3.2

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Group Outreach	Anonymous Event Services	Indicate the total number of "engagements" by summing the number of program referrals.

3.3 Intake Assessment

3.3.1 The program will ensure that an assessment is completed that addresses program eligibility; housing; medical needs; substance use; mental illness; domestic violence; social service needs; and benefits assessment.

3.3.2 Basic client information is collected using the Client Demographics form (*Appendix I*).

3.3.3 The program staff conducting the initial intake assessment is ***required*** to use the intake form (*Appendix I*) provided by DOHMH in order to minimize errors in data reporting.

3.3.3.1 TCC staff is encouraged to supplement the DOHMH Intake Assessment with additional questions required by their agencies and relevant assessment information (e.g. assessment for domestic violence).

3.3.4 *Documentation:* Intake assessment information must be entered into the eSHARE Intake Assessment **Form** *(Appendix J)* before any services can be entered on the eSHARE Individual Services Delivered Form *(Appendix M)*. The eSHARE Intake Assessment form and the eSHARE Reassessment form are **required forms**. When the Intake Assessment or Reassessment is completed in eSHARE in real-time with the client present, a form printed from eSHARE and kept in client files is acceptable supporting documentation.

- Intake Assessments that are entered into agency-specific, internal data systems and not captured in eSHARE are not acceptable.

- Intake Assessments that are completed on forms other than DOHMH eSHARE forms are not acceptable (unless that alternate form version has specifically already been approved by DOHMH).

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Intake Assessment	Services Delivered	

3.4 Comprehensive Care Plan Development

3.4.1 The initial Comprehensive Care Plan (*Appendix K*) summarizes needs identified through the initial TCC program intake assessment.

3.4.1.1 The care plan focuses on the client's needs in up to three (3) TCC areas of focus (see 2.1.1.4) that put the client at risk for homelessness and unstable housing and provides rationale/reasons for why they are selected.

3.4.1.2 General action steps for each area of focus should be included. There may be a number of issues to address but it is important to capitalize on the clients' strengths, skill, and interests in order to identify areas they are willing to address.

3.4.1.3 The care plan must have the written consent of the client and signature of the Transitional Care Coordinator. Every item on the service plan must be assigned a target date of completion and anticipated resources required.

3.4.1.4 Time Requirement: The care plan is usually completed in conjunction with the initial intake assessment. At minimum, the care plan should be completed within thirty (30) business days of program enrollment.

3.4.2 *Documentation:* A completed Comprehensive Care Plan Development service should be reported in eSHARE under "Care Plan / Service Plan" in the "Services Delivered" form.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Care Plan / Service plan	Services Delivered	Service detail must specify "Development of initial plan with this enrollment."

3.5 Reassessment

3.5.1 Program staff will meet with the client to conduct a reassessment every 90-120 days during enrollment to coincide with Phase transitions.

3.5.2 *Documentation:* Reassessment information must be entered into the eSHARE Reassessment **Form** *(Appendix P)* before any services can be entered on the eSHARE Individual Services Delivered Form *(Appendix M)*. The eSHARE Intake Assessment form and the eSHARE Reassessment form are **required forms**. When the Intake Assessment or Reassessment is completed in eSHARE in real-time with the client present, a form printed from eSHARE and kept in client files is acceptable supporting documentation.

- *Reassessments that are entered into agency-specific, internal data systems and not captured in eSHARE are not acceptable.*
- Reassessments that are completed on forms other than DOHMH eSHARE forms are not acceptable (unless that alternate form version has specifically already been approved by DOHMH).
- Reassessment information must be entered into the eSHARE Reassessment **Form** before that reassessment service may be entered on the eSHARE Individual Services Delivered Form.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Other Assessment / Reassessment	Services Delivered	Service detail must specify "Re-Assessment (clinical, psychological, general health/well-being, housing, enrollments, etc.)".

3.6 Comprehensive Care Plan Update

3.6.1 At Reassessment (every 90-120 days), program staff will review client's progress toward achieving goals set in his/her comprehensive care plan. The plan will be updated to reflect any changes identified during the reassessment.

3.6.2 *Documentation:* A completed Comprehensive Care Plan Update service should be reported in eSHARE under "Update to Plan" in the "Service Delivered" form.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Care Plan / Service plan	Services Delivered	Service detail must specify "Update to plan"

3.7 Accompaniment

3.7.1 The Outreach Specialist is expected to accompany clients to HIV primary care and supportive service appointments if needed by the client. Assistance should be offered to all TCC clients (and documented accordingly in suitable facility or program records) and can include:

- Transportation (via subway, Access-A-Ride, taxi, car service)
- Assistance in entering and leaving the medical facility
- Emotional support during their medical visit

3.7.2 It is up to the client to accept the service. Staff should employ motivational interviewing skills to help clients understand the importance of accompaniment.

3.7.3 In the case that a client refuses accompaniment services, program staff must contact either the client or service provider by telephone to verify that the appointment was kept.

3.7.4 *Documentation:* A completed accompaniment service should be reported under the "Services Delivered" form in eSHARE.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Accompaniment	Services Delivered	

3.8 Health Promotion

3.8.1 Health promotion must be conducted on an individual face-to-face basis using the curriculum provided by NYC DOHMH. The discussion should be delivered using motivational interviewing techniques or other methods to engage client.

3.8.2 All health promotion activities can be provided in conjunction with other program services.

3.8.3 At least six (6) core health promotion conversations (as defined in the *Transitional Care Coordination to Homeless and/or Unstably Housed Persons Health Promotion Guide*) must be completed during the current enrollment in order for the client to graduate. Conversations required for graduation within this core section may be repeated as necessary.

3.8.4 Core Health Promotion Topics:

- Me & HIV
- What is HIV?
- What is AIDS?
- How is HIV transmitted?
- How is HIV prevented?
- Substance Use, HIV Transmission & Harm Reduction
- Introduction to Health Maintenance
- Medical Appointments & Adherence

- Why is Adherence to ART important?
- Understanding Social Support
- Disclosure and Networks of Social Support

3.8.5 Discretionary Health Promotion Topic:

- Harm Reduction Plan

3.8.6 If necessary, topics within this core section can also be continued and/or repeated during a session throughout program enrollment.

3.8.7 Programs staff should document health promotion sessions (date and name of topic covered) in the client's file.

3.8.7.1 A template for tracking and documenting progress on the core health promotion topics is provided in the *TCC Health Promotion Curriculum Coverage Log* (*Appendix N*).

3.8.8 *Documentation:* A completed health promotion session should be reported in eSHARE under "Non-Care Coordination Topics" in the "Services Delivered" form.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Health Education / Promotion	Services Delivered	Under health promotion topic coverage, select "Non-Care Coordination health education conversations." Choose a non-Care Coordination topic from the second variable pick list.

3.9 Linkage to Housing Services

3.9.1 The program must facilitate linkage to a housing placement provider, schedule the initial visit, and ensure the client attends that visit either via accompaniment and/or follow-up coordination with service provider activities.

3.9.2 The service is payable once per client enrollment.

3.9.3 If a client is not satisfied with his/her initial choice of housing placement provider, the TCC program staff must work with the client to identify a more suitable provider.

3.9.4 *Documentation:* In order to report the service in eSHARE, staff must first report the activity as "Assistance with Housing" in the "Services Delivered" form, and then indicate that the appointment/visit disposition was completed on the Referrals/Appointments Tracking Log (*Appendix O*).

eSHARE Mapping Step 1

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Assistance with Housing	Services Delivered	Service detail must specify "Referral / Appointment Making." Referral type & follow-up must be captured in the Referrals/Appointment Tracking Log.

eSHARE Mapping Step 2

Associated eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Assistance with Housing *(must have same date as the eSHARE service type above)*	Referrals/Appointment Tracking Log	'Yes' to Client referred for services; 'Yes' to Client has appointment with agency providing service; Referral appointment disposition must be 'Completed'

3.10 Linkage to Primary Care

3.10.1 The program must facilitate the choice of a primary care provider, schedule the initial medical visit, and ensure the client attends that visit either via accompaniment and/or follow-up coordination with service provider activities.

3.10.2 Selection of Primary Care Provider should be done keeping the transfer activity in mind. While the client can select his/her Primary Care Provider of choice, Transitional Care Coordinators may suggest Primary Care Providers who are affiliated with a Ryan White Part A Care Coordination program, Medicaid Health Home, or other case management program (depending on client need).

3.10.3 This service is payable once per client enrollment.

3.10.4 If a client is not satisfied with their initial choice of Primary Care Provider, the Transitional Care Coordinator should work with them to find a more suitable provider.

3.10.5 This service may be reported when either the TCC Program links the client to primary care directly (i.e., Linkage via TCC Program) OR the agency to which the TCC Program transferred the client's case management services completes the linkage to primary care (i.e., Linkage via other case management program).

3.10.6 *Documentation for Linkage to Primary Care* ***via TCC Program****:* In order to report the service in eSHARE, staff must first report the activity as "Assistance with Health Care" in the "Services Delivered" form, and then indicate that the appointment/visit disposition was completed on the Referrals/Appointments Tracking Log (*Appendix O*).

eSHARE Mapping Step 1

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Assistance with Health Care	Services Delivered	Service detail must specify "Referral / Appointment Making." Referral type & follow-up must be captured in the Referrals/Appointment Tracking Log.

eSHARE Mapping Step 2

Associated eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required):*
Assistance with Health Care (must have same date as the eSHARE service type above)	Referrals/Appointment Tracking Log	'Yes' to Client referred for services; 'Yes' to Client has appointment with agency providing service; Select "Primary Medical Care" as the referral service type; Referral appointment disposition must be 'Completed'

3.10.7 *Documentation for Linkage to Primary Care **via other case management program**:* In order to report the linkage in eSHARE, staff must obtain documentation/verification of the date that the client was seen by the doctor for inclusion in the client's chart. TCC staff reports the activity as "Coordination with Service Providers" in the Services Delivered form. The Service Date must reflect the date that verification was obtained from the case management program. TCC Program must also complete a PCSM Update form and use the date of the actual appointment to indicate the client's last PCP visit.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Coordination with Service Providers	Services Delivered	Service detail must specify "Primary Care" AND "Verification." Service Date must reflect the date that verification was obtained from the case management program. A PCSM Update must be completed with the date of the actual appointment to indicate client's last PCP visit. No referral form necessary.

3.11 Transfer to Case Management Program

3.11.1 Clients who successfully link to housing services (that does not include supportive services) and primary care must be transferred to Ryan White Part A Care Coordination, Medicaid Health Home, or other case management program (depending on client need) for completion of Phase 3.

3.11.2 A client actively enrolled in a supportive housing program providing case management services is also allowable under this service type.

3.11.3 In order to facilitate the transfer, the program must:

3.11.3.1 Obtain written consent from the client to release case management records to the new provider and assist with the transfer of the records if needed.

3.11.3.2 Make an appointment for the client with a Ryan White Care Coordination program, Medicaid Health Home or other case management program (depending on client need).

3.11.4 This service is payable once per client enrollment.

3.11.5 *Documentation:* In order to report the service in eSHARE, staff must first report the activity as "Assistance with Social Services" in the "Services Delivered" form, and then indicate that the appointment/visit disposition was completed on the Referrals/Appointments Tracking Log (*Appendix O*).

eSHARE Mapping Step 1

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Assistance with Social Services	Services Delivered	Service detail must specify "Referral / Appointment Making." Referral type & follow-up must be captured in the Referrals/Appointment Tracking Log.

eSHARE Mapping Step 2

Associated eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Assistance with Social Services *(must have same date as the eSHARE service type above)*	Referrals/Appointment Tracking Log	'Yes' to Client referred for services; 'Yes' to Client has appointment with agency providing service; Referral appointment disposition must be 'Completed'

3.12 Post-transfer follow-up

3.12.1 During the third month after the client is graduated from the TCC program and transferred to a case management program, the Transitional Care Coordinator should follow-up with the client or assigned Case Manager to make sure that the new relationship between client and case management program is working well for both parties.

3.12.1.1 This activity must be completed before the end of the thirdmonth after graduation.

3.12.2 *Documentation:* Follow-up conversations with either the client and/or Case Manager is documented in the client chart and reported as a "Coordination with Service Providers" service (see 3.13 below).

3.13 Coordination with Service Providers

3.13.1 Coordination on behalf of the client with the client's medical provider and/or other service providers who are in the position to assist and/or support the client with treatment through telephone calls, face-to-face interactions, appointment making, case conference meetings, and other coordination of services.

3.13.2 *Documentation:* A completed Coordination with Service Providers activity should be reported in the "Services Delivered" form in eSHARE.

eSHARE Mapping

eSHARE Service Type	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)*:
Coordination with Service Providers	Services Delivered	

3.14 Graduation

3.14.1 A client is considered to be a graduate of the TCC program when ALL of the following services have been provided to a client and reported in eSHARE:

1. Linkage to Housing Services
2. Linkage to Primary Care
    a. Linkage *via TCC Program;* or
    b. Linkage *via other case management program*
3. Transfer to Case Management Program
4. Completion of a minimum of six (6) unique Health Promotion sessions
5. Nine (9) months of continuous program enrollment

1.1.2 This service is payable once per client enrollment

1.1.3 *Documentation:* Graduation is not documented separately in eSHARE; graduation is automatically recognized by HIVCS when all criteria (see above) have been met and reported in eSHARE.

3.15 Other Programmatic Services

3.15.1 Program staff should help every client understand where, when, and how to access all health and related services and must ensure the adequacy of resources needed by the client.

3.15.2 The Program ensures that the client has the requisite information for all relevant appointments and access to services by reviewing the care plan with the client and the provider. The Program should also provide the client with reminders of upcoming appointments or plans in the following fashion:

- From the moment a primary care appointment is scheduled, make sure the client is aware of the date and time.
- At every regular face-to-face contact the program will remind the client of all services planned for the upcoming period.

3.15.3 The program ensures that the client has the requisite resources for all relevant appointments and service access by:

- Offering accompaniment to every primary care appointment
- Asking whether the client requires assistance with transportation and/or childcare every time a reminder is provided.

3.15.4 The Program will assist the client in scheduling and rescheduling appointments, when an appointment is missed.

3.15.5 **Interpretation Services:** The Program will ensure interpretation services are available if not accessible on site by the PCP.

- Minor children (<18) are not allowed to be used as interpreters.
- It is also strongly recommended that family members and friends are *not* used for interpretation services.

3.15.6 **Transportation Services:** The Program ensures appropriate transportation resources whenever they are required. These include but are not limited to:

- Access-A-Ride (van transport for the mobility impaired).
- A Metrocard provided by the Program for use on MTA buses and trains (Note: Medicaid fees include Metrocard costs. When the 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. For instance, a client cannot wait for Access-A-Ride and urgently needs transportation to go to a relevant appointment or service and could not schedule a ride in advance. It may not be an emergent situation in which a client would need to call an ambulance.
- A ride in a vehicle owned or leased by the Program or Program staff. All regulatory and liability issues must be addressed in advance.

3.15.7 **Childcare Services**: The Program ensures appropriate childcare resources whenever they are required. These include but are not limited to:

- Appropriately credentialed childcare services at an affiliated agency location.
- Payment for childcare in the client's home when circumstances do not allow bringing the child to the care center.
- The Program offers the same for clients who care for elderly or disabled adults in the home and who cannot remain alone during the time needed for the visit.
- HRSA[8] prohibits payment to clients, and therefore, Programs must develop a system to reimburse childcare providers.

3.15.8 In order to ensure that confidentiality law or related institutional policies does not preclude ready transfer of sensitive personal health information, the Program must ensure that a valid consent to release of HIV information is always on file for each client.

3.15.9 ***Documentation:*** Staff documents all other programmatic services by means of a service tracking log, progress notes, and/or electronic medical record. Interpretation, Transportation, and Childcare Services are not reimbursable services. Documentation must include the following six (6) required elements:

- Service date
- Service start time
- Worker(s) providing service

[8] For more information, refer to http://hab.hrsa.gov/

- Site of service delivery
- Service type(s)
- Applicable service details

eSHARE Mapping

Contract Activity	**eSHARE Service Type**	**eSHARE Entry Form**	**Information required in service details** *(in addition to eSHARE submission required)***:**
Childcare Services	Assistance with Entitlements & Benefits	Services Delivered	Indicate "Arrangement for childcare" in service details.
Transportation Services		Services Delivered	Indicate "Arrangement for transportation" in service details.
Interpreting Services		Services Delivered	Indicate "Arrangement for interpreting services" in service details.

4.0 Roles and Responsibilities

4.1 Overview

4.1.1 The main purpose of this section is to specify roles and responsibilities of Program positions and provide an overview of activities.

4.1.2 Depending on the agency, the responsibilities described and specific and staff titles may vary. One person may assume more than one role in some instances. For large programs, Directors and Supervisors may have deputies to subdivide the role.

4.2 Program Director

4.2.1 Has overall responsibility for operations of the TCC program.

4.2.2 Recruits, hires, and supervises all key personnel; supervises the Transitional Care Coordinators directly and Outreach Specialists indirectly.

4.2.3 Reviews and monitors the status of Program enrollments.

4.2.4 Oversees all monitoring, reporting and quality management activities of the program.

4.2.5 Ensures coordination of resources and logistics for staff training.

4.2.6 Coordinates TCC program activities with participating organizations and oversees the generation of all relevant agency-specific policies and procedures.

4.2.7 Produces summary reports of program activities.

4.2.8 Acts as a liaison between the program and NYC DOHMH.

4.3 Transitional Care Coordinator

4.3.1 Enrolls the client into the program and verifies eligibility.

4.3.2 Performs the Intake Assessment including housing, food, medical provider, substance use, mental illness, case management services and other supplemental assessments.

4.3.3 Conducts Reassessment with each client every 90-120 days during enrollment to coincide with Phase transitions.

4.3.4 Coordinates with formal/informal supports and develops the Comprehensive Care Plan.
4.3.5 Oversees the implementation of the care plan with the support of the Outreach Specialist.
4.3.6 Provides health promotion activities as needed.
4.3.7 Provides back-up to Outreach Specialists as needed.
4.3.8 Collects the Weekly Case Review Form (*Appendix U*) and meets with the TCC team to review all clients on the Outreach Specialists' caseload.
4.3.9 Weekly case conferences with the TCC team will focus on 1-4 clients using the Case Conference Client Summary Forms (*Appendix V).*
4.3.10 Conducts monthly reviews of Outreach Specialists. Reviews include face-to-face assessment of staff competency and chart-based review.
4.3.11 Supervises up to 3 Outreach Specialists (or between 30 – 54 clients).

4.4 Outreach Specialist

4.4.1 Provides health promotion and skills building services to clients.
4.4.2 Accompanies clients to primary care appointments and to other health care and social service encounters, as warranted.
4.4.3 Implements ongoing navigation and logistical support for appointment keeping reminders, transportation, interpretation and childcare arrangements.
4.4.4 Assists the Transitional Care Coordinator in conducting reassessments and follow-ups.
4.4.5 Provides critical input, in regards to client care, to other informal and formal supports based on his/her observations in the field.
4.4.6 Educates, coaches and empowers clients.
4.4.7 The suggested caseload for each Outreach Specialist is between 15 – 18 clients.

4.5 NYC DOHMH

4.5.1 Funds the Transitional Care Coordination Program via Ryan White Part A funds.
4.5.2 Provides programmatic technical assistance.
4.5.3 Provides training/education of program staff.
4.5.4 Monitors program implementation.
4.5.5 Evaluates program performance and clinical outcomes.
4.5.6 Conducts Fidelity Assessments of TCC-CTI model

4.6 Public Health Solutions (PHS)/HIV Care Services (HIVCS)

4.6.1 As NYC DOHMH's Master Contractor, manages Ryan White Part A-funded contracts for the NYC DOHMH.
4.6.2 Provides contractual and fiscal technical assistance.
4.6.3 Monitors contract implementation and compliance.

5.0 Enrollment

5.1 Client enrollment eligibility:

Eligible clients **must** meet all six of the following criteria in order to enroll in the DOHMH Transitional Care Coordination Program. Staff may choose to assess TCC eligibility using a screening form *(Appendix X).*

5.1.1 Criteria include:

5.1.1.1 Household Income below 435% of Federal Poverty Level;

5.1.1.2 Client lives in the New York Eligible Metropolitan Area;

5.1.1.3 Client is at least 18 years of age;

5.1.1.4 Documented HIV positive sero-status;

5.1.1.5 Homelessness and/or Unstably Housed;

5.1.1.6 Client has one or more of the following additional complicating factors:

- Newly diagnosed with HIV;
- Lost to care (i.e., no primary care visit in the past 9 months or ever in New York City);
- Difficulty adhering to ART;
- Difficulty keeping appointments or receive sporadic, irregular care.

Note: Appropriate appointment adherence is best left to the judgment of the medical provider due to the fact that appointments vary according to client needs. The provider will have the best sense of the client's appointment keeping behavior.

5.1.2 Definitions of Homeless and Unstably Housed

- The term **"homeless"** is used to define individuals who: lack a regular and/or adequate nighttime residence; have a primary nighttime residence that is a public or private shelter or dwelling designed to provide temporary living accommodations, including SROs; live in an institution that provides temporary residence for individuals intended to be institutionalized; or live in a public or private place not intended or ordinarily used as a regular sleeping accommodation for human beings.
- The term **"unstably housed"** expands on the definition of "homeless" to also include individuals who frequently move between housing situations, individuals who are facing eviction, and/or individuals who are temporarily living with family or friends.

5.2 Medicaid Health Homes and Dual Enrollment

5.2.1 To ensure Ryan White funds are payer of last resort, TCC staff must ask clients during the intake assessment if they receive services from a Health Home or other comprehensive case management program. TCC

providers must reassess client enrollment status at every Phase change (90-120 days).

5.2.2 Client enrollment status may also be established through documentation of **active services** provided by the Health Home or comprehensive case management program (see 2.7).

5.2.3 Individuals who are in need of treatment adherence services may also be dually enrolled in Health Homes and Ryan White Part A Care Coordination programs.

5.2.4 For **NEW TCC clients only**:

- 5.2.4.1 Individuals who are NOT enrolled in a Health Home/comprehensive case management program may receive the full range of TCC services.
- 5.2.4.2 Individuals who are enrolled in a Health Home/comprehensive case management program but NOT receiving active services may receive the full range of TCC services.
- 5.2.4.3 Individuals who are enrolled in a Health Home/comprehensive case management program AND receiving active services may NOT be enrolled in TCC.

5.2.5 For **EXISTING TCC clients only**:

- 5.2.5.1 Individuals who are NOT enrolled in a Health Home/comprehensive case management program may continue to receive the full range of TCC services.
- 5.2.5.2 Individuals who are enrolled in a Health Home/comprehensive case management program but NOT receiving active services may continue to receive the full range of TCC services.
- 5.2.5.3 Individuals who are enrolled in a Health Home/comprehensive case management program AND receiving active services are eligible for only temporary (up to 6 months or until the end of the 12 month enrollment period) and **limited services** through the TCC Program (see 2.7).

5.3 Referral Source

5.3.1 Referral by a PCP who identifies a client with a need for the Transitional Care Coordination program.

5.3.2 Referral by a source other than a PCP, examples include:

- 5.3.2.1 Referral by the Riker's Island Transitional Healthcare Coordination Consortium (THCC) linking a recent prison release to care or other similar programs.
- 5.3.2.2 Lateral transfer from another TCC program.
- 5.3.2.3 Self-referral or referral from another service provider.
- 5.3.2.4 The inpatient medical service or emergency department of a hospital identifying a client with a need for these services.

- 5.3.2.5 External source linking a client to care such as the DOHMH Field Services Unit (FSU) returning a client who has been lost to follow-up or referring a newly diagnosed client. FSU assists with partner notification and linkage to care.
- 5.3.2.6 An agency that provides HIV testing services.

6.0 Initial Intake Assessment and Comprehensive Care Plan Development

6.1 Overview

6.1.1 The Transitional Care Coordinator is primarily responsible for the intake process and for the social service/benefits assessment.

6.1.2 The Transitional Care Coordinator compiles the documentation of other programs'/departments' assessments.

6.1.3 All information and assessments are compiled and inform the client's Comprehensive Care Plan.

6.1.4 The Comprehensive Care Plan evolves with the client as they progress through the program Phases and thus reflects the changing needs, goals (and related reasons), and action steps.

6.1.5 Only one (1) to three (3) areas of focus (see 2.1.1.4) per Phase should be addressed in Comprehensive Care Plan so that client and staff do not feel overwhelmed.

6.1.6 The areas of focus are intended to be umbrella items and can include specific client goals. For example, identification of legal service goals can broadly be described as a need for benefits and/or entitlements assistance.

6.2 Conducting the Intake Assessment

6.2.1 Staff conducting intake should explain the purpose and structure of the TCC program to enrollees. Included in this discussion should be an explanation regarding the roles and limitations of TCC staff.

6.2.2 Introduce the Outreach Specialist, if possible. If a formal introduction to the Outreach Specialist is not possible, give the Outreach Specialist's contact information to the client and explain that an Outreach Specialist will deliver most of the TCC services. Also provide contact information for the Transitional Care Coordinator.

6.2.3 At intake, program staff must check for enrollment in five large NYC-funded programs:

- Medicaid Health Homes
- Ryan White Part A funded Care Coordination
- Identical Ryan White funded program (TCC)
- HIV Special Needs Plan (SNPs)
- AIDS Adult Day Health Care (ADHC) program

6.2.4 Based on enrollment and eligibility for Medicaid or other funded programs, the program will follow payment procedures to ensure TCC services are not billable to other programs.

6.2.4.1 All contracts must identify a contact from at least one NYS-funded Navigator program and refer clients who may be eligible for expanded Medicaid or for insurance via the NYS Health Plan Marketplace.

6.2.4.2 Under no circumstance should a person receive a similar or identical service from more than one agency. When such duplication is discovered, the TCC program and the provider of the other services should discuss with the recipient which agency best suits his or her needs.

6.2.4.3 Programs will collaborate and coordinate with other care coordination agencies to ensure that people with HIV persons receive comprehensive, non-duplicative—but complementary—services. People with HIV with numerous complex social and/or health/mental health needs will be referred to other agencies that target those specific issues and coordination of services will continue.

6.2.5 The Transitional Care Coordinator will obtain a signed Agreement from the client for release of HIV information and for Program enrollment.

6.2.6 The initial intake assessment process addresses the logistics of care coordination, which includes:

6.2.6.1 Family or social network available to provide support in helping the client meet his/her healthcare needs.

6.2.6.2 Childcare responsibilities impacting daily routine.

6.2.6.3 Client's preferred language.

6.2.6.4 Outstanding criminal justice issues (parole, etc.).

6.2.6.5 General or health literacy impediments.

6.2.6.6 Social barriers to delivering services in the home such as the risk of family violence.

6.2.7 Ensure appropriate and complete contact information is on record (including a contact number where the client can be reached during business hours, cell phone, home number, etc.) and a friend or support contact that will know the clients whereabouts and can be contacted in the event that communication with the client is impossible. A client contact information form should be used to document this information (*Appendix L*).

- ***Find out if the client's HIV status has been disclosed to this person and use appropriate confidentiality procedures.***

6.2.8 Clients referred through a source other than the affiliated medical provider should have a primary care appointment scheduled as soon as possible.

6.2.9 Explain the importance of notifying the TCC program and PCP in the event of a hospitalization or travel.

6.2.10 Screen for and address needs such as domestic violence and mental illness.

6.2.11 *Timeline*: the intake process should preferably be started at the time of client enrollment and with the client present. The intake process should be

initiated (e.g., readiness for program assessed, contact information obtained) within *one business day* of the referral's receipt. If time allows, a comprehensive Intake Assessment should be done at that time; if sufficient time is not available, an appointment should be made to complete the intake and assessment within seven (7) business days.

6.2.12 *Preventing Further HIV Transmission in the context of HIV Care:*

6.2.12.1 Condoms and information on licensed needle exchange programs should be available to clients as necessary (e.g., Outreach Specialists conducting safer sex education in the field should carry condoms to freely distribute to clients).

6.2.12.2 A regularly updated list of licensed needle exchange programs in NYC is available through the following link: http://www.nyc.gov/html/doh/downloads/pdf/basas/syringe_exchange.pdf

6.2.12.3 If a client discloses that they have an HIV negative sex and/or needle sharing partner, the Program should inform the client about their options regarding partner notification.

6.2.12.4 Clients are not required to give the name(s) of their partner(s) to their doctor or disclose their HIV status to anyone.

6.2.12.5 Clients interested in receiving help notifying their partner(s) may be referred to:

- NYC DOHMH Contact Notification Assistance Program at (212) 693-1419 or 311 and ask for CNAP
- HIV Epidemiology and Field Services Unit (FSU) at (212) 442 -6577.

6.2.12.6 Please be aware that for clients experiencing intimate partner violence, partner notification may not be an option.

6.2.13 Housing needs assessment:

6.2.13.1 Staff must evaluate all enrollees with regard to their housing status.

6.2.13.2 A quick verification of last recorded address and stability of the housing arrangement takes place at the time of every face-to-face meeting when possible.

6.2.13.3 Clients should be referred to a housing provider to help find a permanent housing placement. If a permanent placement is not possible, transitional housing may be pursued.

6.2.13.4 If the client is living in a SRO, the TCC staff should assess how long the client has been living there and if they have a desire to move to a more permanent living situation. If yes, proceed as above.

6.3 Conducting the Reassessment

6.3.1 The Program will conduct a reassessment and update the Comprehensive Care Plan at least once every 90-120 days. Providers are required to use the eSHARE Reassessment form *(Appendix P)* provided by

DOHMH. Regular assessment of HIV risk behavior is necessary as an individual's social and environmental situations often change. Regular assessment of client eligibility criteria is necessary because clients may experience a change in income, residency, and/or enrollment in a Health Home or other case management program.

6.3.2 If at reassessment a client is found to be enrolled in a Health Home or other case management program, TCC staff should refer to Section 5.2 (Medicaid Health Homes and TCC Dual Enrollment) of the TCC Program Manual 3.0 for guidance regarding dual enrollment. Individuals who are enrolled in a Health Home/comprehensive case management program AND receiving active services are eligible for temporary (up to 6 months or until the end of the 12 month enrollment period) **limited services** through the TCC Program (see 2.7).

7.0 Case Suspension and Closure

7.1 Overview:

7.1.1 Program must develop and maintain a policy/procedure for case suspensions and closures.

7.1.2 Case suspensions and closures should be documented in eSHARE and may be reflected on the Status Change Information Form (Appendix R).

7.2 Case Suspension

7.2.1 Any anticipated or actual absence from the program or community linkages for more than one (1) month should lead to the client's suspension (with the start date being whenever they became inactive, e.g., became incarcerated, moved into in-patient care or could otherwise not be reached for services). Suspension should be done at the time the program learns of the patient's move and/or absence. Enrollment may be suspended in eSHARE and easily resumed/reactivated without re-enrolling.

7.2.1.1 For clients who have not responded to all efforts of outreach by the Program or the community linkages for at least two (2) sequential months without successful contact, the suspension start date begins at the completion of outreach follow-up activities.

7.3 Case Closure

7.3.1 Reason for case closure must be documented in client records, and must correspond with reasons for case closure as structured in eSHARE. In addition, discharge planning and/or outreach to clients lost to follow-up must be implemented and documented when appropriate. Reasons for closure may include:

- Client has accomplished goals of his or her service plan with no new needs identified,
- Client moved/relocated,
- Client requested transfer to another provider,

- Client incarcerated or institutionalized for a certain number of months,
- Client lost to follow up/unsuccessful reengagement efforts for over a period of one, but not to exceed nine months
- Client tested HIV negative and do not demonstrate high risk behaviors (for programs funded to identify or test clients at-risk for HIV)
- Client died

7.3.2 Graduation

7.3.2.1 In order to graduate from the TCC program, clients must complete all requirements set forth in Section 3.14.

7.3.2.2 Client is closed in eSHARE upon completion of the 4-month follow-up on community linkages with care providers.

7.3.3 Voluntary withdrawal or refusal of treatment

7.3.3.1 A client may refuse further service at any time.

7.3.3.2 When clients are not ready for graduation, the Program staff must inquire why the client wishes to terminate services and recommend remaining in the program.

7.3.3.3 If an attempt to encourage continued engagement with the client is not successful, the Program should:

- Notify the HIV PCP of the decision;
- Dis-enroll the client from the TCC program;
- Document the reason for closing the case on the Status Change Information Form (Appendix R);
- Close the enrollment in eSHARE;
- Offer a referral to another program, as appropriate.

7.3.3.4 Lateral transfer – A client may request transfer to another Transitional Care Coordination program. The TCC program transferring the client must:

- Obtain consent for sharing information;
- Prepare a copy of the TCC records;
- Arrange for referral to the new TCC program;
- Send copy of TCC records to the new Program

7.3.4 Client not benefiting from program

7.3.4.1 If the client is not benefiting from enrollment in the Program, not improving, or not adherent with the plan, the Program may dis-enroll the client and refer to a more appropriate program such as drug treatment, residential care or adult day care.

7.3.5 **Lost to follow-up**

7.3.5.1 Lost to follow-up occurs when all efforts have been made and clients have not been located after two (2) sequential months of outreach.

7.3.5.2 At program discretion, the enrollment may be suspended or closed.

7.3.6 **Permanently unable to participate**

7.3.6.1 Close the client in eSHARE if the client is permanently unable to participate. Reasons may include:

- Death;
- Long-term incarceration (>3 months) or commitment to other institution; OR
- Relocation out of area.

8.0 HIV Patient Confidentiality

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

9.0 Quality Management

9.1 Expectations

9.1.1 The Program's parent organization and all affiliate organizations are expected to maintain quality management protocols and conduct quality management programs in accordance with the standards of their accrediting organization.

9.1.2 The Program Director is responsible for developing suitable case review protocols and developing appropriate quality management reports.

9.1.3 As part of HIV quality management, PCP appointment keeping for clients who graduated should be monitored at least once 120 days after graduation.

9.1.4 Transitional Care Coordination Programs funded by Ryan White Part A are required to participate in New York City's Part A quality management program, including required attendance at the quality improvement meetinsg and activities (if applicable)

9.1.5 Quality Management Plans and Work Plans must be revised annually and submitted to the Project Officer (if applicable) by the end of the contract year 1st quarter.

9.1.6 Transitional Care Coordination Programs are required to participate in organizational assessments on a biennial basis.

9.2 Grievances

9.2.1 Each agency must have an established grievance procedure.

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

10.0 Training Requirements

10.1 Staff Orientation

10.1.1 Employee orientation must 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.

10.2 Required Staff Training Topics

10.2.1 All TCC staff funded to provide direct service must participate in on-going (at least annual) training and education regarding:

- New HIV/AIDS Treatments
- Harm Reduction Approach for alcohol and other drug use
- Mental Health Issues Experienced by the HIV+ Client Population (non-mental health and non-medical program staff must be properly trained to recognize and provide referrals)
- Cultural Competency (capacity to be respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of the program's client population)

10.2.2 Questions on whether certain staff trainings meet the description of required training topics described above should be directed to the DOHMH Project Officer.

10.2.3 DOHMH will provide direct Training of Facilitator (TOF) as well as Training of Trainer (TOT) resources for Transitional Care Coordination Programs funded through Ryan White Part A.

10.2.4 DOHMH will provide ongoing eSHARE training for end users and super users, open to all service categories. Program staff can register for trainings directly from the eSHARE website, under the 'Resources' tab.

10.2.5 DOHMH-sponsored programmatic or implementation-related trainings that are specific to the service category (i.e., TCC) are mandatory. The program must allow staff to attend these trainings.

10.3 Other Staff Training

10.3.1 Additional training needs should be identified by regular staff supervision and performance evaluation and provided to TCC staff on an as needed basis. Examples of suitable training topics include: refresher training, client confidentiality, treatment adherence, motivational interviewing, and linkage to care. A list of training resources has been provided *(Appendix G)*.

10.3.2 All staff trainings must be documented in a staff training log that must be available for audit by the NYC DOHMH and/or Public Health Solutions.

11.0 Monitoring TCC Activities by NYC DOHMH

11.1 Data elements for reporting

11.1.1 Client descriptors and socio-demographic characteristics.
11.1.2 Clinical history and current status.
11.1.3 Care plan outcomes (e.g. appointments kept).
11.1.4 Transitional Care Coordination Phases (*Appendix S*),
11.1.5 Funded Transitional Care Coordination providers are responsible for documenting all required data elements (as specified and occasionally adjusted by DOHMH and HRSA) and entering data in eSHARE for all fields required for data entry.

- eSHARE is not an electronic medical record system or a patient charting system; therefore a system for charting patients 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 client record/patient chart.
- Documentation must include the following six (6) required elements:
  - Service date
  - Service start time
  - Worker(s) providing service
  - Site of service delivery
  - Service type(s)
  - Applicable service details

11.1.6 Reporting requirements include maintaining the specified schedules of updates for data elements being tracked historically over time (e.g., quarterly reassessment).

11.2 Technical Assistance

11.2.1 Ryan White Part A service providers are required to participate in technical assistance activities including but not limited to provider meetings, webinars, teleconferences, and site visits as required by DOHMH. Attendance at provider meetings and site visits by Program staff with managerial responsibilities (e.g. Program Director, Program Supervisor) is mandatory.

11.3 Joint Site Visits

11.3.1 DOHMH and Public Health Solutions will conduct joint site visits to each TCC program on an annual basis. DOHMH will conduct a client record review, including an in-depth review of client charts.
11.3.2 DOHMH will meet with key program staff to discuss programmatic performance. Topics covered include, but are not limited to: Quality management (QM plan and QI project); Data review; Targeted Case Finding; Documentation; eSHARE; and Training needs.
11.3.3 DOHMH will incorporate fidelity assessment into the joint site visit in lieu of formal self-assessment and alignment plan activities.

APPENDICES

Appendix A – Definitions

Accompaniment: An activity designed to increase adherence to a client's treatment plan. For example, an Outreach Specialist accompanies the client 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 client hangs out, the client's favorite park, or other set location near his/her home or work). Accompaniment is intended for high-risk people with HIV who struggle with conventional treatment regimens, and the intent is that even in circumstances where the client is ambivalent about following through with the appointment, the Outreach Specialist can reasonably find him or her. The goal is to provide social support (and advocacy if indicated) and help the client connect to medical care, housing and social services in order to improve clients' health outcomes and reduce rates of hospitalization.[9]

Active Services: Defined as a client having received three (3) or more face-to-face services from a Health Home or a comprehensive case management program within the previous three months.

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 care activities between two or more participants (including the client) involved in a client's care to facilitate the appropriate delivery of health care services, as defined by McDonald et al.[10] The opposite of care coordination is fragmentation of care, which is often seen when the relationship between a single practitioner and a client does not extend beyond specific episodes of illness or disease.[11]

Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through

[9] 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: 429-36.
[10] McDonald KM, Sundaram V, Bravata DM, et al. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. (Vol. 7: Care Coordination).* Rockville, MD: Agency for Healthcare Research and Quality; 2007.
[11] Haggerty JL, Reid RJ, Freeman GK, et al. cited in Bodhenheimer T. Coordinating care—A perilous journey through the health care system. *New England Journal of Medicine.*2008; 358(10):1064.

communication and available resources to promote quality cost-effective outcomes, as defined by the Case Management Society of America.[12]

Case Review: An internal process during which the Program Director reviews cases to ensure that the case management and health promotion activities are proceeding appropriately. Program Directors should perform a case review in a summary fashion for every client 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.

Case Conference: An interdisciplinary meeting during which all Transitional Care Coordination team members involved in providing care to the client (e.g., Program Director, Transitional Care Coordinator, Outreach Specialist) participate and contribute to the process of reviewing documentation and developing the care plan for a client. Each client should be discussed at a case conference before transition to a mainstream case management or supportive housing program.

Client Advocacy: The act of speaking on behalf of clients in order to 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 case management activities in an effort to build upon cooperation and collaboration among providers.

Comprehensive Care Plan: A written plan developed by the client's Transitional Care Coordination team in order to achieve the client's goals. This plan focuses on a few key areas, including housing stability, coordination of care, and health promotion activities. The care plan identifies action steps, responsible parties, and targeted dates for each planned activity to ensure care plan adherence. TCC program staff completing the care plan should check for understanding/agreement and obtain the client's signature.

Comprehensive Care Plan Update: Once the initial care plan is developed, the Transitional Care Coordination team should continue to monitor the client's progress toward their goals. At a minimum, care plans should be updated every 90-120 days and ideally coincide with a client's movement to the next TCC Phase. Clients should also be reassessed upon re-opening/re-enrollment in order to determine their TCC Phase and identify any new needs/goals.

Critical Time Intervention: CTI is an empirically supported case management model originally designed to prevent homelessness in people with severe mental illness during the period following discharge from hospitals, shelters, prisons, and other institutions[13]. CTI experts worked in partnership with NYC DOHMH to develop TCC for people with HIV who are homeless or unstably housed

[12] What is a Case Manager? page. Case Management Society of America Web Site. http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx. Accessed January 10, 2014.
[13] Critical Time Intervention Web Site. www.criticaltime.org. Accessed January 17, 2014.

Cultural Competency: Attitudes, behavior and policies of service providers which can accommodate language, values, beliefs, and behavioral differences of the individuals they serve in a cross-cultural setting.[14]

Harm Reduction: A set of practical and realistic strategies that targets reducing the negative consequences of problematic behaviors, incorporating a spectrum of strategies which meets clients "where they're at", addressing the context in which the behavior is embedded rather than the behavior itself.[15]

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."[16]

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."[17] Health promotion ideally employs motivational interviewing and harm reduction techniques for activities such as medication adherence support, coaching and health education. The level of health promotion interventions will vary according to the client's intensity of needs.

Homeless: The term "homeless" is used to define individuals who: lack a regular and/or adequate nighttime residence; have a primary nighttime residence that is a public or private shelter or dwelling designed to provide temporary living accommodations, including SROs; live in an institution that provides temporary residence for individuals intended to be institutionalized; or live in a public or private place not intended or ordinarily used as a regular sleeping accommodation for human beings.

Interdisciplinary Team: A team that includes professionals representing the disciplines required for a comprehensive approach to meeting the needs of the client. At a minimum, in the first two Phases, the team consists of the Transitional Care Coordinator and Outreach Specialist. However, the clinical provider and housing coordinator may also be included if applicable. By Phase 3, the team should include the case manager and all other relevant formal linkages in the community.

---

[14] U.S. Department of Health and Human Services. Setting the agenda for research on cultural competence in health care: Final report, 2004. http://www.ahrq.gov/research/findings/factsheets/literacy/cultural/cultural.pdf. Accessed January 17, 2014.
[15] Adapted from the Harm Reduction Coalition Web Site. http://harmreduction.org/. Accessed January 17, 2014.
[16] Ratzan SC, Parker RM. Health Literacy Introduction. United States National Library of Medicine Web site. http://www.nlm.nih.gov/archive/20061214/pubs/cbm/hliteracy.html Accessed January 17, 2014.
[17] Health People 2010 Information Access Project. *Health Communication*. Office of Disease Prevention and Health Promotion. http://www.healthypeople.gov/document/html/volume1/11healthcom.htm#_Toc490471359. Accessed December 9, 2008.

Limited Services: Defined as services that are not provided by a Health Home/comprehensive case management program and/or are essential to client's successful transition, including: Health Promotion (a.k.a. HIV Self-Management Support); Linkage to Housing Services; Comprehensive Care Plan and Reassessment & Updates; Coordination with Service Providers; and Post-transfer follow-up.

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

Medical Case Management: The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB)[18] defines medical case management[19] as "a range of client-centered services that link clients 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 clients' 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 assessment of service needs; (2) development of comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes all types of case management, including face-to-face meetings, phone contact, and any other forms of communication."

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

Medication Adherence: Adherence to the recommended treatment regimen by taking all prescribed medications. 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.

Motivational Interviewing: Motivational interviewing (MI) is a counseling style that is collaborative and person-centered. The goal of MI is to help clients explore and resolve ambivalence in order to change unhealthy or problematic health behaviors regarding their HIV care and treatment. Practitioners are careful to avoid arguments and confrontation with clients, which tend to decrease their motivation for change and increase their defensiveness and resistance.

[18] Refer to http://hab.hrsa.gov/publications/november2008/November08.pdf Accessed December 8, 2008.
[19] The Ryan White HIV/AIDS Treatment Modernization Act (HATMA) of 2006 changed to include medical case management as a core service.

Navigation Model: The navigation model aims to advocate for, communicate with, and identify resources for the client, thereby coordinating the complex health care and social services necessary to ensure improved client outcomes. TCC program staff generally focuses on empowering the individual requiring services, rather than attempting to change the health care system as a whole. The model also includes active discussion and education, empowerment and encouragement.

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

Primary Care Provider: The primary medical provider (physician, nurse practitioner, physician assistant) responsible for the client's comprehensive HIV medical treatment.

Supportive Housing: Supportive Housing is defined as affordable scattered-site or congregate housing with the provision of comprehensive supportive services to eligible persons who face multiple barriers in their ability to maintain housing stability. Supportive housing is classified as either permanent or temporary. Permanent housing is intended to be long-term and continued occupancy is expected. Temporary housing is intended to be short-term and no longer than two years.

TCC Phase 0: Outreach: This pre-program phase focuses on targeted case finding and referral to and coordination of HIV testing. Once clients are engaged, confirmed HIV-positive, and referred to the program, they will move to Phase 1.

TCC Phase 1: Transition (Months 1-3): The purpose of this Phase is to provide intensive support and assess the client's resources that exist for the eventual transition of care to both formal and informal supports in the client's community/network. Development of a housing plan should begin in this phase as clients must be connected to a housing placement provider in order to graduate from the TCC program. Linkage to a primary care provider should be prioritized for clients who are not connected to care.

TCC Phase 2: Try-Out (Months 4-6): This Phase is devoted to testing and adjusting the systems of support that were developed in Phase 1. Contact and introductions should be made with a Ryan White Part A medical case management program or other case management program (depending on client's needs) to begin discussion of the client's transition and to introduce the client to the selected provider(s).

TCC Phase 3: Graduation and Transfer of Care (Months 7-9): Phase 3 focuses on completing the transfer of care to a medical provider, housing program, and case management or supportive housing program. This Phase may be repeated if any portion is not successfully completed by the client.

TCC Phase 4: Follow-up (Month 12): The final phase involves a follow-up with the client and/or case manager during the third month after the transition takes place to confirm the continued linkage.. Clients who have fallen out of care can re-enter the program at Phase 2 or 3 upon reassessment and completion of an updated care plan.

Unstably Housed: Expands on the definition of “homeless” (see above) to also include individuals who frequently move between housing situations, individuals who are facing eviction, and/or individuals who are temporarily living with family or friends.

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

Appendix B – Access-A-Ride

The MTA New York City Access-A-Ride (AAR) program provides transportation for persons with disability 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 Transitional Care Coordination Program would be to assist people with HIV 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 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 C – 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 client 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 service provider providing child care to children of clients receiving medical case management services at the same premises. The medical or social service 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 client is receiving medical case management services at a medical provider, the funded program can provide daycare services at the client's home while the client 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.

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 D – Benefits Programs Listed through AccessNYC

https://www.nyc.gov/accessnyc

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 Economic Empowerment and Sustainability (REES)
- 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)
- School Meals
- Summer Meals
- Supplemental Nutrition Assistance Program (SNAP)
- Women, Infants and Children (WIC)

Health Care Services

- Nurse-Family Partnership (for first time pregnant women)

Health Insurance Programs

- Family Planning Benefit Program (FPBP)
- Health Insurance assistance
- Prenatal Care Services through 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

Appendix E – List of Housing Placement Resources in NYC

Organization	**NYC DOHMH – Housing Opportunities for People Living with AIDS (HOPWA)**
Website	http://www.nyc.gov/html/doh/downloads/pdf/ah/ah-hiv-care-hopwa.pdf
Phone	N/A
Address	N/A
Notes	Find information on HOPWA-funded agencies.
Organization	**NYC HIV/AIDS Services Administration (HASA)**
Website	http://www.nyc.gov/html/hra/html/services/hasa.shtml
Phone	212.971.0626
Address	400 Eight Avenue, 2nd Floor New York, NY 10001
Notes	Find information on HASA services by following the *HASA Services* link.
Organization	**NYC DOHMH Division of Mental Health (DMH) – Office of Housing Services**
Website	http://www.nyc.gov/html/doh/html/mental/housing-services.shtml
Phone	N/A
Address	N/A
Notes	Find information on supportive housing units for people living with mental illness by following the link to more information on NY/NY I&II.
Organization	**Center for Urban Community Services (CUCS)**
Website	www.cucs.org
Phone	212.801.3300
Address	198 E. 121st Street New York NY 10035
Notes	From the home page visit the following links: *Services* and *Housing*, for housing information. CUCS also posts a Housing Vacancy Update that you can subscribe to via e-mail.
Organization	**NYC Department of Homeless Services (DHS)**
Website	http://www.nyc.gov/html/dhs/downloads/pdf/intake_drop_in_centers.pdf
Phone	212.361.8000
Address	N/A
Notes	Find information on DHS' intake centers and drop-in centers.

Appendix F – Recommended Staffing Plan

The following table provides recommendations for staffing TCC programs. Please note that the staff titles/positions, functions, and credentials are recommendations from NYC DOHMH. The staffing plan submitted by each applicant will be evaluated based on the proposed program. Funded organizations must ensure that programs are adequately and appropriately staffed.

Recommended Staff Title	Function	Recommended Minimum Credentials
Program Director	• Has overall responsibility for operations of the TCC program. • Recruits, hires, and supervises all key personnel; supervises the Transitional Care Coordinators directly and Outreach Specialists indirectly. • Reviews all Program enrollments and case disposition actions. • Oversees all monitoring, reporting and quality management activities of the program. • Ensures coordination of resources and logistics for staff training. • Coordinates TCC program activities with participating organizations and oversees the generation of all relevant agency-specific protocols. • Produces summary reports of program activities. Acts as a liaison between the program and NYC DOHMH.	• 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' experience managing services similar to those described in RFP
Transitional Care Coordinator	• Enrolls the client into the program and verifies eligibility. • Performs the Intake and Assessment, including the initial social services, logistical, benefits, and other supplemental assessments. • Coordinates with formal/informal supports and develops the Comprehensive Care Plan. • Oversees the implementation of the care plan with the support of the Outreach Specialist. • Provides health promotion activities, as needed. • Provides back-up to Outreach Specialists, as needed. • Collects the Weekly Case Review Form (Appendix U) and meets with the TCC team to review all clients on the Outreach Specialists' caseload. • Weekly case conferences with the TCC team will focus on 1-4 clients using the Case Conference Client Summary Form (Appendix V) provided. • Conducts monthly reviews of Outreach Specialists. Reviews include face-to-face assessment of staff competency and chart-based review. • Supervises up to 3 Outreach Specialists (or between 30 – 54 clients).	• BA/BS, LMSW/LCSW/ LMHC or RN/LPN degree • AND at least 2+ years of case management experience. • Should have strong socio-cultural identification with the target population or experience with homeless population or provision of housing services.

Outreach Specialist	• Provides health promotion and skills building services to clients. • Accompanies clients to primary care appointments and to other health care and social service encounters, as warranted. • Implements ongoing navigation and logistical support for appointment keeping reminders, transportation, interpretation and childcare arrangements. • Assists the Transitional Care Coordinator in conducting social services and benefits reassessment and follow-ups. • Provides critical input, in regards to client care, to other informal and formal supports based on his/her observations in the field. • Educates, coaches and empowers clients. The suggested caseload for each Outreach Specialist is between 15 – 18 clients.	• High school diploma or GED. • Should have strong socio-cultural identification with the target population or experience with homeless population or provision of housing services. • To protect client confidentiality, the hiring of actively enrolled clients from the program or partner medical facility is strongly discouraged.
Clinical Supervisor	• Provides professional and clinically-oriented supervision to the direct services staff	• MSW, LMSW, LCSW

Note on Data Management Staffing: Data reporting and evaluation is a key component of successful program implementation. As such, the NYC DOHMH has included data management support in the overall reimbursement rate. The NYC DOHMH strongly encourages programs to include data management as a funded personnel line. Non-service staff will be allowed in program budgets.

Staff Supervision

Best Practices:

1. Clinical supervision sessions are conducted for all staff who provide services to clients and can be done both individually and/or in group format. Individual sessions in addition to group sessions are not required but are best practice. Expectations for frequency and length of sessions are as follows:

    - scheduled at least two times a month
    - minimum of 60-120 total minutes per month

2. Mental health clinicians who are Transitional Care Coordinators are provided with their own supervision as required by their appropriate licensing requirements.

3. There will be separate programmatic supervision sessions scheduled to cover programmatic topics.

4. The clinical supervisor and programmatic supervisor will meet monthly to collaborate and support each other's supervision of the team.

5. Create and disseminate an internal template for clinical supervision sessions to assist in planning and recording meetings.

6. Each of the clinical supervisors needs to be oriented by program staff to the program manual and intervention design of the TCC program upon hire and on an annual basis.

7. Create and disseminate a portfolio of training resources, including sample outlines, a list of agencies that offer free or low cost trainings, and training materials.

Appendix G – Agencies that Provide Training

NYC DOHMH Training and Technical Assistance Program	The HIV Training Institute, through the New York City Department of Health and Mental Hygiene, conducts professional educational training to staff and volunteers of hospitals, clinics and community based organizations that provide HIV counseling, test, prevention and care services. – **Sample Trainings:** Fundamentals of HIV Prevention Counseling; Enhanced Outreach; Motivational Interviewing; Working with Clients Living with HIV/AIDS and Co-Occuring Mental Health Disorders; HIV Testing Modules; various trainings related to the CDC DEBIs – **Fees:** Free – **Contact:** TTAP@health.nyc.gov – **Website:** http://www.cvent.com/d/7cq6hp
New York State Department of Health AIDS Institute	HIV Education and Training Programs are responsible for coordinating training and information dissemination efforts to support the ongoing effectiveness of non-physician health and human services providers involved in the field of HIV/AIDS. **Sample Trainings:** Positive Prevention: Connecting Care and Prevention; Working with Older Adults Living with HIV/AIDS; Intro to Co-Occurring Disorders for Clients with HIV/AIDS; Supporting Sexual Health Among Young MSM of Color; Active Drug Users and HIV/HCV Retention in Care and Treatment Adherence – **Fees:** Free – **Contact:** hivet@health.state.ny.us or (518) 474-3045 – **Website:** http://www.hivtrainingny.org/ –
AIDS Education and Training Centers of New York and New Jersey	The AIDS Education and Training Centers of New York and New Jersey offers training to physicians, nurses, physician assistants, and other professionals. The goal of the organization is to train and educate health care professionals in the New York City Area. The program offers five levels of training: didactic presentations, skills building, clinical training, clinical guidance, and technical assistance. – **Sample Trainings:** Clinical Research and HIV: Working with Consumers; Exploring Cross-Cultural Communication; Treating Adolescents with HIV – **Fees:** Free – **Contact:** (212) 304-5530 – **Website:** http://www.nynjaetc.org/training.html
AIDS Community Research Initiative of America	The HIV Health Literacy Program (HHLP) offers staff training to a range of AIDS-serving organizations and community-based organizations throughout New York City and State. Technical assistance and capacity building equip groups to integrate HIV healthcare and treatment education information into the services they provide their own HIV-positive and at-risk clients. – **Sample Trainings:** HIV health literacy workshops, The Role of the Non-Medical Provider in Health Literacy & Counseling; Presentation Skills: Engaging the Client; Confidentiality & Boundary Issues; Adherence Strategies; Treatment Issues for Women

	– **Fees:** Free – **Contact:** info@acria.org or (212) 924-3934 – **Website:** http://www.acria.org/programs_and_services
The Harm Reduction Coalition	Provides trainings dedicated solely to harm reduction topics including harm reduction philosophy, training harm reduction leaders, and create awareness of the rights of drug users. – **Sample Trainings:** Recognizing and Preventing Burnout, Working with Transgender Clients in a Harm Reduction Model, Women and HIV, Overdose Prevention, LGBT Friendly Therapy, and Counseling Skills for Harm Reduction Counselors – **Fees:** Varies ($0 - $70) – **Contact:** Must sign up online; see link below – **Website:** http://support.harmreduction.org/site/PageServer?pagename=calendar
Cicatelli Associates	In conjunction with the New York State AIDS Institute and the CDC, Cicatelli offers a plethora of trainings and programs related to HIV/AIDS, including psychosocial training programs suited for mental health providers. – **Sample Trainings:** Interdisciplinary Case Conferencing, Developing Skills for Enhanced Outreach, Enhancing the Partnership between Client and Case Manager, Sexuality, Gender and HIV, and Promoting Adherence to HIV Treatment – **Fees:** Free – **Contact:** technicalassistance@cicatelli.org, or (212) 594-7741 – **Website:** http://www.cicatelli.org
National Development and Research Institutes (NDRI)	Provide training and development for staff working in substance abuse, HIV/AIDS, mental health and related fields. Specialize in training providers who service traditionally hard-to-reach and vulnerable populations. – **Sample Trainings:** HIV Testing: Skills Practice Session, Introduction to Case Management, HIV Disclosure, Cultural Competency, HIV/AIDS Confidentiality Law, Domestic Violence, Domestic Violence in Lesbian, Gay, Bisexual and Transgendered Communities, and Methamphetamines and MSMs – **Fees:** Free – **Contact:** (212) 845- 4550 – **Website:** http://training.ndri.org/
University of Rochester Medical Center	Offers training to health and human services providers for staff of community based organizations, social workers, health educators, outreach workers, counselors, and other health care professionals. – **Sample Trainings:** ABCs of Hepatitis and HIV Infection, Adapting Evidence-based Behavioral Interventions, Behavioral Interventions for Special Populations: Incarcerated Women and Adolescents, Developing Skills for Enhanced Outreach - Part I and II, Improving Health Outcomes for HIV+ Individuals Transitioning form Correctional Settings to the Community – **Fees:** Free – **Contact:** chbt@monroecounty.gov or (585) 753-5382 – **Website:** http://www.urmc.rochester.edu/CHBT/courses.htm

Appendix H – Anonymous Event Services Form

ANONYMOUS EVENT SERVICES FORM
(TCC, OHY, EIS, & JTI)

Program Staff: For a small event (≤ 20 participants), you may circle race, ethnicity, gender, age group, and referral status for each person and tally at the bottom. However, tracking for individuals is optional. Required fields appear in the top section with bolded border and (for Ryan White only) in the bottom row of sub-totals with bolded border.

DATE (MM/DD/YYYY):	**START TIME: __ __ : __ __ am/pm** *Optional for JTI*	**END TIME: __ __ : __ __ am/pm** *Optional for JTI*
WORKER(S) PROVIDING SERVICE (STAFF MEMBERS AT EVENT): *Optional for JTI*		
SITE OF SERVICE (LOCATION): ❑ Program site (*Specify:* _____) ❑ Client home ❑ Other field site (*Specify:* _____) ❑ Phone		
BRIEF DESCRIPTION (NOTES): *Optional for Ryan White*		
TOTAL INDIVIDUALS CONTACTED: _____		

#	Race						Ethnicity		Gender			Age Group						Program Referral	
1	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
2	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
3	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
4	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
5	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
6	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
7	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
8	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
9	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
10	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
11	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
12	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
13	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
14	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
15	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
16	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
17	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
18	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
19	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
20	B	W	AS	NA	PI	O	H	NH	M	F	T	<12	13-18	19-24	25-34	35-44	45+	Yes	No
Sub-totals	**B___**	**W___**	**AS___**	**NA ___**	**PI ___**	**O___**	**H ___**	**NH ___**	**M___**	**F___**	**T___**	**<12___**	**13-18___**	**19-24___**	**25-34___**	**35-44___**	**45+___**	**Y___**	**N___**

Race: B – Black/African American; **W** – White; **AS** – Asian; **NA** – American Indian/Alaskan Native; **PI** – Native Hawaiian/Pacific Islander; **O** – Other
Ethnicity: H – Hispanic; **NH** – Non-Hispanic
Gender: M – Male; **F** – Female; **T** – Transgender
Age Group: Age in years

Appendix I – Common Demographics

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 J – Intake Assessment

INTAKE ASSESSMENT
(MCM, TCC, PRS, TSC)

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=PRS; 4=TSC

I. Clinical Information
Chart Review or Client Interview

ALL **Date of first known visit to this agency for any service:** _____/_____/_____ (mm/dd/yyyy)

1 **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 ❑ Other (Specify_____) ❑ Unknown

ALL *- except optional for NYC-MCM*
Do you currently have a Primary Care Physician (PCP) / HIV primary care provider?
❑ Yes ❑ No

3 4 **If you needed medical care in the community tomorrow, would you go back to the same primary care provider you were seeing before your most recent time here (at Rikers)?**
❑ Yes ❑ No ❑ Don't Know

3 4 *If No,* **Why would you not go back to that same primary care provider in the community?**

❑ Location/transportation – not convenient
❑ Location/proximity – too close to stuff that got me here
❑ Insurance – changed or is not accepted
❑ Scheduling difficulties
❑ Wait time – too long
❑ Staff – treated poorly
❑ Rush – too little time with provider
❑ Trust/privacy –could not trust Dr. with my info
❑ Sensitivity/concern – provider had lack of concern
❑ Care – disagreed about best care
❑ Comfort – not comfortable asking questions
❑ Language – language barrier
❑ Listening – provider did not listen to me
❑ Competence – did not feel in the best of hands
❑ Being seen – fear of being seen/recognized
❑ Setting – clinic was: noisy, messy, or unpleasant
❑ No reason
❑ Nothing in particular
❑ Other (Specify: _____)

ALL **Last PCP visit *prior* to enrollment:** _____/_____/_____ (mm/dd/yyyy) OR ❑ Unknown ❑ N/A

1-NYC-MCM only **Initial/referral visit with PCP within this program:** _____/_____/_____ (mm/dd/yyyy)

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC; 3=PRS; 4=TSC

Client Name: _____

Most recent CD4 counts and Viral Load measures from on or before the program enrollment date:
(Start with the most recent)

1 2 3 4 **CD4 Records**	*If none are available, check box at right:* ❑ No CD4 count on record	
CD4 count	**CD4 %** *(optional)*	**Date (mm/dd/yyyy)**

1 2 3 4 **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	

1 2 3 4 **Hospitalizations and 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"*				

1 2 3 4 **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
- ❑ Kidney disease
- ❑ Hepatitis C
- ❑ Tuberculosis (TB)
- ❑ Other (Specify: _____)

1 2 3 4 **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: _____)

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC

Client Name: _____

1 2 3 4 **Pregnant:** ❑ Yes ❑ No ❑ Unknown ❑ N/A (male) *If No, Unknown or N/A, go to Section II.*

1 2 3 4 *If Yes,* **Date of report of client's pregnancy to program:** _____/_____/_____ (mm/dd/yyyy)

1 2 3 4 **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)

1 2 3 4 *If Yes,* **When was client enrolled in prenatal care:**

❑ First trimester ❑ Second trimester ❑ Third trimester

❑ At time of delivery ❑ N/A ❑ Unknown

1 2 3 4 **Estimated Due Date:** _____/_____/_____

OR select one of the following: ❑ N/A ❑ Unknown

1 2 3 4 **Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?**

❑ Yes ❑ No ❑ N/A ❑ Unknown

II. Antiretroviral Treatment (ART) Review

Chart Review or Client Interview

1 2 3 4 **Is client currently prescribed ART?**

❑ Yes *If Yes, Complete regimen detail below.* ❑ No *Skip this table.*

1 2 3 4 **HIV medication names**	1 2 3 4 **Dosage**		1 2 3 4 **# Doses**	1 2 3 4 **Frequency**	1 2 3 4 **Date Started (mm/yyyy)**
	# per Dose	**Dose Unit (pills, ccs, mls)**			
1.				❑ Daily ❑ Weekly	_____/_____
2.				❑ Daily ❑ Weekly	_____/_____
3.				❑ Daily ❑ Weekly	_____/_____
4.				❑ Daily ❑ Weekly	_____/_____

1 2 3 4 *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

Legend:

1 *= Required; 1= Optional*

Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC

Client Name: _____

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 below. Otherwise, skip to Section V.)*

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, HIS, Tricare		_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A
❑ Other public insurance		_____/_____/_____	_____/_____/_____ ❑ Unknown ❑ N/A

V. Financial Information ALL — *Client Interview*

What is your annual household income? $_____ per year

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC

Client Name: _____

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 *1 2 3 4* *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, then 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	___ times (units) weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Declined (no answer)
Alcohol	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times (units) weekly *or* ❑ < weekly ❑ Declined	
Marijuana	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Declined (no answer)
PCP/Hallucinogens	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Crystal Meth	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Cocaine/Crack	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Heroin	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Rx Pills to get high	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Hormones/steroids	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Patch ❑ Injected ❑ Declined (no answer)
Anything else: _____	❑ Yes ❑ No ❑ Declined	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled ❑ Injected ❑ Declined (no answer)

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC

Client Name: _____

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)

1 2 3 4 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

1 2 3 4 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

1 2 3 4 **Have you ever shared needles or injection equipment with others?**
❑ Yes ❑ No ❑ Declined

1 2 3 4 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 *1 2 3 4* — *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=PRS; 4=TSC

Client Name: _____

VIII. General Health and Well-Being 1 2 3 4 *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
❑	❑	❑	❑	❑

SF-12v2™ Health Survey © 1994, 2002 by QualityMetric Incorporated and Medical Outcomes Trust. All Rights Reserved.
SF-12® a registered trademark of Medical Outcomes Trust.
(SF12v2 Standard, US Version 2.0)

Client Name: _____

IX. Disability Status [ALL] *Client Interview*

Are you deaf or do you have serious difficulty hearing? ❑ Yes ❑ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)? ❑ Yes ❑ No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ❑ Yes ❑ No

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

Do you have difficulty dressing or bathing? ❑ Yes ❑ No

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

OR ❑ **Client's age is less than 15 years old**

X. Living Arrangement/Housing Information *Client Interview*

[1] [2] 3 4 **Are you currently enrolled in a housing assistance program?** ❑ Yes ❑ No ❑ Declined

[1] [2] 3 4 *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

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=PRS; 4=TSC

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)

ALL *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 1 2 — *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 1 2 3 4 — *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=PRS; 4=TSC

Client Name: _____

1-NYC-MCM only ***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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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=PRS; 4=TSC

Appendix K – TCC Comprehensive Care Plan

Transitional Care Coordination Care Plan

Date Created: ____/____/________

Current TCC-CTI Phase: ________ **Phase Transition Date: ____/____/______**

Client Name: ____ **Client Record #:** ______________________________

TCC Staff: Please complete or update this form along with the client's Reassessment and transition to the next TCC-CTI Phase. As new issues arise, please identify them and list action steps starting in Section 3.

Section 1: TCC-CTI Focus Areas

1a: Specific Housing Goal: ____ **Date Resolved:** ____/____/_____

Reason: ____

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	❑ HASA ❑ TCC ❑ OS ❑ Client ❑ Other: _________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ HASA ❑ TCC ❑ OS ❑ Client ❑ Other: _________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ HASA ❑ TCC ❑ OS ❑ Client ❑ Other: _________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ HASA ❑ TCC ❑ OS ❑ Client ❑ Other: _________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____

1b: Specific Primary Care Provider Goal: ____ **Date Resolved:** ____/____/_____

Reason: ____

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	❑ PCP ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ PCP ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ PCP ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ PCP ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____

Client Name: ______________________________________

1c: Specific Care Coordination Goal: ____ **Date Resolved:** ____/____/_____

Reason: ____

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	❑ CM ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ CM ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ CM ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ CM ❑ TCC ❑ OS ❑ Client ❑ Other: __________		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____

Section 2: Health Promotion Conversations

2a. Conversations to be Covered	Target Date	Completion Date:
Please list topics to be completed before next plan update		
Conversation A: Me & HIV		
Conversation B: What is HIV?		
Conversation C: What is AIDS?		
Conversation D: How is HIV transmitted?		
Conversation E: How is HIV prevented?		
Conversation F: Substance Use, HIV Transmission & Harm Reduction		
Conversation G: Harm Reduction Plan (discretionary)		
Conversation H: Introduction to Health Maintenance		
Conversation I: Medical Appointments & Adherence		
Conversation J: Why is Adherence to ART Important?		
Conversation K: Understanding Social Support		
Conversation L: Disclosure and Networks of Social Support		

Client Name: _____

SECTION 3: OTHER ISSUES IDENTIFIED

In this section, please identify other (and new/emerging) issues or goals and the steps taken to address them.

3a. OTHER GOAL 1: _____ **DATE RESOLVED:** ____/____/_____

REASON: _____

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____

3b. OTHER GOAL 2: _____ **DATE RESOLVED:** ____/____/_____

REASON: _____

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____

3c. OTHER GOAL 3: _____ **DATE RESOLVED:** ____/____/_____

REASON: _____

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____
	❑ TCC ❑ OS ❑ Client ❑ Other: _____		Completed?: ❑ Yes ❑ No ❑ N/A or Other Notes:	____/____/_____

Client Name: _____

Notes: _____

Client:	_____ Signature	**Date:**	___/___/___ m m / d d / y y
Program Staff:	_____ Name _____ Signature	**Date:**	___/___/___ m m / d d / y y

Appendix L – Support Contacts and Client Locator Form

TCC SUPPORT CONTACT INFORMATION FORM

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

TCC staff: This form is to be used for the purposes of identifying support contacts. ***Do not reveal client health, program, or HIV status information to any support contact listed below unless you have the explicit consent of the client.***		
Refer to Common Demographics for client contact information		
Current Home Address:		
Street:	**Apartment/Unit:**	
City:	**State:**	**Home ZIP Code:**
Home Visit Location:	❑ Same as Current Home Address	
Street:	**Apartment/Unit:**	
City:	**State:**	**ZIP code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		

SUPPORT CONTACTS *Read to Patient:*

One of the goals of this program is to help you connect with existing or forge new supports in the community. Is there someone close to you that you would like to have actively involved in your care? That person can be a family member, friend, other service provider, clergy, etc. If you can't think of anyone now, is there someone that you know that you would like to have involved in your care at some point in the future? When we reach out to this person, we will not reveal any information about your health unless we have permission from you.

Contact 1 Name:	**Relationship:**	
Street or Intersection:		
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		
Client's consent obtained to involve contact?	❑ Yes ❑ No	
Aware of client's HIV Status	❑ Yes ❑ No	
Agreed to be involved in client's care?	❑ Yes ❑ No	

Contact 2 Name:	**Relationship:**	
Street or Intersection:		
City:	**State:**	**ZIP Code:**
Primary telephone number:	(_____) _____ -_____	
Alternate telephone number:	(_____) _____ -_____	
Primary E-mail:		
Client's consent obtained to involve contact?	❑ Yes ❑ No	
Aware of client's HIV Status	❑ Yes ❑ No	
Agreed to be involved in client's care?	❑ Yes ❑ No	

Appendix M – Services Tracking Log

SERVICES TRACKING LOG
(MCM/TCC/PRS/TSC)

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 and Transportation, 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 (1=MCM-NYC only); 2=TCC, 3=PRS; 4=TSC*

Service Date (mm/dd/yyyy)	Service Start Time/End Time	Worker(s) Providing	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: _____) *PRS only: If Discharge plan,* **Was a referral given?** ❑ Yes ❑ No *(Optional) If Yes,* **Referral/Appointment Tracking form date:** __/__/____ OR ❑ No Match
____/____/_____ 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) Providing	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 ❑ Court Advocacy ❑ 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 3 4*	*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 ❑ Court Advocacy ❑ 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 3 4*	*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 ❑ Court Advocacy ❑ 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 3 4*	*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 ❑ Court Advocacy ❑ 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 for MCM & TCC (Select all that apply)* ❑ 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) Providing	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	❑ **Coordination with service providers** *2 3 4*	**Service providers involved:** *(Select only one)* ❑ Primary care ❑ Other healthcare services ❑ Social services ❑ HASA	**Coordination activity:** *(Select only one)* ❑ Case conference ❑ Appointment making ❑ Verification ❑ Other (Specify:_____)
____/____/_____ 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** *1 2*	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	❑ **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	❑ **Case finding** *1*	*(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*	*(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	❑ **DOT** *1**	**Dose directly observed?** ❑ Yes ❑ No	
____/____/_____ 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	

Service Date (mm/dd/yyyy)	Service Start Time/End Time	Worker(s) Providing	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	❑ **Crisis intervention** *4*	**Detail on crisis type/need:** *(Select all that apply)* ❑ Food ❑ Shelter ❑ Clothing ❑ Safety		
____/____/_____ Travel Time: ___ ___ : ___ ___ (hours) (minutes)	**Start time:** __ __ : __ __ am/pm End time: __ __ : __ __ am/pm		❑ Program site (Specify: _____) ❑ Client home ❑ Other field site (Specify: _____) ❑ Phone	❑ **Transportation** *4*	**Transportation to:** *(Select only one)* ❑ Medical ❑ Jail ❑ Prison ❑ Home ❑ Housing Program ❑ Employment Office/Program ❑ Substance Use Treatment Program ❑ Mental Health Treatment Program ❑ Entitlement Office ❑ Case Management Program ❑ Dental ❑ Pharmacy ❑ Food Service Provision ❑ Legal Services	**Transportation from:** *Optional (Select only one)* ❑ Medical ❑ Jail ❑ Prison ❑ Home ❑ Housing Program ❑ Employment Office/Program ❑ Substance Use Treatment Program ❑ Mental Health Treatment Program ❑ Entitlement Office ❑ Case Management Program ❑ Dental ❑ Pharmacy ❑ Food Service Provision ❑ Legal Services	**Type of transportation:** *Optional* *(Select only one)* ❑ Paid ride ❑ Token/Ticket

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Program Staff Completing Form: _____ Name _____ Signature **Date Completed:** ___/___/___ m m / d d / y y

Appendix N – Health Promotion Curriculum Coverage Log

TCC HEALTH PROMOTION CURRICULUM COVERAGE LOG

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

Complete the Curriculum Coverage Log whenever a conversation is discussed with the patient. Write in the dates of the visits that included curriculum material, for each conversation. When a conversation 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) 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.

CONVERSATIONS	DATE STARTED (mm/dd/yy)	DATE(S) CONTINUED (mm/dd/yy)	DATE COMPLETED (mm/dd/yy)	NOTES (challenges, needs, order changes, or next steps)
Conversation A: Me & HIV (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation B: What is HIV? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation C: What is AIDS? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation D: How is HIV Transmitted? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation E: How is HIV Prevented? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation F: Substance Use, HIV Transmission & Harm Reduction (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation G: Harm Reduction Plan (Discretionary)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation H: Introduction to Health Maintenance (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	

CONVERSATIONS	**DATE STARTED (mm/dd/yy)**	**DATE(S) CONTINUED (mm/dd/yy)**	**DATE COMPLETED (mm/dd/yy)**	**NOTES (challenges, needs, order changes, or next steps)**
Conversation I: Medical Appointments & Adherence (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation J: Why is Adherence to ART Important? (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation K: Understanding Social Support (Core)	___ / ___ / ___	___ / ___ / ___ ___ / ___ / ___	___ / ___ / ___	
Conversation L: Disclosure and Networks of Social Support (Core)	___ / ___ / ___	___ / ___ / ___ / /	___ / ___ / ___	

Staff Member Completing Form:	Name	Signature	**Date:**	/ / m m / d d / y y

Appendix O – 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:** ____/____/____ (m m / d d / y y)

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:** ____/____/____ (mm/dd/yy)

Appendix P – Reassessment

REASSESSMENT
(MCM, TCC, PRS, TSC)

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=PRS; 4=TSC

I. Clinical Information

Chart Review or Client Interview

1 2 3 4 **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"*				

1 2 3 4 **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
- ❑ Kidney disease
- ❑ Hepatitis C
- ❑ Tuberculosis (TB)
- ❑ Other (Specify: _____)

1 2 3 4 **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=PRS; 4=TSC

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: _____)

1 2 3 4 **Pregnant:** ❑ Yes ❑ No ❑ Unknown ❑ N/A (male) *If No, Unknown or N/A, go to Section II.*

1 2 3 4 If Yes, **Date of report of client's pregnancy to program:** _____/_____/_____ (mm/dd/yyyy)

1 2 3 4 **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)

1 2 3 4 If Yes, **When was client enrolled in prenatal care:**

❑ First trimester ❑ Second trimester ❑ Third trimester

❑ At time of delivery ❑ N/A ❑ Unknown

1 2 3 4 **Estimated Due Date:** _____/_____/_____

OR select one of the following: ❑ N/A ❑ Unknown

1 2 3 4 **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

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC

Client Name: _____

Insurance Type	Insurance details	Effective Date (mm/dd/yyyy)	End/Expiration Date (mm/dd/yyyy)
❑ 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, HIS, Tricare		_____/_____/_____	_____/_____/_____ ❑ 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 *1 2 3 4* — *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	___ times (units) weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Declined (no answer)
Alcohol	❑ Yes ❑ No ❑ Declined	___ times (units) weekly *or* ❑ < weekly ❑ Declined	
Marijuana	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Declined (no answer)
PCP/Hallucinogens	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC

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 ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Cocaine/Crack	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Heroin	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Rx Pills to get high	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Inhaled/snorted ❑ Injected ❑ Declined (no answer)
Hormones/steroids	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Patch ❑ Injected ❑ Declined (no answer)
Anything else: _____	❑ Yes ❑ No ❑ Declined	___ times weekly *or* ❑ < weekly ❑ Declined	❑ Orally ❑ Smoked ❑ Inhaled ❑ 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)

1 2 3 4 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

1 2 3 4 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

1 2 3 4 **Have you ever shared needles or injection equipment with others?**
❑ Yes ❑ No ❑ Declined

1 2 3 4 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=PRS; 4=TSC

Client Name: _____

VI. Behavioral Risk Reduction 1 2 3 4 — *Client Interview*

In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)? *If No, skip to Section VII.*	❑ Yes	❑ No	❑ Declined
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=PRS; 4=TSC

Client Name: _____

VIII. General Health and Well-Being 1 2 3 4 *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
❑	❑	❑	❑	❑

SF-12v2™ Health Survey © 1994, 2002 by QualityMetric Incorporated and Medical Outcomes Trust. All Rights Reserved.
SF-12® a registered trademark of Medical Outcomes Trust.
(SF12v2 Standard, US Version 2.0)

Client Name: _____

IX. Disability Status ALL — *Client Interview*

Are you deaf or do you have serious difficulty hearing? ❑ Yes ❑ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)? ❑ Yes ❑ No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ❑ Yes ❑ No

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

Do you have difficulty dressing or bathing? ❑ Yes ❑ No

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

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:

1 2 3 4 **Are you currently enrolled in a housing assistance program?**	❑ Yes ❑ No ❑ Declined	1 2 3 4 *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

Legend:
1= Required; 1= Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC

Client Name: _____

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
ALL **Have you been homeless any time since your last assessment?** ❑ Yes ❑ No ❑ Declined	ALL *If Yes,* **When were you last homeless?** _____/_____ (mm/yyyy)

ALL *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 1 2 — *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 1 2 3 4 — *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=PRS; 4=TSC

Client Name: _____

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=PRS; 4=TSC

Appendix Q – 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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Staff Member Completing Form: _____ Name	_____ Signature	Date ___/___/___ m m / d d / y y

Appendix R – Status Change Information Form

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 S – TCC Phase Date Form

Agency

E = estimated due date **A** = actual date

TCC Worker: Take latest updated copy of form whenever you go into the field. **TCC Coordinator**: Keep form updated. Make copies for TCC workers. Bring to all team meetings for reference during case review. Remind TCC workers of upcoming transitions, and monitor that they write phase plans on time.

TCC Phase Date Form

Client		TCC Worker	Dates											Client Dropped	
Name	ID	Initials		Enrolled	Initial Assessment	Start Phase 1	Re-Assessment	Start Phase 2	Re-Assessment	Start Phase 3	Re-Assessment	Start Phase 4	End TCC	Reason	Date
			E:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ REF	
			A:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ DIED	
			E:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ REF	
			A:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ DIED	
			E:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ REF	
			A:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ DIED	
			E:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ REF	
			A:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	❑ DIED	

Appendix T – TCC Progress Note

Agency	TCC Provider Code	Client ID

TCC Progress Notes

Date of this meeting, call or other contact: ___ / ___ / _____
MM DD YYYY

Client Name: _____

Current Phase #: Phase O ☐ Phase 1 ☐ Phase 2 ☐ Phase 3 ☐ Phase 4 ☐

Type of contact: *(CHECK ONE ONLY)*

- Meeting (in person) ☐
- Attempted meeting (e.g., no show) ☐
- Phone call ☐
- Attempted call (e.g., busy, no answer) ☐
- Other (letter, e-mail, fax) ☐

People contacted: *(CHECK ALL THAT APPLY)*

- Service provider (formal support) ☐
- Family, friends (informal support) ☐
- Client ☐

_____ LOCATION *(for meetings)*

_____ LIST PERSONS ON CALL / AT MEETING *(name/title/agency or relationship)*

Note:

Next step:

Appendix U – TCC Clinical Supervision Meeting Form

AGENCY: _____

TCC Clinical Supervision Meeting Form

Date of this meeting: ___ / ___ / _____ (MM / DD / YYYY) **Supervisor Name:** _____

TCC PROVIDER NAME: STAFF NAME

Client ID	TCC Provider Name	Reason for discussing this client *(CHECK ONE ONLY)*					Discussed in this meeting (√)
		new case presentation	problem arose	missing client	case closing	other, specify	

Clinical Supervisor's Name: _____ Signature _____ Date _____

TCC staff Name: _____ Role: _____ Signature: _____ Date _____

Appendix V – TCC Case Conference Client Summary

Transitional Care Coordination
Case Conference Client Summary

In preparation for your case conference, please answer the following questions (if applicable) in regards to a client with whom you are currently practicing TCC-CTI:

1) **Please provide some basic information about the client's background:**

   Age: Click here to enter text. **Gender:** Click here to enter text. **Race/ethnicity:** Click here to enter text.

   Level of education: Click here to enter text. **Occupation:** Click here to enter text.

   Health Status: Click here to enter text.

   Number of children (if any): Click here to enter text. **Parenting role (if applicable):** Click here to enter text.

   Family History Information: Click here to enter text.

   Psychosocial history (childhood, adolescence, young adulthood, work history, history in the criminal justice system, personal relationships, cultural/spiritual identification, military background, etc.):
   Click here to enter text.

2) **What phase of CTI is the client currently in? (0, 1, 2, 3 or 4)** Click here to enter text.

3) **What are the clients' presenting problems? What is causing his/her homelessness? Keeping in Mind the areas of focus of TCC-CTI and the CTI approach of not working on more than three treatment areas, what does the client say she/he wants help with? What other things do you think she/he needs?** Click here to enter text.

4) **List any psychiatric diagnoses, substance abuse history, or medical histories you know about the client:**
   Click here to enter text.

5) **What is their psychodynamic formulation?** (Psychodynamic formulation is a statement that identifies potential areas of **resistance to treatment** by listing the biological, social, psychological, and environmental characteristics of a person): Click here to enter text.

6) **What is the clients' relationship with their CTI case manager like?** Click here to enter text.

7) **How have you engaged the client? What strategies will you use for engagement?** Click here to enter text.

8) **Which CTI treatment areas are you working on with the client? What progress, if any, have you made with the client since working with him/her:** Click here to enter text.

9) **List any major difficulties, issues or complications you have had with the client:** Click here to enter text.

10) **What do you believe may be the underlying causes of these difficulties?** Click here to enter text.

11) **What barriers are you going to work on with the client for the remainder of the CTI phase? In particular, what are their risk factors for homelessness? How will you plan for their long-term needs?** Click here to enter text.

12) **What would you, as a provider, like help with when working with this client?** Click here to enter text.

Appendix W – TCC Transfer of Care Coordination Form

AGENCY NAME

Transitional Care Coordination

Transfer of Care Form

TCC Client Name: Click here to enter text. **TCC Client Chart Number:** Click here to enter text.

Provider Category	Provider Contact Info	Releases of Information	Follow-up Care Plan (please note all major agreed upon follow-up activities)
Case Management **Date of Transfer:** MM/DD/YY	Case Management Agency: Click here to enter text. Case Manager: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Primary Care Physician ☐Housing Provider ☐Other Click here to enter text. ☐Other Click here to enter text. ☐Other Click here to enter text. ☐Other Click here to enter text.	
Housing **Date of Transfer:** MM/DD/YY	Housing Provider/Housing Placement Provider: Click here to enter text. Contact Name: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Primary Care Physician ☐Case Manager ☐Other Click here to enter text. ☐Other Click here to enter text. ☐Other Click here to enter text. ☐Other Click here to enter text.	
Primary Care Physician **Date of Transfer:** MM/DD/YY	Primary Care Provider: Click here to enter text. Contact Name: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Housing Provider ☐Case Manager ☐Other Click here to enter text. ☐Other Click here to enter text. ☐Other Click here to enter text. ☐Other Click here to enter text.	
Other: Click here to enter text. **Date of Transfer:** MM/DD/YY	Provider or Informal Support: Click here to enter text. Contact Name: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Case Manager ☐Primary Care ☐Housing Provider ☐Other Click here to enter text. ☐Other Click here to enter text.	

Provider Category	Provider Contact Info	Releases of Information	Follow-up Care Plan (please note all major agreed upon follow-up activities)
Other: Click here to enter text. **Date of Transfer:** MM/DD/YY	Provider or Informal Support: Click here to enter text. Contact Name: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Case Manager ☐Primary Care ☐Housing Provider ☐Other Click here to enter text. ☐Other Click here to enter text.	
Other: Click here to enter text. **Date of Transfer:** MM/DD/YY	Provider or Informal Support: Click here to enter text. Contact Name: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Case Manager ☐Primary Care ☐Housing Provider ☐Other Click here to enter text. ☐Other Click here to enter text.	
Other: Click here to enter text. **Date of Transfer:** MM/DD/YY	Provider or Informal Support: Click here to enter text. Contact Name: Click here to enter text. Phone Number: Click here to enter text. Email: Click here to enter text.	Check if Releases of Info signed to facilitate communication with the following: ☐Case Manager ☐Primary Care ☐Housing Provider ☐Other Click here to enter text. ☐Other Click here to enter text.	

_____ _____

Client Signature **Date**

_____ _____

TCC Staff Signature **Date**

Copies of Plan to: Click here to enter text.

Appendix X – TCC Eligibility Screening Form

TRANSITIONAL CARE COORDINATION SERVICES (TCC) SCREENING FORM

Program staff members along with each client will develop a comprehensive care plan that will ensure that the client is connected to a wide range of service including, but not limited to, medical, health case management, housing benefits and support network **(6 Areas of Focus)**

NAME: _____ **DATE:** _____

ADDRESS: _____

PHONE: _____ **ALTERNATE PHONE:** _____

DOB: _____ **AGE:** _____ **SEX:** _____

ELIGIBILITY

Eligible patients must meet all four of the following criteria to enroll in the TCC Program:

- ❑ Household Income below 435% of Federal Poverty Level
- ❑ Client lives in the New York Eligible Metropolitan Area
- ❑ Are at least 18 years of age
- ❑ Documented HIV positive sero-status
- ❑ Homelessness and/or unstably housed

Have one or more of the following additional complicating factors:

- ❑ Are newly diagnosed with HIV
- ❑ Were lost to care, i.e. no primary care visit in the past 9 months or ever in New York City
- ❑ Have difficulty adhering to ART
- ❑ Have difficulty keeping appointments; or receive sporadic, irregular care

*Note: Appropriate appointment adherence is best left to the judgment of the medical provider due to the fact that appointments vary according to patient needs. The provider will have the best sense of appointment keeping behavior.

Acceptable proof of HIV status will include (check all that applies)

- ❑ M11Q
- ❑ Documentation of Active HIV Viral Load/TCELL
- ❑ Physician (M.D., N.P., P.A.) signature/written medical reports

COMMENTS:

_____

_____

STAFF SIGNATURE: _____

Appendix Y – TCC eSHARE Mapping

e·share
Electronic System for HIV/AIDS Reporting & Evaluation

Mapping of Service Types & Contract Activities

Updated 2/1/2014

Service Category: Transitional Care Coordination (TCC)

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.

	Contract Activity	eSHARE Service Type	eSHARE Entry Form	Site of Service	Information required in service details *(in addition to eSHARE submission required)*:	Payment Point?
1	Targeted Case Finding and Outreach Events	Group Outreach	Anonymous Event Services	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)	Indicate the total number of "engagements" by summing the number of program referrals.	Y
2	Assessment	Intake Assessment	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)		Y
3	Comprehensive Care Plan Development	Care Plan / Service plan	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)	Service detail must specify "Development of initial plan with this enrollment."	Y
4	Reassessment	Other Assessment / Reassessment	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)	Service detail must specify "Re-Assessment (clinical, psychological, general health/well-being, housing, enrollments, etc.)"	Y
5	Comprehensive Care Plan Update	Care Plan / Service Plan	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)	Service detail must specify "Update to plan."	Y
6	Accompaniment	Accompaniment	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)		Y
7	Coordination with Service Providers	Coordination with Service Providers	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone		Y
8	Health Promotion	Health Education / Promotion	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____)	Under health promotion topic coverage, select "Non-Care Coordination health education conversations." Choose a non-Care Coordination topic from the second variable picklist.	Y

e·share
Electronic System for HIV/AIDS Reporting & Evaluation

Mapping of Service Types & Contract Activities

Updated 2/1/2014

Service Category: Transitional Care Coordination (TCC)

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.

	Contract Activity	eSHARE Service Type	eSHARE Entry Form	Site of Service	Information required in service details *(in addition to eSHARE submission required)*:	Payment Point?
9	Linkage to Housing Services	Assistance with Housing	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone	Service detail must specify "Referral / Appointment Making." Referral type & follow-up must be captured in the **Referrals/Appointment Tracking Log**.	Y
10	Linkage to Primary Care *via TCC Program*	Assistance with Health Care	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone	Service detail must specify "Referral / Appointment Making." Referral type & follow-up must be captured in the **Referrals/Appointment Tracking Log**.	Y
11	Linkage to Primary Care *via other case management program*	Coordination with Service Providers	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone	Service date must reflect the date that verification was obtained from the case management program. Service detail must specify "Primary Care" AND "Verification." No referral form necessary. Complete a PCSM Update form and use the date of the actual appointment to indicate the client's last PCP visit.	Y
12	Transfer to Case Management Program	Assistance with Social Services	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone	Service detail must specify "Referral / Appointment Making." Referral type & follow-up must be captured in the **Referrals/Appointment Tracking Log**.	Y
13	Post-transfer follow-up	Coordination with Service Providers	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone		Y
14	Childcare Services	Assistance with Entitlements & Benefits	Services Delivered	Specify one of the following: 1) Client home 2) Other field site (Specify:_____) 3) Program site (Specify:_____) 4) Phone	Indicate "Arrangement for childcare" in service details.	N
15	Transportation Services		Services Delivered		Indicate "Arrangement for transportation" in service details.	
16	Interpreting Services		Services Delivered		Indicate "Arrangement for interpreting services" in service details.	