STATE OF MISSOURI
HIV CASE MANAGEMENT MANUAL

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Missouri Ryan White Case Management Manual

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SECTION 1.0-PROGRAM OVERVIEW

1.1 MISSOURI HIV CASE MANAGEMENT MANUAL PURPOSE

The Missouri HIV Case Management Manual establishes policies and procedures for Ryan White HIV Case Management services in the state of Missouri. The HIV Case Management Manual is an evolving document focusing on performance standards and the provision of quality service delivery within the RW Case Management system. For further guidance regarding specific policies and procedures for other services provided within the Missouri HIV Case Management system, consult the applicable program or region-specific manual (Missouri Statewide Services Manual, Outstate Services Manual, regional manuals, etc.).

HIV CASE MANAGEMENT SYSTEM DEFINITION

HIV Case Management Core Medical Services are medical, psychological, or other services necessary for the treatment of HIV, AIDS, and/or related conditions (including treatment adherence). The coordination and follow up of Human Immunodeficiency Virus (HIV) treatments is a component of HIV Case Management. These voluntary services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and affected family members' needs and personal support systems. HIV Case Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a 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 re-evaluation and adaptation of the plan as necessary over the life of the client.

INTENT:

Statewide HIV Case Management services, regional services, and individual agencies collaborate to identify and eliminate barriers and increase the number of people living with HIV who are able to access medical care. Access to HIV Case Management services is assured by processes that: survey the community to identify unserved, underserved, and emerging populations; increase community awareness of Case Management services; establish links to referral sources; and seek to eliminate barriers to engagement in medical care. HIV Case Management services are to be delivered in a culturally competent manner that respects a person's race, ethnicity, gender, gender identity, sexual orientation, support system, country of origin, etc.

RYAN WHITE AS PAYER OF LAST RESORT:

The Ryan White System is required by federal law to be the payer of last resort for all services provided to clients. In order to ensure the payer of last resort status, clients receiving any funded services are required to apply for and use any available alternate funding source. At the time of enrollment, annual update, and six-month check-in, the HIV Case Manager will assess the availability of all public, private, and community resources.

Refer to specific policy manuals (***i.e.***, Missouri Statewide Services Manual, Outstate Services Manual, regional policy manuals) for specific instructions on the payer of last resort

requirements for each service

1.2 MODEL OF HIV CASE MANAGEMENT

Ryan White HIV Case Management services may be provided to individuals who are residing in an inpatient/residential facility (long-term hospitalization, nursing home, rehab facility, city/county jail, etc.); however, Ryan White funds must be used as payer of last resort and not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made (ex: if facility provides medications as part of their services, ADAP cannot be accessed). See Missouri Statewide Services Manual and appropriate Recipients for access to additional services.

PURPOSE OF HIV CASE MANAGEMENT:

The primary purpose of Missouri's HIV Case Management system is to assist clients with establishing and maintaining HIV medical care. The intent of HIV Case Management is to assist clients in reaching the fullest level of engagement in their HIV medical care. Engagement in HIV medical care is defined as documentation of a minimum of two viral load lab tests, which may or may not include a CD4 or verified medical care visit, in the electronic client database. The HIV Case Manager assesses engagement in HIV medical care at the time of enrollment, six-month check-in, annual update, and as needed throughout the year. The client has the right to refuse to engage in medical care, realizing that to do so may jeopardize their health. While engagement in HIV medical care is an expectation for case managed clients, no client is prohibited from enrolling in or remaining in Case Management services for failure to successfully engage in medical care. HIV Case Managers identify clients who are not fully engaged in medical care, offer support to improve engagement, and document all attempts to engage the client in medical care. The HIV Case Manager must assist the client in obtaining proof of engagement in HIV medical care. (See Section6.0).)

SECTION 2.0-ACCESS STANDARD

2.1 HIV CASE MANAGER AND CLIENT RIGHTS, ROLES, AND RESPONSIBILITIES

The HIV Case Management Program is coordinated by the Missouri Department of Health and Senior Services for those living with the Human Immunodeficiency Virus (HIV). Services are based on program eligibility, assessed need, and available funding**.** Case Management is a collaborative partnership between the client and the HIV Case Manager. This partnership entails assessing client needs, linkage to resources through an individual service plan, and periodic reassessment with the goal of increased access to and participation in medical care.

HIV CASE MANAGER RIGHTS AND RESPONSIBILITIES:

1. Provide timely, professional, and culturally sensitive HIV Case Management services.
2. Follow federal and state statutes regarding confidentiality of client information and records.
3. Participate in quality assurance and improvement activities at the agency, regional, and state levels.
4. Be knowledgeable of and adhere to policies and procedures of the HIV Case Management system as a whole and agency-specific policies.
5. Maintain client contact and monitor client participation in medical care as defined by HIV Case Management policy.
6. Document required information, eligibility, and activities in the electronic client database in accordance with the Missouri HIV Case Management Manual.
7. Complete all required paperwork and documentation in accordance with the Missouri HIV Case Management Manual.
8. Utilize policies and procedures to communicate client concerns to appropriate parties.
9. Collaborate with the clinical care team to promote engagement and retention in medical care to help the client achieve the highest possible level of health and health-related quality of life.
10. Assist the client in developing an individualized service plan that will address needs that have been identified and actions required to accomplish the goal of engagement in and maintenance of HIV medical care.
11. Collaborate with the client to locate and access services and community resources that may be needed for the client to establish or maintain HIV medical care.
12. Ensure the confidentiality and the privacy of client information, except when necessary to prevent serious, foreseeable, and imminent harm to oneself or others.

CLIENT RIGHTS AND RESPONSIBILITIES:

The Case Management process is a collaborative process between the client and HIV Case Manager. The client's rights and responsibilities in this process are:

SECTION 2.0-ACCESS STANDARD

1. The right to Case Management without cost to the client's self, family, or guardian if eligibility requirements are met.
2. The right to freedom of choice of participating qualified service providers within program/provider capacity.
3. The right to have confidentiality maintained according to Missouri state statutes and the federal Health Insurance Portability and Accountability Act (HIPAA).
4. The right to HIV Case Management services that are delivered in a timely, professional, and culturally sensitive manner.
5. The right to be informed of policies and procedures for removal and readmission to Case Management services.
6. The right to a copy of the client's Case Management record upon receipt of a signed and dated request.
7. The right and responsibility to use the complaint, grievance, and appeal process to address any issues or concerns that may arise without fear of reprisal.
8. The responsibility to respect the HIV Case Manager's personal and professional boundaries.
9. The responsibility to utilize available services and community resources to assure that the Ryan White System is the payer of last resort.
10. The responsibility to remain engaged in HIV medical care while receiving Ryan White System funded services.
11. The responsibility to arrive promptly or give advance notice of the need to change Case Management appointments.
12. The responsibility to notify the HIV Case Manager immediately of any major life changes, including residency, phone number, income, health coverage, health status, number of dependents, etc.
13. The responsibility to complete required updates and to provide all requested information and documentation.
14. The responsibility to participate in the development of an individualized service plan and complete agreed-upon actions in order to establish or maintain HIV medical care.
15. The responsibility to demonstrate appropriate behavior during Case Management appointments, while in Case Management or at other service provider agencies, as outlined in the Policies for Removal and Readmission from Case Management Services.
16. The responsibility to be cooperative and participatory during interactions.

2.2 COMPLAINT, GRIEVANCE, AND APPEAL PROCESS

Clients have a right to participate in grievance procedures when they believe their rights have been violated.

The HIV Case Management system has a process that is to be utilized when a client has a complaint or grievance or wishes to appeal a decision.

SECTION 2.0-ACCESS STANDARD

POLICY:

1. Clients have a right to complain, file a grievance, or appeal a policy or procedural decision when an issue or conflict is identified within the HIV Case Management system. Issues may arise with the HIV Case Manager, other HIV Case Management staff, the HIV Case Management agency, or HIV Case Management system policy and procedures.
2. The HIV Case Manager will handle all complaints, grievances, or appeals professionally and in a timely manner, following all outlined policies and procedures.
3. Each local HIV Case Management agency and/or system will:
    a. Personalize the statement of the complaint/grievance/appeal standard, policy, and procedure to your agency and provide it to all clients.
    b. Document receipt of complaints, grievances, or appeals and the associated resolution in the client's record in the electronic client database. Maintain a separate file of all written complaints, grievances, or appeals. The actual written complaint, grievance, or appeal must not be scanned into the electronic client database. If there is an accompanying Incident /Quality Management Report, see the Quality Management Standard.
    c. Provide proof of an impartial, fair, and expedited review process.

PROCEDURE:

The role of the HIV Case Manager in the complaint, grievance, and appeal process is to:

1. Review and provide a copy of the Complaint, Grievance, and Appeal policy to the client at enrollment, annual update, and upon request. The client must acknowledge receipt of the policy by initialing and signing the client signature page.
2. Upon receipt of a complaint, grievance, or appeal, the HIV Case Manager will:
    a. Refer the client to the party associated with the complaint if needed. The client may be referred directly to the individual's agency supervisor if requested.
    b. Document all interactions with or on behalf of the client in the electronic client database.
    c. Notify the agency supervisor that a complaint was received; the agency supervisor will determine any follow-up action that is needed.

The role of the Case Management agency/system in the complaint, grievance, and appeal process is:

1. The agency will contact the client within **five (5) business days** of receipt of the grievance to schedule an appointment to discuss the grievance.
2. Within **thirty (30) days** of the grievance discussion, a **written** explanation of the resolution of the grievance, including any actions taken, will be sent to the client.
3. Additional personnel may be consulted in accordance with agency/regional policies.

4. If an appeal is received, the Regional Case Management Supervisor and/or Quality Service Manager will send a response to the client, the staff member, and agency supervisor within **thirty (30) business days.**

If a client feels that the above process has not adequately addressed their concerns, they have a right to file an appeal with the applicable Ryan White Recipient.

SECTION 3.0 - ELIGIBILITY FOR HIV CASE MANAGEMENT

ELIGIBILITY REQUIREMENTS FOR HIV CASE MANAGEMENT

Eligibility criteria for engagement in HIV Case Management must meet federal and programmatic requirements. Eligibility criteria allow the HIV Case Management System to serve clients and assure that resources are used efficiently and effectively.

The following are the eligibility criteria necessary to be enrolled in the HIV Case Management System:

3.1 Documentation of HIV+ status

3.2 Documentation of Residency

3.3 Documentation of Income

All documentation must be received within 30 days from the Enrollment appointment. The client is not considered enrolled until eligibility documentation or Rapid Enrollment Attestation Form (REA) is obtained. If REA is being used to verify eligibility, follow Rapid Enrollment Policy and Procedure (Section 5).

NOTE: Recipients may ask for further corroborating documentation of eligibility at their discretion.

3.1 DOCUMENTATION OF HIV + STATUS

POLICY:

HIV+ status must be documented in the electronic client database. This includes both entry in the Diagnosis module and verification scanned into the Documents module at the time of enrollment or transfer (if documentation of HIV+ status is not already present in the Documents module). Documentation must include the client's name and one other identifier (DOB, Social Security Number, and/or Residency). If acceptable documentation is not available at the time of enrollment, the client will not be enrolled and must remain in Intake status.

Documentation received prior to January 1, 2011 (***i.e.***, signed physician letter/progress notes, MIRF, handwritten flow sheets of HIV+ status) will be accepted for:

- Clients who have such forms of documentation that were scanned into the client's record prior to 01/01/11, and
- Clients who have not been closed from HIV Case Management since 1/01/11

Clients who have been closed from Case Management will be required to provide acceptable documentation of HIV+ status as outlined below.

PROCEDURE:

Acceptable documentation of HIV+ status is listed below:

1. Western Blot test results report form.

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2. Rapid, Rapid confirmatory test results from DHSS-funded testing site on the approved DHSS form.
3. Missouri Department of Corrections medical records printout (from HIV Accountability Records System).
4. A copy of a laboratory report indicating a reactive or detectable nucleic acid amplification test (NAAT)/detectable viral load.
    a. A qualitative test indicates the presence of the HIV but does not measure the number of copies of the virus. This result is reported as reactive/detected or non-reactive/not detected. Only reactive/detected results are accepted as proof of HIV infection.
    b. A quantitative test measures the number of copies of the virus per milliliter. This type of test may be referred to as a "viral load." This result is reported as the number of copies per milliliter. Undetectable viral load results are not acceptable as proof of HIV.
5. Copies of laboratory reports indicating two positive (reactive/qualitative) HIV immunoassays, which are based on different antigenic constituents or principles. Examples include:
    a. A reactive fourth-generation antigen (Ag)/antibody (Ab) combination test *ALONG WITH* an antibody differentiation immunoassay test (***i.e.***, Multispot) indicating the presence of HIV-1 and/or HIV-2 antibodies.
    b. A reactive EIA *ALONG WITH* an antibody differentiation immunoassay test (***i.e.***, Multispot) indicating the presence of HIV-1 and/or HIV-2 antibodies.
6. A copy of a laboratory report indicating the completion of an antibody differentiation immunoassay test (***i.e.***, Multispot) indicating the presence of HIV-1 and/or HIV-2 antibodies. (Note: a positive/reactive antibody differentiation immunoassay test does not meet the CDC- recommended HIV testing algorithm definition for the diagnosis of HIV but will be accepted for enrollment in HIV Case Management and other Missouri Ryan White services with no additional documentation required.)
7. A copy of laboratory test results, which meet any of the Clinical and Laboratory Standards Institute, approved algorithms for the diagnosis of HIV. The HIV Case Manager must consult with their agency supervisor, who will contact the Regional Supervisor or Quality Service Manager to ensure that the results submitted meet approved diagnosis standards.
8. A copy of the flowsheet from an electronic medical record (EMR)/electronic health record (EHR) or patient portal screenshot. The document must include the following:
    a. Client name
    b. Date of birth or social security number.
        i. If the date of birth or social security number is not present, an identification number can be used. If only an identification number (ex:

medical records number) is present, additional documentation matching client's date of birth or social security number from the same EMR/EHR (ex: face sheet or demographics page) must also be scanned into the electronic client database.

c. Acceptable documentation of HIV+ status:

i. Positive Western Blot

ii. A copy of a laboratory report indicating a reactive or detectable nucleic acid amplification test (NAAT)/detectable viral load.

1. A qualitative test indicates the presence of the HIV but does not measure the number of copies of the virus. This result is reported as reactive/detected or non-reactive/not detected. Only reactive/detected results are accepted as proof of HIV infection.

2. A quantitative test measures the number of copies of the virus per milliliter. This type of test may be referred to as a "viral load." This result is reported as the number of copies per milliliter. Results, which include a less than sign (<), are not acceptable as proof of HIV infection.

iii. Copies of laboratory reports indicating two positive (reactive/qualitative) HIV immunoassays, which are based on different antigenic constituents or principles. Examples include:

1. A reactive fourth-generation antigen (Ag)/antibody (Ab) combination test ALONG WITH an antibody differentiation immunoassay test (i.e., Multispot) indicating the presence of HIV-1 and/or HIV-2 antibodies.

2. A reactive EIA ALONG WITH an antibody differentiation immunoassay test (i.e., Multispot) indicating the presence of HIV-1 and/or HIV-2 antibodies

iv. A copy of a laboratory report indicating the completion of an antibody differentiation immunoassay test (i.e., Multispot) indicating the presence of HIV-1 and/or HIV-2 antibodies. (Note: a positive/reactive antibody differentiation immunoassay test does not meet the CDC recommended HIV testing algorithm definition for the diagnosis of HIV but will be accepted for Enrollment in HIV Case Management and other Missouri Ryan White services with no additional documentation required.)

9. Documentation obtained from local or the HIV State Surveillance Coordinator (***i.e.***, WebSurv lab printout, fax, report, e-mail confirmation from local or state HIV

surveillance coordinators). This documentation must only be sought in the event that the above documentation cannot be obtained from the provider.

HIV Case Managers must not enter any additional service referrals until documentation of HIV+ status is uploaded into the electronic client database. If the client cannot supply any of the above, additional testing to confirm HIV status will be required before the Enrollment proceeds. See Enrollment with Positive Screening/Preliminary Test policy below.

Note: If a client states that a genotype HIV testing was conducted to confirm HIV+ status, the regional supervisor must consult with the Director of HIV Case Management to determine if the testing type is accepted by HIV State Surveillance Coordinator. If the test was conducted in Missouri and accepted by the HIV State Surveillance Coordinator, the test will be accepted as proof of HIV+ status.

ENROLLMENT WITH POSITIVE SCREENING/PRELIMINARY TEST (3RD OR 4TH GENERATION/RAPID TEST):

Clients who present for an Enrollment with a positive screening/preliminary test only (3rd generation, 4th generation, rapid, etc.) will be permitted to enroll in HIV Case Management services for up to thirty (30) days while confirmatory test results (Multispot, NAAT, etc.) are obtained and must be documented using the "Verification of Preliminary Positive" document type in the electronic client database. If documentation of the confirmatory test results is not obtained within this thirty (30) day period, all referrals must be closed, and the client record inactivated. Acceptable documentation of a preliminary positive must include the client's name, date of birth, test date, type of test, test result, and testing site information (phone number, address).

3.2 Documentation of Residency

POLICY:

Proof of residency in the state of Missouri and/or Case Management region must be scanned into the Documents module of the electronic client database at the time of Enrollment and Annual Update. Failure to provide proof of current residency within the thirty (30) days will result in closing the client to HIV Case Management services until documentation is provided. The document's address to verify residency must match the address listed in the Housing module in the electronic client database.

Acceptable proof of documentation of residency must be current and include the client's name and physical address; P.O. boxes are not acceptable. Current is defined as:

1. Correspondence/documents dated within the last 60 days.
2. Lease agreement or Housing Assistance Verification form still in effect for the address where the client resides.

SECTION 3.0 - ELIGIBILITY FOR HIV CASE MANAGEMENT

PROCEDURE:

1. Obtain one of the following acceptable forms of documentation from the client and scan into the Documents modules of the electronic client database.
    a. Current lease agreement in the client's name
    b. Current renter's insurance statement
    c. Current Housing Assistance Verification form signed by the landlord
    d. Current Mortgage coupon/statement
    e. Current utility bill in the client's name (including cable, internet, cell phone bills)
    f. Current paycheck
    g. Current bank or credit card statement
    h. Current correspondence from any government agency (local, state, federal)
    i. Current voter registration card
    j. Letter from shelter staff verifying client's residency
    k. Current property tax receipt in the client's name
    l. Certified mail receipt with client signature
    m. Current postmarked envelope from HSI or Ryan White Case Management Agency.
    n. Correspondence from private health, life, auto, disability, or real estate insurance company such as an active policy or EOB.
    o. Current medical bill.
    p. Written attestation from supportive housing agency, on agency letterhead, currently providing support for the client.
    q. Pension/Retirement Award Letter
    r. Strike benefits correspondence from Union
    s. Ryan White Institutional Release Form – signed and completed by the institution
    t. Complete Residency Verification Form if no other documentation is available.
    u. Rapid Enrollment Attestation Form (valid for up to 30 days)
2. Complete, update and/or verify the Housing module in the electronic client database.
3. Residency documentation must match the verified entry in the Housing module.

SECTION 3.0 - ELIGIBILITY FOR HIV CASE MANAGEMENT

3.3 Documentation of Income

POLICY:

To participate in the Missouri Ryan White HIV Case Management System, a client's **gross income** (see definition of income below) must be at or below 300% of federal poverty level guidelines.

All income sources must be obtained and verified at the time of enrollment and annual update. Reimbursements (i.e. adoption/foster subsidies, mileage, or per diems) are not counted toward a client's gross income.

See Section 3.4 for policies and procedures on client's self-reported changes in income.

Income is defined as:

1. Client's **gross** income (before any deductions); *AND*, (if applicable)
2. The **gross** income of **spouse and all dependents** living in the housing unit (see below for definition of dependent). If the client is legally married but not living in the same household as their spouse, the client must initial the attestation on the Income Attestation Form.

A **dependent (non-spouse)** is defined by having **all four** of the following:

1. *Relationship* - A group of two or more persons related by birth, marriage, adoption, or legal placement.
2. *Residency* - the person /s must live in the same housing unit for a minimum of six months and one day each year.
3. *Age* - the person must be:

   a. Under 19 at the end of the year they are claimed;

   b. OR under age 25 and a full-time student for at least five months of the year;

   c. OR any age and determined totally and permanently disabled by Social Security.
4. *Support* - the person did not provide more than half of their financial support during the year.

PROCEDURE:

1. Collect documentation of all sources of the client, spouse, and dependent income. Reference the Income Determination Form to ensure that all sources of income are addressed with the client. Scan all income documentation into the Documents module. See the table below for acceptable forms of documentation for each income type.
2. Enter all client, spouse, and dependent income in the electronic client database's Income module to calculate total monthly/annual income. If calculations are needed, the HIV

Case Manager must show income calculations on the income proof documentation or use the Income Calculator Tool.

3. Complete a separate entry in the Income module for each income source provided by the client, spouse, and/or dependent. Identify the recipient of each income source, if not the client. If spouse and/or client reports no income, a separate "No Income" entry must be entered for each individual. The Income module will automatically calculate all applicable income sources to determine the Federal Poverty Level.
4. All income documentation must match the entries in the Income module.
5. Enter the number of dependents in the Demographics module (**includes spouse and all other dependents**). This number **does not** include the client and may be zero if no other individual in the residence meets the dependent definition.
6. The number of dependents entered in the Demographics module must match the Social Supports module in the electronic client database. Each entry must have the name, date of birth, and relationship to the client for each dependent. The entry for the spouse of the client must also list the spouse's social security number. If the date of birth is unknown, utilize the closest month/day/year known.

The following table will be used to determine if a particular income type is to be included in calculations and what type of documentation can be used as acceptable proof. No other resource will be accepted in determining sources of income. Consult with the Agency Supervisor, Regional Supervisor, Quality Service Manager, and/or Director of HIV case management for clarification of income sources/amounts to be included.

Type of Income	Acceptable Forms of Income Documentation
Employment Income	
Wages, tips, bonuses, overtime pay, and salaries from employment before **any** deductions. The gross income is reported. (Do **NOT** deduct alimony or child support payments paid or other garnishments)	Two pay stubs both dated within 60 days of the date of enrollment and/or annual update. The pay stub must identify the employee, show the amount earned and period of time covered (annualized to determine annual income). ***See below guidance for clients with new employment** *OR* Signed and dated letter from employer on company letterhead specifying amount to be earned per pay period and length of the pay period. *OR* Electronic earnings statement that includes employee name, the amount earned, and period of time covered to determine annual income.

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Type of Income	Acceptable Forms of Income Documentation
	If no other income documentation is available, federal income tax forms from the immediate prior year will be accepted but must include all attachments & W-2's for employed clients and those with other sources of income. Tax forms must reflect current employment and income. The figure on line 7 must be used to reflect income from wages, tips, salary, overtime, and bonuses. **The information must be received by April 30 to be considered current to avoid service interruption.**
Working for cash	Client reports and attests to amounts received on Income Attestation Form
Non-farm self-employment (receipts from a person's own unincorporated business after deduction for operating expenses).	*Federal income tax form 1040 for the immediate prior year with all attachments. The "Net Profit or Loss (Total Income)" line from each IRS Schedule C or Schedule C-EZ form is the Self-Employment income amount that will be used to calculate monthly income. For negative amounts, zero ($0) must be entered in the Income module. Tax information **must be received by April 30th to be considered current and to avoid service interruption. For guidance regarding newly self-employed, see below.**
Farm self-employment receipts from a farm, which one operates as an owner, renter, or sharecropper after deduction for farm operating expenses.	*IRS tax form 1040 with all attachments, The Net Profit or Loss (Total Income)" line from each IRS Schedule F form is the Self-Employment income amount that will be used to calculate monthly income.

Public Assistance Benefits (Does not include non-cash federal or state benefits such as food stamps)	
Temporary Assistance for Needy Families (TANF)	Award letter from agency showing the amount and period received *OR* Screenshot from the state government website (ex. MyDSS.mo.gov)

Other Sources of Income	
Social Security (SSDI, SSA) including funds	Award letter from the agency showing the

received on behalf of dependents living in the housing unit before any deductions. The cost of Medicare premiums is not deducted from the annual amount for income determination. Back payment owed to client must not be included as income.	amount and period received (only needed once per the calendar year)
Pension payments, including railroad retirement, private and government pensions, including veteran's payment and military retirement	Award letter from the agency showing the amount and period received (only needed once per the calendar year)
Child support received on behalf of dependents living in the housing unit	Copy of payment records furnished by the Court signed and dated showing the amount of payment *OR* Copy of monthly receipt from the state agency *OR* Online printout of child support deposits received showing amount and dates from the past 31 days *OR* Copy of divorce decree showing the amount of support
Other regularly occurring cash support from a family member or someone not living in the housing unit	Client reports and attests to amounts received on Income Attestation Form
No Income	Client reports and attests to having no income on the Income Attestation Form
College or university scholarships, grants, fellowships, and assistantships minus the cost of tuition, books, and educational fees; *does not include student loans due to payback requirement*	Award letter for fund received and receipts for expenditures for allowed costs
Training stipends minus the cost of tuition, books, and fees	Award letter for funds received and receipts for expenditures for allowed costs
Unemployment Compensation	Documentation of amount from Department of Labor and Industrial Relations (DOLIR) (ex: a copy of check issued by the agency or printout from the website) *OR* Bank or Money Network Debit Card statement showing deposits for the past 31 days

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Long or Short-Term Disability	Copy of recent pay stub indicating long or short-term disability amount *OR* Award letter signed by the employer *OR* Statement from the agency showing the amount and period received
Individual Retirement Account (IRA)/401k distributions minus early withdrawal penalties	IRS Form 1099 *OR* Statement from financial institution showing amount and period received
Regular insurance or annuity payments	IRS Form 1099 *OR* Statement from financial institution showing amount and period received
Periodic receipts from estates or trusts	Copy of trust with amount and period indicated, IRS tax form 1040 and Schedule E and Schedule K-1 *OR* Copy of check(s)
Dividends received on investments or capital gains	See IRS tax form 1040 and IRS Schedule B for Dividends and/or Schedule D for Capital Gains *OR* A dividend statement from a bondholder or stock company
Interest earned savings or checking accounts, money market funds, certificates of deposit	See IRS tax form 1040 and IRS Schedule B
Net rental income – total rent receipts minus expenses and interest on mortgage payments. If subletting space to another, all rent received must be reported as income.	See IRS tax form 1040 and IRS Schedule E
Net royalties after management fees	See IRS tax form 1040, IRS Schedule E
Professional enterprise, or partnership	See IRS tax form 1040, with Schedule E and Schedule K-1.
Net income from prizes, awards, gambling, raffle, or lottery winnings	Casino or lottery documents IRS tax form 1040, IRS Schedule 1
Strike Benefits from Union Funds	Documentation or correspondence from Union stating benefit amount, duration, and frequency

Alimony received	Copy of payment records furnished by a court signed and dated, showing the amount of payment *OR* Copy of monthly receipt from a state agency *OR* Online printout of alimony deposits received showing amount and dates from the past 31 days *OR* Copy of divorce decree showing the amount of support
Worker's compensation or settlements (Single lump-sum settlements must not be included as income)	Award letter from signed by the agency *OR* Statement from the agency showing the amount and period received

The HIV Case Manager may send a communicate in the electronic client database to the ADAP and Rebate Liaison to request income verification. If a client is receiving income from a source not listed in the above table or the acceptable documentation is not available, an exception request must be submitted to the appropriate Recipient prior to the authorization of services.

CALCULATION OF INCOME:

The following examples must be used to calculate monthly income based on pay stubs. The HIV Case Manager must show how all wage/tip/overtime/salary calculations were derived using the space provided on the Income Calculator Tool or the proof of income documentation. At least two pay stubs will be required to make an accurate calculation. This calculation must be made using gross income, including tips, bonuses, overtime, etc. Select the appropriate method below based on the client's frequency of pay:

INCOME WITH WEEKLY PAY:

1. Total the amount of gross income from *two* weekly pay stubs dated within the past 60 days.
2. Multiply by 26 to calculate an average yearly income.
3. Divide by 12 for the average monthly gross income.

Although using two weekly pay stubs dated within the past 60 days is preferred, the use of *four* weekly paycheck stubs (required for Kansas ADAP recipients) will be accepted using the following calculations:

1. Total the amount of gross income from *four* weekly pay stubs dated within the past 60 days.

2. Divide by 2 for the average two-week pay.
3. Multiply the amount by 26 for the yearly total.
4. Divide by 12 for the average monthly gross income.

NOTE: Do not add four weeks of pay together; this does not accurately reflect the average monthly income. Average out the income as directed above.

INCOME WITH BI-WEEKLY PAY (EVERY OTHER WEEK)**:**

1. Total the gross income from two pay stubs dated within the past 60 days (paid every other week).
2. Divide by 2 for average two-week gross income.
3. Multiply the average two-week income by 26 for a yearly average gross income.
4. Divide the yearly average by 12 to arrive at the monthly average gross income.

INCOME WITH BI-MONTHLY (TWICE A MONTH):

1. Total the gross income from two pay stubs dated within the past 60 days (paid twice a month). This is the monthly gross income.
2. Multiply the monthly amount by 12 to arrive at the yearly gross income.

INCOME WITH MONTHLY PAY:

1. Total the gross income from two most recent pay stubs (two months of pay stubs).
2. Divide by 2 for the average monthly income.

For pay schedules that do not fit any of the options described above, consult with your Regional Supervisor and/or QSM.

INCOME WITH VARYING PAY SCHEDULES, INCLUDING GIG ECONOMY:

1. Total the amount of gross income from two weeks' worth of pay statements dated within the past 60 days.
2. Multiply the sum of the two-week income by 26 for a yearly average gross income.
3. Divide the yearly average by 12 to arrive at the monthly average gross income.

CLIENTS WHO ARE NEWLY SELF-EMPLOYED (NO SELF-EMPLOYMENT IN PREVIOUS TAX YEAR):

1. The client must notate self-employment income using the two most recent monthly bank statements.
2. Tax documentation must be provided when available.

SECTION 3.0 - ELIGIBILITY FOR HIV CASE MANAGEMENT

CLIENTS WHO ARE NEWLY EMPLOYED WITH ONLY ONE PAYCHECK STUB (UPDATE OR ENROLLMENT ONLY):

1. Newly employed clients will provide first paycheck stub to their HIV Case Manager. The client has forty-five (45) days to submit additional paycheck stub(s).

2. The HIV Case Manager will use the first paycheck stub to calculate a client's annual income by referencing the corresponding pay schedules as outlined above. The HIV Case Manager will document client's income in the Income Module by selecting the "Other" income type and add a note indicating that only one paycheck stub has been submitted.

    a. Ex: If a client is paid every two weeks, the HIV Case Manager will calculate income by assuming the amount on the client's second paycheck stub will be the same as the first paycheck stub. The same will be done for clients paid weekly, bi-monthly, etc.

3. The HIV Case Manager will put the Case Management referral in for forty-five (45) days.

4. Once additional income documentation is received, the HIV Case Manager will re-calculate and re-verify income in the electronic client database by closing out the "Other" entry in the Income module and adding a new entry in the Income module that corresponds to the correct income type for the client.

5. Upon receipt of the additional paycheck stub(s), the HIV Case Manager must extend the HIV Case Management referral to align with the original twelve-month time frame.

    a. If the updated calculations show the client's income is over 300% FPL, the HIV Case Manager must follow the Case Closure Policy (Section 8).

6. The HIV Case Manager will alert the DHSS Benefits Administrator and/or all applicable Recipients by placing eligible referrals in 2SRR.

3.4 SELF-REPORTED ELIGIBILITY CHANGES

HIV Case Managers are required to collect eligibility documentation at the enrollment and annual update. If a client **self-reports** a change within the 12-month certification period (i.e. not at enrollment or an annual update), HIV Case Managers may need to collect additional eligibility documentation depending on the type of change reported.

POLICY and PROCEDURE:

1. Residency Change
    a. New residency documentation is not required if client moves within same region. The HIV Case Manager must end the existing housing entry and add a new entry with current address. Documentation of residency is not required to update the housing

module. The verified date must be left blank until the client provides corresponding documentation. Documentation must be obtained at the next annual update.

b. If client moves from one region to another, HIV Case Manager must follow the Transfer Out of Region Policy (Section 7).

c. If client moves out of Missouri, the HIV Case Manager must follow The Transfer A Client to Another State Policy (Section 7) and the Case Closure Policy (Section 8). Regional TGA case closure policy may vary.

2. Income Change
   a. New income documentation is **not** required if the client reports a change in income that decreases or does not increase their FPL. The HIV Case Manager must end the existing income entry and add a new entry with current income source and amount. Documentation of income is not required to update the Income module. The verified date must be left blank until the client provides corresponding documentation. Documentation must be obtained at the next annual update.

   b. New income documentation is required within sixty (60) days if the client reports a change of income that increases their FPL. Services may be impacted if a client is unable to provide updated income within the above timeframe.

      i. If the client's FPL remains at or below 300%, HIV Case Managers must follow the Documentation of Income Procedure (Section 3.3).

      ii. If the client's FPL exceeds 300%, HIV Case Managers must follow the Case Closure Policy (Section 8). Income documentation must be scanned into the electronic client database.

3.5 CASE MANAGEMENT EXCEPTION REQUESTS

POLICY

Case Managers may submit exception requests for case management services which are outside of the scope of existing policies or established service limits. Exceptions cannot be submitted for clients who do not meet core eligibility requirements. There is no guarantee that an Exception Request will be approved. All Exception Requests must be reviewed and approved by the appropriate Case Management Agency Supervisor or QSM prior to submitting to the DHSS Director of HIV Case Management or the Part A Regional Case Management Supervisor. The following procedure has been established to guide HIV Case Managers through the necessary steps for submitting case management specific exception requests.

PROCEDURE:

1. HIV Case Manager must get approval from Case Management Agency Supervisor or QSM prior to submitting an Exception Request.
2. HIV Case Manager must upload all documentation that supports the need for a Case Management Exception Request.

SECTION 3.0 - ELIGIBILITY FOR HIV CASE MANAGEMENT

3. HIV Case Manager must complete the Exception Request Narrative clipping in the Case Management service referral explaining the reason for the exception and all barriers or negative health outcomes that the client may face if the Exception Request is not approved.
4. For Part A TGAs, HIV Case Managers must refer to regional policy.
5. For Outstate, HIV Case Managers must select the appropriate case management referral and submit or resubmit the referral in "1EXC – Exception Submitted" status.
    a. If approved, the Director of HIV Case Management will enter a Case Management Exception encounter, and send a communicate to the HIV Case Manager asking them to change the case management referral status to "8ENR".
    b. If denied, the Director of HIV Case Management will enter a Case Management Exception encounter, and send a communicate to the HIV Case Manager asking them to close the case management referral (7CLS).

SECTION 4.0-HIV CASE MANAGEMENT ACTIVITIES

Case Management Forms and Electronic Client Database

The Missouri HIV Case Management system requires specific documentation to be entered into the electronic client database in order for clients to access services. All interactions, eligibility documentation, and RW specific forms must be documented in a timely, objective manner and maintained in a complete, confidential file. The electronic client database is the primary repository of client-specific information and provides modular, comprehensive support for case management services. A physical file may be maintained according to agency policy, but all information must be entered into the electronic client database.

4.1 MO RYAN WHITE CASE MANAGEMENT FORMS

POLICY:

The Missouri HIV Case Management system uses multiple forms to delineate the roles and responsibilities of the agency, HIV HIV Case Manager, and the client. The required forms listed below must be given and explained to the client, and any subsequent questions must be addressed. Documents requiring a direct signature must be signed and dated by the client, either physically or electronically. Documents not requiring a direct signature must be initialed on the Client Signature Form.

PROCEDURE:

1. HIV Case Managers must provide the below forms to clients, answer any client questions, and obtain a direct signature, verbal attestation or initials when required.

    a. HIV Case Management Authorization for Release of Protected Health Information (PHI) (at least annually) Requires a direct or electronic signature from the client.

    b. Medicaid Screening Tool

    c. Client Signature Form - client must initial and sign—physically or electronically—to indicate review/receipt/completion of the following items: (Enrollment and Annual Update only)

        i. MCMAT

        ii. ISP

        iii. Client Rights and Responsibilities

        iv. Policies for Removal and Readmission into HIV Case Management and/or Services

        v. Complaint, Grievance, and Appeal Process

        vi. Acknowledgment (Notice of Agency Privacy Policies)

2. The following forms/tools are optional and can be utilized with the client at the HIV Case Manager's discretion.

Note: while the forms listed below are considered optional for general Case Management purposes, many may be required for specific programs.

a. Budget Planner Form

b. Medical Information Request Form (MIRF)

c. Income Determination Form

d. Electronic Communication Release

e. Agency-Specific Release(s)

4.2 ELECTRONIC CLIENT DATABASE MODULES

POLICY:

All information gathered from the client must be entered into the electronic client database. The following modules in the electronic client database must be reviewed, updated, and/or verified: Case Status, Housing, Demographics, Social Support, Professional Contacts, Documents, Assessment/Interview, Service Plan, Service Referrals, Encounters, Health Coverage, Income, Employment, Diagnosis, Verified Medical Care, and Labs. See Missouri Case Management User Data Rules for specific data entry instructions.

PROCEDURE:

1. Review each module for accuracy:

a. If the existing information in the module remains unchanged, update the "verified date" data field using the date the information was reviewed and verified with the client.

b. If the module's information has changed, enter an "end date" and inactivate any entries that are no longer current. Enter a new log entry with the current information, including the start date and verified date when appropriate.

2. HIV Case Managers must review, verify, and update the following modules as described below.

a. Case Status- Update as needed to reflect current standing (I.e case closure or re-open) in RW Case Management.

b. Housing- See the detailed information regarding the entry of residency (Section 3)

c. Demographics- The client's **legal first and last name** must be used in the electronic client database. The client's chosen name may be listed in the Alias data field.

d. Social Support- Enter emergency contact (if provided) and all dependents (Section 3).

e. Professional Contacts- Enter Ryan White Case Manager and HIV Medical Provider.

f. Documents – Scan and upload any required documents.

g. Assessment/Interview -See the detailed information regarding completing the Missouri Case Management Assessment Tool (MCMAT). (Section 4)

h. Service Plan - See the detailed information regarding completion of the Individual Service Plan (Section 4).

i. Service Referrals - See the detailed information regarding the entry of Service Referrals (Section 4)

j. Encounters - A progress note documenting relevant information obtained during the visit must be attached to the encounter (Section 4).

k. Health Coverage- Enter all current health care coverage. Refer to Statewide Services Manual Appendix C1 for additional guidance.

l. Income- See the detailed information regarding the entry of income (Section 3)

m. Employment- Optional

n. Diagnosis- Enter if change in status

o. Verified Medical Care- Enter Verified Medical Visit, CD4 labs, and/or viral load, if not already documented in the Labs module.

p. Labs- Review as needed.

4.3 MISSOURI CASE MANAGEMENT ASSESSMENT TOOL (MCMAT)

The assessment is a collaborative, client-centered process. The HIV Case Manager will assess client perceptions of their health, strengths, needs, and barriers to accessing medical care. Using information gathered through the assessment process, the HIV Case Manager and the client will collaborate to develop an Individual Service Plan (ISP). The purpose of the MCMAT is to provide a method for the client and HIV Case Manager to collaborate in determining the client's strengths, resources, and needs in the following areas:

- Health
- Social
- Financial
- Self-Determination

POLICY:

1. Completion of the MCMAT must occur at the Enrollment, Annual Update, and as needed as determined by the HIV Case Manager. Completion of the MCMAT is also required at the time of transfer from Direct Enrollment Services (DES) or Resource and Referral. Refer to Specialty Case Management Manual(s) for additional guidance.

2. The MCMAT interview may be conducted in-person with the client or over the phone at a site that is mutually agreed upon by the client and HIV Case Manager. Social supports, such as but not limited to a spouse or other family members, may be included at the client's request.
3. The MCMAT will be entered into the electronic client database within **two (2) business days** of completion.
4. The MCMAT will serve as the basis for developing the Individual Service Plan (ISP).
5. Collaboration with other appropriate professionals and review of client records, as needed, may assist in the assessment and Individual Service Plan development if warranted by individual client circumstances.

PROCEDURE:

1. The HIV Case Manager utilizes the MCMAT to assess client in four areas of assessment – Health, Social, Financial, and Self-Determination & Goal-Setting.
2. The assessment has four possible scoring levels (0, 1, 2, or 3). In each scoring level, multiple criteria could represent a client's circumstances. If no score is selected, the Area of Assessment defaults to zero.
3. Based on the client's responses and the observations of the HIV Case Manager, the HIV Case Manager will check all the criteria that apply to the client. The highest scoring level in each Area of Assessment with one or more checked criteria will indicate the overall score for that Area of Assessment.
4. Scores and associated notes may be documented on the optional MCMAT worksheet but must be recorded in the electronic client database within **two (2) business days**.
5. Clients scoring a 2 or 3 on the Substance Use Behaviors Area of Assessment must also complete the CAGE-AID assessment. The CAGE-AID assessment is a screening within the MCMAT used to identify signs of substance misuse. The CAGE-AID is a separate assessment in the Assessment/
6. Interview log in the electronic client database and must be entered within **two (2) business days**.
7. Clients who score above 1 on the Activities of Daily Living (ADL) Area of Assessment may be appropriate for the SPPC/Waiver Program. Refer to regional SPPC/Waiver policy for referral process.
8. Risk Reduction and Medical Adherence Areas of Assessment must be documented in the Enrollment/Annual Update clipping note regardless of MCMAT score.
9. Any Areas of Assessment scoring greater than 0 must be documented in the Enrollment/Annual Update clipping note. The note must explain the circumstances identified by the client and/or HIV Case Manager regarding each evaluated Area of Assessment.

10. The client and HIV Case Manager will collaboratively decide which Areas of Assessment identified through the MCMAT will be addressed on the Individual Service Plan.

11. All information obtained through completion of the MCMAT is used to:

    a. Develop an agreed-upon Individual Service Plan (ISP),

    b. Make appropriate service referrals,

    c. Guide documentation of the client's progress through the core functions of the HIV Case Management system.

4.4 INDIVIDUAL SERVICE PLAN (ISP)

The development, implementation, monitoring, and adaptation of the Individual Service Plan (ISP) are crucial components of the Ryan White HIV Case Management system. The ISP is used to identify a client's needs and goals to achieve successful engagement in HIV medical care. The primary goal of each client's ISP is to establish and/or maintain HIV medical care. The ISP is made up of two main components: the overall goal and the Areas of Assessment.

POLICY:

1. The ISP will be monitored and adapted collaboratively with the client at a minimum at Enrollment, the Annual Update, and the Six Month Check-In.
2. The ISP will be modified to reflect any changes in the client's situation or progress toward achieving identified goals/needs. Only current needs and goals should be reflected on the ISP.
3. Encounters are attached to the Area of Assessment in the ISP to document the client's movement toward their goal of establishing or maintaining HIV medical care. At minimum, Update and Enrollment encounters must be attached to all ISP Areas of Assessment.
4. Clients enrolled in Medical Case Management are required to have at least 1 active Area of Assessment in the ISP.

PROCEDURE:

1. The ISP is developed after the completion of the MCMAT at the time of Enrollment.
    a. The two components of the ISP are the goal and the Areas of Assessment:
        i. **Goal** - A client's ISP goal will be either establishing or maintaining HIV medical care. Clients who are actively engaged in HIV medical care must have a goal of maintaining HIV medical care. Clients not currently engaged in HIV medical care must have a goal of establishing HIV medical care. The goal must be changed from establish to maintain when both the client and HIV Case Manager have determined that the client is actively engaged in HIV medical care.

ii. **Area of Assessment** - The client and HIV Case Manager collaborate to determine which Areas of Assessment will be placed in the ISP. The HIV Case Manager will select the specific Area of Assessment and enter a progress note identifying the need/goal and actions using the ISP clipping.

2. All active Areas of Assessment in the ISP must be reviewed and addressed at the Annual Update and Six Month Check-In at a minimum or as changes occur.
   a. If no change has occurred in an Area of Assessment, the HIV Case Manager must:
      i. Update the verified date to align with when the Area of Assessment was addressed with the client.
      ii. Attach the encounter to the Area of Assessment. The encounter progress note must contain a description of progress or actions made toward the identified Area of Assessment.
   b. If a change has occurred in any Area of Assessment, in addition to the above steps the HIV Case Manager must also first add a progress note describing the change to the specific Area of Assessment using the MO CM Service clipping.

4.5 SERVICE REFERRALS

The creation of a service referral indicates that eligibility has been determined, all required documentation has been scanned into the electronic client database, and the HIV Case Manager has assessed the need to enroll the client in a specific service. The Service Referrals module allows for communication and coordination necessary to authorize enrollment in services.

POLICY:

1. A referral must be completed by the HIV Case Manager on behalf of the eligible client when it has been determined that a service is needed. A referral must be entered when a client:
   a. **Enters** a service/program
   b. **Re-enters** a service/program after a break in services
   c. **Is eligible to continue** in a service/program after the appropriate update has been Completed
2. Case Management referrals must be entered for a maximum of twelve months and must include a follow-up date for the Six Month Check-In. The twelve month referral timeframe will always be based on the month the Enrollment/Annual Update was completed. See the below table for referral schedule dates.

SECTION 4.0-HIV CASE MANAGEMENT ACTIVITIES

ENROLLMENT SERVICE REFERRAL TABLE

ENROLLMENT COMPLETED IN:	REFERRAL START DATE IS:	FOLLOW-UP DATE/6-MONTH CHECK-IN DATE IS:	REFERRAL END DATE IS:
January	Day of Enrollment	June 30th	December 31st
February	Day of Enrollment	July 31st	January 31st
March	Day of Enrollment	August 31st	February 28th (29th)
April	Day of Enrollment	September 30th	March 31st
May	Day of Enrollment	October 31st	April 30th
June	Day of Enrollment	November 30th	May 31st
July	Day of Enrollment	December 31st	June 30th
August	Day of Enrollment	January 31st	July 31st
September	Day of Enrollment	February 28th (29th)	August 31st
October	Day of Enrollment	March 31st	September 30th
November	Day of Enrollment	April 30th	October 31st
December	Day of Enrollment	May 31st	November 30th

ANNUAL UPDATE SERVICE REFERRAL TABLE

ANNUAL UPDATE DUE/CM REFERRAL EXPIRES DURING THE MONTH OF:	NEW REFERRAL STARTS ON:	FOLLOW-UP DATE/6 MONTH CHECK-IN DATE	SERVICE REFERRAL ENDS ON:
January	February 1st	July 31st	January 31st
February	March 1st	August 31st	February 28th (29th)
March	April 1st	September 30th	March 31st
April	May 1st	October 31st	April 30th
May	June 1st	November 30th	May 31st
June	July 1st	December 30th	June 30th
July	August 1st	January 31st	July 31st
August	September 1st	February 28th (29th)	August 31st
September	October 1st	March 31st	September 30th

SECTION 4.0-HIV CASE MANAGEMENT ACTIVITIES

October	November 1st	April 30th	October 31st
November	December 1st	May 31st	November 30th
December	January 1st	June 30th	December 31st

PROCEDURE:

1. All clients actively enrolled in HIV Case Management services **must have** one of the service referral types listed below, **with the exception of** Positive Start-Transitional Connections clients. At the time of Enrollment, the client is always referred to either:

   STLTGA – Case Management – HIV Case Management for all clients located in the St. Louis Transitional Grant Area.

   KCTGA – Case Management – HIV Case Management for all clients located in the Kansas City Transitional Grant Area.

   OUTSTATE – Case Management – HIV Case Management for all clients located in the Central, Northwest, Southeast, or Southwest regions.

3. Case Management referrals must be entered for 12 months and are renewed annually as long as the client continues to meet eligibility requirements and is assessed as needing the service.
4. HIV Case Managers must enter a follow-up date to indicate the month the client is due for a 6 month check-in. See referral schedule table above.
5. Referrals must include the contract and funding source appropriate for each HIV Case Manager.
6. Clients enrolled in a specialty Case Management program must have a specialty Case Management referral in addition to the Case Management Referral. Refer to specialty program procedures for guidance.

4.6 ENCOUNTERS

The client's Encounter log records the utilization of Ryan White's services and activities. This log displays information about the services a client has received. It is used to document all interactions with the client and interactions on behalf of the client. The encounter notes screen is used to document the details of the encounter.

POLICY:

1. Encounters must be entered for all interactions and/or activities.

2. All encounters reflecting HIV Case Management activities must be added using the Case Management referral and must include the HIV Case Manager's appropriate funding source.
3. Encounters must be entered within **two (2) business days.** Documentation must never be entered prior to the occurrence of the event.
4. HIV Case Managers must complete, at minimum, at least one face-to-face encounter during the client's 12-month certification period.
5. J code encounter types must be used (see appendix "I" for Case Management Encounter Codes, Glossary, and Outcome Drop-Down list). Encounter codes may vary by region/specialty program requirements.
6. A progress note must be completed for all encounters.
7. Multiple encounters of the same type occurring on the same day may be consolidated into one Encounter and/or progress note. The duration of the encounter must reflect the totality of the time spent on all consolidated encounters.
8. Travel time must be included in the associated Encounter rather than documenting separately.

4.7 PROGRESS NOTES:

Progress notes are used to capture the content of all interactions with or on behalf of the client and must include all relevant information. Progress notes must be written in a manner such that, in the HIV Case Manager's absence, another system user would be able to readily identify the client's current situation and needs in order to adequately provide needed services and support.

POLICY:

1. A corresponding progress note must be completed for every encounter entered by the HIV Case Manager.
2. Multiple encounters occurring on the same day may be consolidated into one summary progress note.
3. Progress notes must be entered as they occur and must be completed no more than **two (2) business days** following the interaction. Documentation must never be entered prior to the occurrence of the event.
4. The progress note must provide a detailed description of the interaction with or on the behalf of the client. Client notes must include only relevant information in appropriate detail, ***i.e.***, only provide information directly relevant to the delivery of services for intended client outcomes.
5. Progress notes must distinguish clearly between facts, observations, hard data, and opinions. In addition to providing accurate information, direct quotes from the client, caregivers, or other professional staff may be used to provide a full picture of the

client or situation. Progress notes must not assign blame on individuals and must be free from irrelevant speculation and offensive or subjective statements. Information may be shared with the client and/or other agencies. Therefore, records must be legible and free from jargon and slang terms.

6. Progress notes must use correct grammar, spelling, and appropriate standardized abbreviations. See Appendix H for a list of approved abbreviations.
7. In case of documentation errors, the HIV Case Manager must consult with the agency supervisor to clarify how to handle the error; the regional Quality Service Manager must be contacted to request a deletion.
8. Clippings must be used when policy dictates.

5.0-ENGAGEMENT AND RETENTION IN HIV CASE MANAGEMENT

ENGAGEMENT STANDARD SUMMARY

Entry into HIV Case Management is designed to help people living with HIV establish and maintain HIV medical care. Prior to a client's decision to engage in Case Management, several processes may occur. When a client decides to enroll in Case Management services based on inquiry, an Intake will occur, followed by case assignment. Engagement in HIV Case Management is assured by the processes of Inquiry, Intake, Agency assignment, and Case assignment.

5.1 INQUIRY

POLICY:

Any individual can contact the HIV Case Management system to obtain more information about eligibility for and services provided by the program. Callers will be given information regarding community resources regardless of their intent to enroll in the system.

PROCEDURE:

1. The representative will provide information as requested by the caller.
2. The representative will inquire if the caller is in medical care. If not, the representative will provide information on available providers.
3. If client requests an intake the representative will refer the caller to the Intake Cordinator or complete the Intake.

5.2 INTAKE

POLICY:

When a client contacts a representative of the Ryan White HIV Case Management System wanting to engage in HIV medical care and HIV Case Management services, they must first be screened for any immediate needs requiring a referral to emergency medical or community services. Referrals for HIV Case Management services may also come from a variety of sources, including but not limited to: providers' offices, state and local public health systems, emergency rooms, hospitals, STD clinics, family/friends, and any other Ryan White partners. Client, their guardian or power of attorney, must provide written or verbal consent to complete an Intake.

The function of the Intake and screening is to:

1. Establish the client's willingness and eligibility to participate in HIV Case Management.
2. Gather information that will assist in decision making regarding immediate needs.
3. Assign the client to the appropriate HIV Case Management agency.

5.0-ENGAGEMENT AND RETENTION IN HIV CASE MANAGEMENT

Intake is a separate process documented in the electronic client database and demonstrates to the referring and receiving agencies that an Intake has occurred. Completing the Intake process will indicate the client is ready for case assignment and must be contacted to schedule an enrollment. The process by which clients enter the HIV Case Management system may vary by region or agency.

PROCEDURE:

1. Once consent to complete an Intake is provided, an individual with appropriate experience to assess client needs will conduct the Intake (***e.g.***, HIV Case Manager, Lead HIV Case Manager, agency supervisor, designated Intake Coordinator, etc.). **This person will be referred to as the Intake Coordinator in this document.**

2. The Intake Coordinator will utilize the HIV Case Management Intake/Data form (or DHSS-approved Regional Intake Form) to gather all required information and obtain verbal consent for entry into the electronic client database. The form must be scanned into the Documents module of the electronic client database.

3. The Intake Coordinator will discuss with the client all eligibility requirements of the Missouri HIV Case Management system as outlined in Section 3 of this manual and provide the client with a list of items that may be useful to bring to the first meeting with the HIV Case Manager. The list may include but is not limited to:

    a. Documentation of HIV+ status

    b. Documentation of Residency

    c. Documentation of Income

    d. Documentation of Health Coverage - (i.e. Insurance cards, Proof of Medicaid Application, etc) if applicable

    e. Driver's license or photo identification card

        i. If there is a legal name change, see the Legal Name Change Policy in Section 9 for a list of acceptable documentation.

    f. Social Security card or proof of Social Security number

        i. If there is a legal name change, see the Legal Name Change Policy in Section 9.

    g. Medical records the client has available, such as CD4 and viral load labs

    h. Name and contact information for the client's primary and/or specialty health care provider(s), if currently in medical care.

4. Search for the client in the electronic client database to ensure a duplicate record is not created. The Intake Coordinator must search by the following items individually:
    a. Legal last name
    b. Legal first name
    c. Social Security Number (If the client has a valid Social Security Number)
    d. Date of Birth.
5. If there is no match, a new file must be added by clicking the "add new" button on the search page. If the client already exists in the electronic client database, select the existing file. The following modules must be completed and/or updated by the Intake Coordinator prior to agency assignment. These modules may be completed individually or by using the Ryan White Intake Workflow (Appendix A). The Intake Coordinator must <u>not</u> "verify" any fields in the electronic client database.
    a. Demographics
        i. Enter a household size in the Demographics module (includes the client and all other individuals living in the residence, regardless of familial relationship).
    b. Case Status - Select "Open" for a new client; "Re-opened" for previously enrolled clients.
    c. Diagnosis
    d. Housing
    e. Service Referrals - An Intake service referral will be entered for 30 days, starting the date the Intake was completed.
        i. If the client does not enroll prior to the expiration of the Intake service referral and continues to actively work toward enrollment, a one-time 30-day extension of the Intake service referral is permitted. HIV Case Managers must notify the supervisor of the extension and change the end date of the referral. A progress note must be added to the Intake referral documenting the reason for the extension.
    f. Encounters - An Intake Encounter must be completed using an Intake clipping. If the enrollment is done simultaneously as the Intake, a separate encounter must be added for each activity. A progress note documenting relevant information that will assist in case assignment must be attached to the Intake encounter.
    g. Communicate – Send a communicate message in the electronic client database to the individual responsible for case assignment **within two (2) business days**.
6. The completion of the Intake process will result in a referral to an appropriate individual for HIV Case Management assignment.

5.0-ENGAGEMENT AND RETENTION IN HIV CASE MANAGEMENT

5.3 HIV CASE MANAGEMENT ASSIGNMENT

POLICY:

The process by which a client is assigned to an HIV Case Manager may vary by region or agency. When the Intake Coordinator assigns a client to an agency, a communicate message is sent to the individual responsible for the case assignment. This individual will review the client's file and assign an HIV Case Manager within **two (2) business days**.

Care must be taken to ensure that the client is referred to the appropriate HIV Case Management and/or specialty Case Management program or agency (ex: Linkage to Care, Positive Start Transitional Case Management, Resource and Referral Case Management, etc.). **The HIV Case Management agency must have a plan to provide backup/coverage if the individual responsible for the case assignment is absent from the workplace.**

PROCEDURE:

1. The individual responsible for the case assignment must review all pertinent modules in the electronic client database to assist in making an appropriate Case Management assignment. The Intake Coordinator may be contacted if additional information and/or case conferencing is needed prior to the case assignment.
2. The individual responsible for the case assignment must inform the assigned HIV Case Manager and/or agency supervisor of the assignment **within two (2) business days** so the client can be contacted for enrollment (Section 5).

5.4 ENROLLMENT STANDARD

PURPOSE:

Enrollment in HIV Case Management is defined as a series of activities conducted to establish a client's eligibility to access Ryan White services for those clients new to the Missouri Ryan White System. These activities include assessing a client's strengths and resource needs, and collaboratively developing an ISP to address both the medical and supportive needs of the client.

POLICY:

1. The assigned HIV Case Manager will contact the client within two (2) business days of assignment to schedule the Enrollment appointment.
2. Every effort must be made to ensure that the Enrollment appointment occurs within thirty (30) days of the HIV Case Manager assignment.
    a. All contact attempts must be documented in the electronic client database. If there is a delay with the Enrollment, all attempts to contact the client, results of the contact, and

reasons for delay will be entered in the encounter/progress notes portion of the electronic client database. Refer to agency or regional policy to determine next steps.

b. A minimum of three (3) attempts will be made to contact the client.

3. The HIV Case Manager must conduct the Enrollment face-to-face at a site mutually acceptable to the client and HIV Case Manager. All eligibility documentation must be obtained and scanned into the electronic client database before the Enrollment can be completed and services provided. All modules in the electronic client database must be verified at the time of Enrollment.

   a. For clients who need immediate access to Core Medical Services (Section 1) and cannot immediately provide income and/or residency eligibility documents at Enrollment, refer to Section 5.5 for Rapid Enrollment Standard.

4. HIV Case Managers must obtain copies of the following documents from the client, if available:

   a. Driver's license or other photo identification card (State ID, Passport, Military ID)

   b. Any insurance, MO HealthNet, Medicare, or Veteran's Administration cards as applicable

   c. Social Security card

   d. Medical records the client has available, specifically CD4 and Viral Load counts

5. All information captured during the Enrollment visit and subsequently provided by the client will be entered into the electronic client database within two (2) business days. All information obtained during the Intake process must be verified and updated as needed.

PROCEDURE:

1. Determine if the client has a Departmental Client Number (DCN) by calling the Department of Health and Senior Services HIV care program at 573-751-6439. If the client does not have a DCN, request that one be assigned. The client's name, social security number, and date of birth will be needed to obtain a DCN. If the client has not yet been assigned a DCN, the client's Race, Ethnicity and Language will also be needed.

2. Review and discuss eligibility requirements and obtain the required documentation from the client (Section 3).

3. Review and complete the required Missouri HIV Case Management system forms with the client (Section 4).

4. Review, complete and/or verify all appropriate electronic database modules (Section 4)

5. Complete the MCMAT (Section 4).

6. Develop the Individual Service Plan in collaboration with the client (Section 4).
7. Enter appropriate service referrals (Section 4).
8. Enter an enrollment encounter/progress note using the Enrollment/Annual update clipping (Section 4).

All information gathered from the client must be entered into the electronic client database (Section 4). An Enrollment/Annual Update workflow has been established to assist in the completion of required modules; the use of the workflow is optional. See Appendix B for the Enrollment/Annual Update workflow.

5.5 RAPID ENROLLMENT STANDARD

PURPOSE:

Provide clients with immediate access to limited Core Medical Services when they are unable to immediately provide income and/or residency eligibility documents at Enrollment. These limited services include:

- AIDS Drug Assistance Program (ADAP)
- Outpatient/Ambulatory Health Services
- Medical Case Management

POLICY

Clients are eligible for Rapid Enrollment if they have previously accessed Missouri Ryan White Case Management Services, regardless of time passed since case closure, or are able to provide documentation of HIV+ status. Acceptable documentation of HIV+ status must be uploaded to the electronic client database before services can be provided. Clients must attest to meeting current income and residency requirements. This process assures immediate access to Core Medical Services for clients who cannot provide income and/or residency documentation at the time of Enrollment. Clients are granted a 30-day window to provide acceptable income and residency documentation (Section 3) and complete the full Enrollment process.

PROCEDURE:

1. If acceptable documentation of HIV+ status is not already uploaded into the electronic client database, HIV Case Manager must obtain and scan into the database.
2. Sign the Rapid Enrollment Attestation Form (HIV Case Manager may sign on behalf of client with verbal attestation) and upload to the electronic client database.
3. Determine if the client has a Departmental Client Number (DCN) by calling the Department of Health and Senior Services HIV care program at 573-751-6439. If the client does not have a DCN, request that one be assigned. The client's name, social security

number, and date of birth will be needed to obtain a DCN. If the client has not yet been assigned a DCN, the client's Race, Ethnicity and Language will also be needed.

4. Complete and verify Income and Housing modules.
5. Enter appropriate case management/specialty service referral(s) for 30 days and place in 2PEN status.
6. Enter appropriate non-case management service referrals for Core Medical Services. Refer to applicable manuals or regional policy for additional guidance.
7. Enter *Rapid Enrollment* encounter with a progress note utilizing the Rapid Enrollment clipping.
8. Before the end of the 30-day window, complete full, face-to-face Enrollment with the client; this includes obtaining acceptable income and residency eligibility documents (Section 3) and completing the following activities:
    a. Upload any outstanding eligibility documentation to the electronic client database.
    b. Verify or update Income and Housing modules
    c. Complete or verify all remaining electronic database modules
    d. Review and complete the required Missouri HIV Case Management system forms with the client
    e. Complete the MCMAT
    f. Develop the Individual Service Plan in collaboration with the client
    g. Enter *Enrollment* encounter with a progress note utilizing the Enrollment/Annual Update clipping.
    h. Update the current case management/specialty service referral(s) end date to reflect the full 12 month-long certification period (Section 4) and place in 8ENR status.
    i. The HIV Case Manager will alert the DHSS Benefits Administrator and/or all applicable Recipients by placing the Part B Core Medical Service Referrals in 2SRR. Enter all other non-case-management service referrals once full enrollment is complete.
9. Case Closure Policy & Procedure (Section 8) must be followed if any of the following are not completed by the end of the 30-day window:
    a. Client does not provide acceptable income and residency documentation.
    b. Client provides acceptable documents and is determined ineligible for services.
    c. Client does not complete full Enrollment, including MCMAT and/or Individual Service Plan.

10. If a client wants to re-engage in services after being closed, they must complete the intake process (Section 5.2). If another Rapid Enrollment is needed, the HIV Case Manager must submit an exception request. Refer to Recipient for guidance.

5.6 ANNUAL UPDATE STANDARD

PURPOSE:

The HIV Case Management Annual Update is defined as a series of activities conducted to establish a client's continued eligibility to access Ryan White services. It is also intended to re-assess a client's strengths, resources, and needs/goals to collaboratively develop a strategy to address both the medical and supportive needs of the client.

POLICY:

Ongoing monitoring and re-evaluation of the client's status through a formal Annual Update process assures that HIV Case Management supports the client's progress toward the goals of engagement in and maintenance of HIV medical care. To ensure payer of last resort status for the Ryan White HIV Case Management System, HIV Case Managers will follow a 12-month referral process for all Ryan White funded services.

PROCEDURE:

1. The assigned HIV Case Manager will attempt contact with the client no less than 30 days, but up to 60 days prior to the Case Management referral end date to schedule the Annual Update appointment.

    a. A minimum of three (3) documented attempts will be made to contact the client; a varied approach may be needed to make contact with the client (ex: phone calls, emails, mailed letters, etc.)

    b. All contact attempts must be documented in the electronic client database. If the client does not return calls or make contact to set an Annual Update appointment or is unable to meet with the HIV Case Manager within the 30-day limit, all attempts to contact the client, results of the contact, and reasons for delay will be entered in the encounter and progress notes portion of the electronic client database.

    c. Refer to Case Closure Policy & Procedure (Section 8) when appropriate.

2. Requirements for conducting the Annual Update face-to-face will vary depending on whether the client has a suppressed or unsuppressed viral load.

    a. For clients who have a suppressed viral load, the Annual Update may be completed face-to-face or via phone, depending upon client preference, client availability, access to transportation, etc. The HIV Case Manager must offer to conduct the Annual Update face-to-face at a site mutually acceptable to the client and HIV Case Manager.

   b. For clients who have an unsuppressed viral load, the Annual Update must be conducted face-to-face at a mutually acceptable site to the client and HIV Case Manager.

3. Review and discuss eligibility requirements and obtain required documentation from the client. All eligibility documentation must be obtained prior to the continuation of services; (Section 3).
4. Review and complete the required Missouri HIV Case Management system forms with the client (Section 4).
5. Complete the MCMAT (Section 4)
6. Develop the Individual Service Plan in collaboration with the client (Section 4)
7. Enter the appropriate service referrals (Section 4)
8. Enter an Annual Update encounter and progress note (Section 4) using the Enrollment/Annual update clipping.

All information gathered from the client must be entered into the electronic client database. An Enrollment/Annual Update workflow has been established to assist in the completion of required modules; use of the workflow is optional. See Appendix B for the Enrollment/Annual Update workflow.

EARLY ANNUAL UPDATES:

1. If the update cannot be completed in the month in which it is due, the update may be completed up to 60 days prior to the case management service referral end date. After the Annual Update is completed, the HIV Case Manager must:
   a. Edit the end date of the active case management service referral to the end of the current month.
   b. Enter a new case management service referral for 12 months (see Section 4) beginning the 1st of the next month.
   c. When applicable, appropriate service providers may need notified that the Annual Update was completed early.
2. If a client needs to complete the Annual Update prior to the above 60-day window, the HIV Case Manager must obtain approval from the Agency Supervisor/QSM.
3. Agency Supervisor/QSM must document approval in appropriate case management service referral. Any other non-Case Management service referrals will need to be addressed with the appropriate administrator.

PAST DUE ANNUAL UPDATES:

1. If the client is unable to complete their Annual Update in the specified timeframe, all referrals will expire, and the client will be unable to receive Ryan White funded services.

2. If the client completes the update within one calendar month after the current referral end date, the HIV Case Manager must proceed with the completion of the update. The start date will be backdated to the first of the month, and the end date will not change. Client will keep their regular update schedule.
3. Documentation during this time must be entered using the expired referral. If the update has not been completed by the end of the calendar month, the case must be closed.
4. If the client presents for the update more than one calendar month from the referral end date, the HIV Case Manager must complete a new Intake and Enrollment. The client's update schedule will then change to correspond to this new timeframe. If enrolling a client, refer to the Enrollment Standard for guidance.

See the Service Referral table in Section 4 for appropriate referral start and end dates.

5.7 SIX MONTH CHECK-IN STANDARD

PURPOSE:

The purpose of the Six Month Check-In is to re-evaluate a client's strengths, resources, and needs/goals; and to collaboratively reassess the strategy developed by the HIV Case Manager and client to address both the medical and supportive needs of the client.

POLICY:

HIV Case Managers are required to monitor and re-evaluate the client's progress towards the goals of engagement in and maintenance of HIV medical care at a Six Month Check-In. This Check-In should be completed in the month of the case management service referral follow-up date. The Six Month Check-In is not required to be completed face-to-face.

PROCEDURE:

1. The assigned HIV Case Manager will attempt contact with the client in the month of the case management service referral follow-up date to complete the Six Month Check-In.
    a. A minimum of three (3) documented attempts will be made to contact the client; a varied approach may be needed to make contact with the client (ex: phone calls, emails, mailed letters, etc.)
    b. If a Six Month Check-In is not completed, clients will not be closed from services.
        i. For clients who are virally suppressed (documented viral load less than 200 copies with in the last 12 months), no further action is required until the Annual Update is due.
        ii. For clients who are **not** virally suppressed or do not have evidence of care in the last 12 months, the HIV Case Manager will attempt contact at least

twice per month until the Check-In is completed or the Annual Update is due.

2. The Six Month Check-In must include a discussion of the following topics with the client:
    a. Changes to Health Coverage (Section 2)
    b. Treatment Adherence and Engagement in Care
    c. Risk Reduction
    d. Individual Service Plan Progress
3. Update and/or verify the Individual Service Plan in collaboration with the client (Section 4).
4. Enter the appropriate Service Referrals, if client needs have changed (Section 4).
5. Enter a Six Month Check-In encounter and progress note (Section 4) using the Six Month Check-In clipping.
6. A Six Month Check-In workflow has been established to assist in the completion of required modules (Appendix C).

If a client self-reports a change to income or residency, please see Section 3.

SECTION 6.0-MONITORING ENGAGEMENT IN HIV STANDARD

MONITORING ENGAGEMENT IN CARE STANDARD

PURPOSE:

The purpose of this policy is to provide guidance for HIV Case Managers as they work with clients to improve their viral load suppression and retention in care.

POLICY:

Engagement in Care is evidenced by two suppressed viral load labs at least 90 days apart within the last 12 months. Any evidence of care must be documented in the electronic client database. HIV Case Managers must work with client to obtain labs, if not already documented in the database. If the Engagement in Care standard has not been met, the HIV Case Manager must include *Health-Adherence (Medication & Treatment)* in the ISP to address actions and steps needed to achieve viral load suppression and/or engagement in care.

PROCEDURE:

1. If the electronic client database does not show evidence of two viral load labs at least 90 days apart within the last 12 months, the HIV Case Manager must obtain labs.

    a. HIV Case Managers may obtain labs directly from the provider's electronic medical records (EMR) system, or verbally from the provider's office, and document in the *Verified Medical Care* Module. If labs are not present in the EMR, HIV Case Managers must enter a *Labs Review* encounter and process to step three (3).

    b. If the HIV Case Manager does not have access to the provider's EMR, they must request confirmation of the most recent viral load/CD4 labs and document using the *Labs Request* encounter type. Labs received must be documented in the *Verified Medical Care* module.

2. If the Engagement in Care standard has been met (two suppressed viral load labs, at least 90 days apart within the last 12 months), no further action is required.

3. If the Engagement in Care standard has not been met (two suppressed viral load labs, at least 90 days apart within the last 12 months):

    a. The HIV Case Manager will include *Health-Adherence (Medication & Treatment)* in the ISP that identifies actions and interventions that will be performed to address client-identified barriers to achieving viral load suppression and/or engaging in HIV medical care. Interventions may include peer support, developing a contact schedule, teach back on labs, and/or attending medical appointments with client/communicating with provider.

SECTION 7.0-TRANSFER STANDARD

TRANSFER STANDARD

Clients may transfer within the Missouri Ryan White HIV Case Management System for a variety of reasons. Transfers may occur within the Case Management agency to a new HIV Case Manager, between Case Management agencies within the current region, or a Case Management agency outside of the region. The HIV Case Manager may also help clients transfer to a state outside of the Missouri Ryan White HIV Case Management coverage area. All transfers will utilize a systematic process that responds to the client's needs, HIV Case Manager, agency, and system.

POLICY:

1. A transfer may be initiated for any of the following reasons:
    a. Client request; agency supervisor approval required
    b. HIV Case Manager request; agency supervisor approval required
    c. Supervisory decision for caseload distribution
    d. Client requires or requests specialty Case Management services
    e. Client relocation outside of the agency area, regional service area, or state
2. Refer to the regional policy for transfers within the region.

7.1 TRANSFERRING A CLIENT BETWEEN REGIONS WITHIN THE MISSOURI RYAN WHITE SYSTEM

PROCEDURE:

If aware of the transfer in advance:

1. The transferring HIV Case Manager will:
    a. Report to the supervisor the reason(s) for transfer (if applicable).
        i. If the client-requested transfer is denied, the receiving Regional/Agency Supervisor will explain the reason for denial in the electronic client database
        ii. If the client-requested transfer is denied, the transferring Regional/Agency Supervisor will provide the client with an explanation of the reason for denial and information regarding the complaint, grievance, and appeal process.
    b. Contact the agency/region that will be receiving the transfer to initiate case assignment. Refer to the Case Management Map and Contact List published on the MO DHSS website (https://health.mo.gov) for Intake contact/protocol.
    c. Provide the client with the name and contact information for the receiving agency and/or HIV Case Manager.
    d. Complete the "Transfer Workflow" or review the following modules in the electronic client database:

i. Housing
ii. Demographics - update Program Information
iii. Social Support
iv. Professional Contacts - update the HIV Case Manager; close the current HIV Case Manager and enter the new HIV Case Manager, if known
v. Documents –eligibility and Payer of Last Resort documents
vi. Assessment - MCMAT
vii. Service Plan
viii. Service Referrals – keep regional Case Management referral active until the transfer is completed as indicated by new regional Case Management referral
ix. Encounters - enter 'Transfer Encounter' (Transfer to Case Manager In Region/Transfer to Case Manager Out of Region) with detailed progress note including any pertinent client information, outstanding issues, or pending items
x. Health Coverage
xi. Income
xii. Verified Medical Care - must be updated with most recent lab results and verified medical visit
xiii. Communicate -
    1. Send a communicate to the receiving HIV Case Manager/Agency Supervisor/Intake Coordinator/QSM regarding the official transfer of the client's case.
    2. After confirmation of the completed transfer, a communicate must be sent to any other user who needs knowledge of the transfer (HSI and owners of non-Case Management referrals).

*If any of the items listed above are not present, not current, or pending, the transferring HIV Case Manager must take steps to notify the receiving HIV Case Manager and/or agency to ensure a seamless transfer.

2. The receiving HIV Case Manager will:

    a. Enter an Intake Referral into the client chart and document all client interactions. See Intake Policy (Section 4). Consult with agency supervisor as needed regarding HIV Case Manager assignment.

    b. Review the 'Transfer Encounter' progress note and contact the transferring HIV Case Manager with any questions or required clarification.

    c. Collect new residency documentation. If applicable, collect new income documentation (Section 3.4). Consult with the receiving agency supervisor to determine whether an Enrollment/ Update must be completed.

i. If a new MCMAT is completed at the time of transfer receipt, an updated MCMAT is still required at the client's Annual Update.

d. Attempt to contact the client within two (2) business days of case assignment. If the HIV Case Manager is unable to make contact with the client, a minimum of three (3) attempts must be documented within a thirty (30) day period.

e. Enter region-specific Case Management referral once regional eligibility has been verified. If not completing an annual update, the referral end date must align with the previous region's case management referral end date.

f. Once the transfer is complete, the receiving HIV Case Manager will send a communicate to the transferring HIV Case Manager to close regional referrals.

If unaware of transfer in advance:

1. The receiving HIV Case Manager will:

   a. Enter an Intake Referral into the client chart and document all client interactions. See Intake Policy Section 4. Consult with agency supervisor regarding HIV Case Manager assignment as appropriate.

   b. Work with the client immediately to prevent any gaps in services.

   c. Collect new residency documentation. If applicable, collect new income documentation (Section 3.4). Consult with the receiving agency supervisor to determine whether an Enrollment/ Update must be completed.

      i. If a new MCMAT is completed at the time of transfer receipt, an updated MCMAT is still required at the client's Annual Update.

   d. Complete the 'Transfer Workflow' or review the following modules in the electronic client database:

      i. Housing

      ii. Demographics - update Program Information

      iii. Social Support

      iv. Professional Contacts - update the HIV Case Manager; close the current HIV Case Manager and enter the new HIV Case Manager, if known

      v. Documents –eligibility and Payer of Last Resort documents

      vi. Assessment – MCMAT

      vii. Service Plan

      viii. Service Referrals – Enter region-specific Case Management referral once regional eligibility has been verified. If not completing an annual update, the referral end date must align with the previous region's case management referral end date.

ix. Encounters – enter a 'Transfer to Case Manager Out of Region' Encounter with a detailed progress note including any pertinent client information, outstanding issues, or pending items

x. Health Coverage

xi. Income

xii. Verified Medical Care

xiii. Communicate - must be sent to the transferring HIV Case Manager regarding the official transfer of the client's case within two (2) business days.

e. The receiving HIV Case Manager will alert the transferring HIV Case Manager within **two (2) business days** that the client has relocated to the region.

2. The transferring HIV Case Manager will:

a. Review the 'Transfer Encounter' progress note and contact the receiving HIV Case Manager to provide clarification as needed.

b. Close the regional Case Management referral after the receiving HIV Case Manager has confirmed that the transfer is complete.

c. After confirmation of completed transfer, a communicate must be sent to any other user who needs knowledge of the transfer (HSI and owners of non-Case Management referrals).

7.2 TRANSFERRING A CLIENT TO ANOTHER STATE:

1. The **transferring** HIV Case Manager will use the following protocol to transfer a client's case to a state outside of the **Missouri Ryan White system**:

a. The client will identify where they are moving and the anticipated relocation date.

b. The HIV Case Manager will assist the client in researching and identifying Ryan White services and/or agencies in the client's new community. The HIV Case Manager may choose to initiate contact with agencies on the client's behalf or partner with the client. If client- level data is to be provided, a release of information must be completed and scanned into the electronic client database.

c. Information obtained regarding available resources must be provided to the client; all information provided to the client must be documented in the electronic client database.

d. The HIV Case Manager must initiate a conversation regarding moving preparedness with the client to ensure minimal service interruption (***i.e.***, sufficient amount of medications, transfer of health coverage benefits, etc.)

e. Provide verification of HIV status if requested by the client.

f. When the HIV Case Manager is aware that the client has officially moved out of the Missouri Ryan White service area, the client's file must be inactivated and closed in the electronic client database according to the Case Closure Standard (Section 8).

SECTION 7.0-TRANSFER STANDARD

2. Clients relocating from the State of Kansas to Missouri:

   a. The **receiving** Missouri HIV Case Manager will use the following protocol to receive a transferred case from **the State of Kansas** (excluding the KCTGA-designated counties of Leavenworth, Johnson, Wyandotte, and Miami):

   b If the transferring HIV Case Manager is unable to get the Client File Sharing Consent (See SCOUT Support Files) at the time of transfer, the receiving HIV Case Manager must create a duplicate file in the electronic client database and complete the Client File Sharing Consent form to have the files merged. Please reference the HSI-Electronic Client Database Client File Sharing Policy for more detailed instructions.

   c. The receiving HIV Case Manager will complete an Enrollment (Section 5).

SECTION 8.0-REMOVAL, READMISSION, AND CASE CLOSURE STANDARD

8.1 REMOVAL AND READMISSION

PURPOSE:

HIV Case Management is a voluntary program based on eligibility requirements, assessed need, and available funding. Clients may choose to decline participation in HIV Case Management at any time. Clients may be removed from HIV Case Management at the discretion of the HIV Case Management system. If a removed client seeks readmission to HIV Case Management services, designated individuals within the HIV Case Management system will re-evaluate the situation to determine eligibility. A final decision may be based upon the use of the appropriate complaint, grievance, and appeal process.

POLICY:

The following may result in permanent or time-limited closure to Missouri HIV Case Management and will require Regional Case Management Supervisor (RCMS), Quality Service Manager (QSM), and/or Recipient approval:

1. Endangering the life of an HIV Case Manager or others at the HIV Case Management agency or referral agency
2. Threatening and/or abusive behavior
3. Fraud
4. Criminal activity on agency property
5. Disrespectful or discourteous behavior
6. Carrying or displaying weapons during appointments or visits

The following may result in closure until the successful completion of stipulated requirements. The HIV Case Manager must consult with the agency supervisor to determine any stipulations; the RCMS, QSM, or Recipient may be consulted as needed:

1. Unable to locate and/or failure to respond to communication
2. Failure/refusal to provide requested information and documentation or comply with program requirements

Any other identified concerns/infractions not listed above must be brought to the attention of the agency supervisor if the HIV Case Manager deems that closure may be warranted. Individual agencies may implement agency-specific closures independently; regional or statewide closures require the appropriate Recipient(s) approval.

PROCEDURE:

1. Document all activities leading to consideration of closure, including RCMS/QSM/ Recipient approval (if required) in the electronic client database.

2. Consult with agency supervisor regarding circumstances leading to closure. Consultation must include discussion of any other services that may be impacted by the client's closure

   from Case Management and may include a discussion with other parties, as appropriate. A determination will be made at this time regarding the closure, including the timeframe for closure and any stipulated requirements that must be met prior to readmission.

3. The client must be notified of the closure in writing; the letter must include the reason for closure, timeframe for closure, and any stipulated requirements that must be met prior to readmission. Scan copy of closure letter into Documents module.

4. For closures due to not responding to communication or not providing requested information/documentation, written notification of the closure will come from the HIV Case Manager.

5. Written notification of case closure due to all other policy violations will come from Agency Supervisor, RCMS, QSM, Recipient, etc., as appropriate.

6. If the client is unable to receive mail, documentation of the closure conversation with the client must be entered in the progress note section of the closure encounter.

7. In addition to the closure letter, the client must be provided with a copy of the *Complaint, Grievance, and Appeal Policy* and the *Removal and Readmission Policy*.

CRITERIA FOR CONSIDERATION FOR READMISSION TO HIV CASE MANAGEMENT AND/OR SERVICES:

1. Specified closure timeframe has been met.
2. Demonstration that required stipulations have been achieved *(*may require additional HIV Case Management Authorization for Release of Protected Health Information).
3. Submission of all required documentation prior to readmission.
4. The HIV Case Management agency and/or other designated entity will re-evaluate requests for readmissions.

8.2 CASE CLOSURE

PURPOSE:

Clients may be closed from HIV Case Management Services for various reasons. Closing a client correctly from Case Management is necessary to maintain accurate data, run accurate reports, and clearly identify service dates for a client utilizing the Ryan White System. There may be times when a client will be closed to HIV Case Management services in some regions, but not to the entire electronic client database.

SECTION 8.0-REMOVAL, READMISSION, AND CASE CLOSURE STANDARD

POLICY:

1. Case closure must occur within **five (5) business days** for the following reasons:
    a. Death
    b. Rule violation (may result in suspension or permanent closure)
    c. Case Management service referral expiration.
    d. Client initiated closure at a time other than at a regularly scheduled Update (client requests closure, client is moving out of state, client is incarcerated in Missouri Department of Corrections, etc.). The HIV Case Manager will document the reasons for closure in a progress note.
    e . The client is HIV negative.
2. In some cases, the HIV Case Manager may be actively working to engage or retain the client in services. In these cases, it may be appropriate to delay full closure of the client's file; delays of this nature must not extend for greater than 30 days. After 30 days, the closure must be immediate. The HIV Case Manager must consult with the agency supervisor if opting to delay full closure and document all contacts with/on the client's behalf. No services are provided during this time.
3. Once a case closure is completed, the client must be notified by their HIV Case Manager. Notification may consist of letter, email, text, phone call, etc.

PROCEDURE:

The Case Closure Workflow and has been established to assist in completion of required modules; use of the workflow is optional. If a client is deceased, all end dates must correspond with the date of death, not the date of entry.

Note that there may be programs within each region (Part C clinics, housing providers, food providers, etc.) that will require specific modules to remain active following Case Management case closure; please consult with any applicable programs for their closure guidelines. The following steps must be taken to update the appropriate modules in the client's record when closing a client from HIV Case Management services:

1. Search Client: select the correct client to be closed.
2. The following modules must be modified for clients who are being closed to Case Management services:
    a. Demographics: Review the client's Demographic module. If the client is deceased, enter the date of death and select the corresponding cause. If the exact date of death is unknown, enter the first day of the month of death. Additionally, change the active button from " yes" to "no" to close out the case from the electronic client database. Remove the HIV Case Manager's name from the Case Management dropdown box by selecting the blank/null selection located at the top of the dropdown menu.

b. Case Status: Enter the end date (the date the client's case is effectively closed) and select an option from the "Why Closed" dropdown. If the client is being closed with a time-limited suspension or permanent closure, the HIV Case Manager must indicate that by entering an additional note in the progress notes section; the note must include the reason for suspension/closure, the date at which the client will be considered for Enrollment, and any stipulated requirements that must be met prior to readmission. If the client is permanently closed, the progress note must clearly state the reason why.

The below are criteria for closing a client to HIV Case Management, and the HRSA required case status "Why Closed" code:

Case Status:

CLTCONOUP	Client contacted, update not complete
CLTSSNOIN	Client self-sufficient (not over income)
DECEASED	Deceased: Client has passed away
INCARCERATE	Incarcerated: Client is now incarcerated in a county, city, state, federal jail, or prison.
INSTITUTIO	Other medical institution (Psychiatric, etc.)
LOT CALF	Long term care/assisted living facility
NOT FIN E	Client over income
OUT OF STA	Relocated out of state
POLICYVIO	Policy Violation (aggression, fraud, etc.)
UNLOCNOUP	Unable to locate client, update not completed

c. Documents: Scan any remaining documents, letters, or other forms of communication that were mailed to/on behalf of the client before or during the closure process.

d. Professional Contacts: Enter an end date, verified date, and change the "Active" status to "No" for only the HIV Case Manager entry in Professional Contacts.

e. Service Referrals: If the service referral is already expired or closed, this step is not needed.

   i. To close a Case Management referral, change the "Active" status to "No," and change the end date to the date of closure (including specialty Case Management). The referral status must be changed to 7CLS.

   ii. To close non-Case Management referrals made to HSI (ADAP, Insurance Continuation, Outpatient/Ambulatory, etc.), HIV Case Managers must change the referral status to 2SRR and enter a note in the service referral indicating reason for Case Closure(Communicate to HSI not needed)

f. Communicate: A communicate message must be sent to any other user(s) who needs knowledge of this change in status, and any other service providers to which a referral has been made.

g. Encounter: Enter *Case Closure* encounter.

h. Progress Notes: The progress note must detail the circumstances surrounding the client's closure. If the client is being closed with a temporary suspension or permanent closure, include the reason for suspension/closure, the date at which the client will be considered for enrollment, and any stipulated requirements that must be met prior to readmission. If the client is permanently closed, please state clearly the reason why.

3. For clients who have negative HIV results:

   a. The HIV Case Manager must:

      i. Scan into Documents – 1 VERIF NEG – Verification of Negative HIV Status (attached and scanned in negative HIV lab test once received as requested)
      ii. Deactivate Case Management service referrals and proceed with the case closure workflow
      iii. Send a communicate message to the agency supervisor and RCMS/QSM
      iv. If continued support is provided to the client and documented in the electronic client database, the RCMS/QSM must be notified

   b. The RCMS/QSM must:

      i. Change Encounters to RSR ineligible
      ii. In the Diagnosis Module, indicate the client is HIV Negative

8.3 ELECTRONIC CLIENT DATABASE ALERT

PURPOSE:

This feature acts as a warning to inform electronic client database Users of clients who engaged in fraudulent or violent behavior or pose a safety risk to others. It also includes clients currently suspended or banned from Ryan White services. When clients violate any rule listed on the "Policies for Removal and Readmission from Case Management" or present an imminent safety concern for the staff or affiliated parties, the HIV Case Manager will notify their Agency Supervisor of the rule violation/imminent safety concern.

POLICY:

The RCMS and/or QSM and relevant recipients determine which clients require an electronic client database alert and the content of the alert note.

PROCEDURE:

SECTION 8.0-REMOVAL, READMISSION, AND CASE CLOSURE STANDARD

1. Upon observing/becoming aware of a rule violation/imminent safety concern, HIV Case Managers will immediately notify their Agency Supervisor.
2. The HIV Case Manager will document the incident in the electronic client database.
3. The HIV Case Manager will document the case conference in the electronic client database.
4. Agency Supervisor (AS) contacts RCMS/QSM to notify of violation of rules or potential safety/security risk.
5. The RCMS/QSM determines the necessity of an alert and consults with relevant recipients and parties.
6. If an alert is needed, the QSM adds this feature and a note to the client's file in the electronic client database.

WHEN A CLIENT WITH AN ALERT MAKES CONTACT:

1. When a client with an alert contacts a Ryan White staff member, the staff member will review the alert in the electronic client database.
2. If nothing in the alert indicates the client is suspended from services, the staff member will consult with their Agency Supervisor.

If the alert indicates that the client is suspended from services, a designated staff member will remind the client of the suspension and provide the client the phone number for the Agency Supervisor or designated staff member who will follow up with the RCMS/QSM.

SECTION 9.0-RECORD AND DOCUMENTATION STANDARD

9.1 CONFIDENTIALITY AND SECURITY STANDARD

All interactions with or on the behalf of clients must be documented in a timely, objective manner and maintained in a complete, confidential file. The electronic client database is the primary repository of client-specific information. A physical file may be maintained, according to agency policy, but all information must be entered in the electronic client database.

POLICY:

Ryan White HIV Case Managers will:

1. Maintain confidentiality, according to HIPAA and HITECH guidelines.
2. Ensure two locks protect all physical files.
3. Ensure all computer files are password-protected, and work area secured when unattended.
4. Comply with all state, federal, HIPAA, and HITECH guidelines concerning maintaining confidentiality and HIV.
5. Comply with agency-specific written HIPAA/HITECH policies regarding the acquisition of records by the client. Consult with Recipient/agency supervisor/QSM immediately and prior to the release of confidential information.
6. Comply with agency-specific written HIPAA/HITECH policies regarding how to handle the transfer of records in response to a subpoena or search warrant. Consult with Recipient/agency supervisor/QSM immediately and prior to the release of confidential information. Ensure that other client names are not in records requested by the courts.
7. Comply with agency HIPAA/HITECH policies regarding electronic communication (email, text) with clients. Current HIPAA and HITECH confidentiality must be used.
8. Release records of deceased clients only to a legal executor designated in a Letter of Testimony (Will) or Letter of Administration (court appointment).
9. Release records in accordance with HIPAA/HITECH standards.
10. Maintain closed records and records of deceased clients for a minimum of six (6) years for adults; for minors, maintain records for at least six (6) years after the age of 21. If a client has not been enrolled in Ryan White services within the past six (6) years or greater, the physical record must be destroyed.
11. Retain any records that are currently under legal review, regardless of the timeframe.
12. Maintain a listing by name, DCN, date closed, and reason for closure for all destroyed records.
13. Safeguard clients' confidentiality at all times by keeping files closed, turning computer screen away from public view, using fax cover sheets marked ‘confidential,’ and including client names or other identifying information only in secure, encrypted emails. When faxing, inquire about the confidentiality of the physical area of the fax recipient.

14. Notify the administrator of the electronic client database immediately when a user's database access must be terminated or when the required/approved level of security access has changed.
15. Under no circumstances should a user of the electronic client database share password information with another individual (includes other HIV Case Managers, student interns, volunteers, auditors, etc.).

9.2 CASE MANAGEMENT RECORD REQUEST

POLICY:

1. All clients in HIV Case Management have the right to request their HIV Case Management record. This includes the right to inspect and/or obtain a copy of the Protected Health Information, as well as to direct the covered entity/agency to transmit a copy to a designated person or entity of the individual's choice. The client's request to direct the PHI to another person must be in writing, signed by the client, and clearly identify the designated person and where to send the PHI.
2. HIPAA/HITECH guidelines must be used for any redactions necessary. Two categories of information are expressly excluded from the right of access:
    a. Psychotherapy notes the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, and maintained separately from the rest of the patient's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501
    b. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).
3. If the agency maintains physical HIV Case Management records, excluding documentation in the electronic client database, the record must be kept for six years.
4. Record requests must be completed in writing by the client or legal guardian and/or legally appointed representative. An agency may require the client to use the agency's own supplied form. Provided using the form does not create a barrier to or unreasonably delay the individual from obtaining access to PHI. Agencies are encouraged to offer clients multiple options for requesting access to PHI.
5. The agency must provide access to the PHI request no later than thirty (30) calendar days from receiving the client's request. HIV Case Managers must work with their Recipient/agency supervisor/QSM on all client requests.

PROCEDURE:

1. The client must notify the agency staff of the record request in writing.
2. The client may be provided with an agency form that can be used to assist the client in obtaining information related to the request. This form is not required; the client may choose to write the request without the use of a form.

3. If not already involved, the supervisor and Recipient will be notified of the record request.
4. The agency's Case Management supervisor will scan the written record request in the electronic client database.
5. Missouri Department of Health, any affected Recipient, and HSI will coordinate the printing of all requested documentation.
6. The record request will be processed according to the client's preference (mail, in person, electronic).

9.3 ELECTRONIC COMMUNICATION

POLICY:

The Ryan White system requires securing Protected Health Information (PHI) on all mobile media, laptops, workstations, servers, and externally hosted sites to comply with HIPAA/HITECH.

1. This policy and the guidelines apply to all workforce members in the Ryan White System who use, collect, and/or access PHI.
2. Protected Health Information contained on laptops or workstations are required to be either file, folder, or full disk encryption. All mobile devices (such as smartphones and tablets) connected to the secure network and transmit PHI (e.g., email) must accept Information Security Standards to encrypt and protect the information and devices. External storage drives (e.g., backup tapes, removable drives such as "jump drives" or "flash drives") will need to be able to encrypt the PHI. If using text messaging, an example to secure these messages would be to utilize a bi-directional text messaging service or other features that secure the text on Outlook vs. texting on a mobile device.
3. Files that contain PHI that are transmitted across the Internet (e.g. email attachments, reports with PHI, etc.) will need to have the attachment encrypted.
4. Workforce members will secure their user IDs and passwords for the electronic client database and agency. They will not share these passwords with another person or vendor. Any forwarding of secure and/or encrypted email to any external services is not permitted.
5. Email and text communication should not be used in case of emergency issues. A phone call is most appropriate for such issues. Secure email and text messaging must be used for activities such as appointment confirmation. The use of personal mobile devices is discouraged due to security issues. Refer to agency policy for more information regarding HIPAA and HITECH.

PROCEDURE:

The process for documenting in the client's electronic record is detailed in specific policies throughout this and other associated manuals.

SECTION 9.0-RECORD AND DOCUMENTATION STANDARD

9.4 SCANNING

POLICY:

1. A comprehensive client record in the electronic client database assists in the provision of HIV Case Management. Scanning documents into the record allows other users to have access to information for timely service provision. Additionally, Ryan White funded providers may have access to add documents and information about services they provide to inform HIV Case Managers.
2. HIV Case Managers will assure the confidentiality of the documents by leaving no documents in view of the public while they are being scanned. Agencies are required to place scanning equipment in a confidential location.
3. Documents will be scanned into the electronic client record within **two (2) business days of receipt.** Timely scanning of documents is required to avoid delays in the provision of services.
4. Documents that have been scanned may be shredded according to agency policy.

PROCEDURE:

1. Below is the list of documents to be scanned. There may be additions to this list based on your region, agency requirements, or programmatic requirements.
    a. Scan one time or with a change**:**
        i. Verification of HIV positive status
        ii. State identification card/driver's license if available (including with legal name change)
        iii. Insurance card or documentation if applicable (including with legal name change)
        iv. Verification of Medicare A, B, & D if applicable (including with legal name change)
        v. Social Security card if available (including with legal name change)
    b. Scan at each Enrollment/Annual Update:
        i. Case Management authorization for Protected Health Information (PHI)
        ii. Client Signature Form
        iii. Verification of Income (see Section 3 for specific guidelines)
        iv. Verification of Residency in Missouri and case management region
        v. Verification of legal name change

vi. Verification of MO HealthNet application or Missouri Pre-eligibility Tool (if receiving applicable services – See Missouri Statewide Services Manual)

2. Two types of documentation of legal name change must be provided before a client name can be changed in the electronic client database. The following are acceptable types of documentation:
   a. Marriage License/Certificate
   b. Adoption Certificate
   c. Driver/Non-Driver's License or State ID
   d. Social Security Card
   e. Passport
   f. Official Court Document/Court Order
   g. Military ID

3. Other documentation may be scanned per regional/agency/specific-program policy. For further guidance regarding Statewide or Outstate requirements, please see the Missouri Statewide Services Manual and/or Outstate Services Manual. Refer to Document Description with Category List (Appendix K) for guidance on the appropriate selection of document type.

9.5 DOCUMENTING PrEP REFERRALS:

POLICY:

The HIV Case Manager will document the following activities:

1. PrEP referrals for clients' partners
2. PrEP discussions with clients/clients' partners and resources for accessing PrEP

PROCEDURE:

1. The HIV Case Manager will discuss PrEP with their clients/clients' partners as appropriate.
2. The HIV Case Manager will enter the appropriate encounter for this interaction in the electronic client database. The HIV Case Manager will insert a progress note that accompanies the encounter in the electronic client database.
3. The HIV Case Manager will add the "PREP – Individual Referred to PrEP Resources" Activities and Procedures code to the encounter.

SECTION 9.0-RECORD AND DOCUMENTATION STANDARD

9.6 ELECTRONIC SIGNATURES

POLICY:

Client electronic signatures are acceptable. All electronic signature platforms must be HIPPA/HITECH compliant and be approved by MO DHSS. Using these platforms does not change requirements for face-to-face encounters.

SECTION 10.0-EMERGENCY PREPAREDNESS GUIDANCE

EMERGENCY PREPAREDNESS GUIDANCE

POLICY:

In the event of an emergency, such as a pandemic, natural disaster, terrorist attack or otherwise, the Recipient is responsible for determining if/when the policy will apply. Ensuring the safety of clients and HIV Case Managers during an emergency is a top priority for the Ryan White Case Management System. While case management activities are normally an interpersonal process with face-to-face interactions, this process can be adjusted during an emergency. The purpose of this policy is to provide guidance to Ryan White HIV Case Managers and supervisors.

HIV Case Managers must obtain all required eligibility determination documentation for all updates. For those clients who are unable to provide the required eligibility documentation prior to the end of the current case management referral, client can verbally attest to meeting program eligibility using the Emergency Preparedness and Response Limited Access Attestation Form (EPRF) until acceptable documentation can be provided. HIV Case Managers must continue to assist clients with obtaining required documents. Verbal signatures may be used for approved forms and the annual face-to-face requirement is suspended for the duration of the emergency.

PROCEDURE:

1. Verification of Eligibility Documentation
    a. The HIV Case Manager must review the EPRF with the client.
    b. The client must verbally attest to meeting program eligibility requirements.
    c. The HIV Case Manager must sign EPRF and upload into the electronic client database.
2. HIV Case Managers may use "verified over the telephone, (due to emergency)" in lieu of client signatures on the following forms, when applicable:
    a. Universal Attestation Form
    b. Medicaid Screening Tool
    c. Income Attestation Form (IAF)
    d. Residency Verification Form (homelessness only)
    e. ADAP/HICP Affidavit of Missed or Declined Health Insurance Form
    f. Specialty Case Management Forms (may vary by program).
3. The following forms require a client signature (physical or electronic) but will not impact client's enrollment into RW Case Management.
    a. Release for PHI
    b. Health Insurance Continuation Program Release form

Note: In regard to ensuring health and safety of both HIV Case Managers and clients, individuals are encouraged to follow local safety guidelines.

SECTION 11.0 – QUALITY MANAGEMENT STANDARD

QUALITY MANAGEMENT STANDARD

The Missouri Ryan White HIV Case Management System's integrity is ensured through ongoing evaluation of care and services and dissemination of information to HIV Case Managers and agencies. Analysis of various reports identifies system strengths as well as areas for study and improvement. These reports are based on data contained in the statewide electronic client database.

11.1 EVALUATION OF CARE AND SERVICES

The Ryan White National Monitoring Standards require that Recipients:

1. Develop strategies for ensuring that services are consistent with the guidelines for improving access to and quality of HIV health services.
2. Conduct chart reviews and visits to agencies to monitor compliance with the Quality Management Plan and Ryan White's quality expectations.
3. Participate in quality management activities as contractually required.
4. Ensure compliance with relevant service category standards of care.
5. Collect and report data for use in measuring performance.

POLICY:

1. Electronic client records will be audited at minimum annually and compared with an established standard for HIV Case Manager performance. Performance not meeting the established standard may result in the implementation of a corrective action plan.
2. Chart audit and performance measures are developed based on previous findings and HIV Case Management standards.
3. Reports of annual audits are shared regionally, with HIV Case Management agencies, and individual HIV Case Managers.

PROCEDURE:

1. QSM, RCMS, Educators, and others as assigned will conduct the audit.
2. Results of annual or focused audits may identify items that can be the basis of quality improvement activities as well as areas for continuing education and training.

11.2 INCIDENT/QUALITY MANAGEMENT REPORTING

The MODHSS utilizes an Incident/Quality Management Report to document and report issues, complaints, errors, hotline calls, and other concerns. The form is to be submitted within **two (2) business** days of the occurrence/incident. Information gathered will track occurrences and identify trends to promote quality assurance and improvement. If the report includes a client

name, a DCN must be included.

The Incident/Quality Management Report is not part of the client record and needs to be maintained in a separate file. No reference must be made to the report in the electronic client record. Future encounter/progress notes must contain objective documentation of significant issues identified in the Incident/Quality Management Report.

DISTRIBUTION:

Submit **typed** form to agency Case Management supervisor for submission to Regional Supervisor and/or QSM. The completed form will be forwarded to the DHSS Director of Case Management.

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APPENDICES

APPENDIX A – INTAKE WORKFLOW

A. INTAKE WORKFLOW:

Module	Intake Workflow Pop Up Screen
Search Client	Search for a client in the database. Search SEPARATELY by first name, last name, SS#, and date of birth. Check for duplicate client.
Case Status	Enter the appropriate case status for the client (open or re-open) and start date.
Demographics	Enter information from Intake/ Data Form into Module.
Documents	Upload Intake/Data form and any other provided documentation into the Module.
Diagnosis	Enter HIV Diagnosis Information.
Housing	Enter the physical and mailing address information provided.
Service Referral	After assessing eligibility, enter Intake Service Referral.
Encounters	Enter an Intake encounter. Enter a progress note that corresponds to the Encounter utilizing the information from the Intake/Data Form.
Health Coverage	Record all sources of current Health Coverage. Enter a progress note as needed.
Income	Document all income, including spousal and dependent income, per Section 3.0of Case Management Manual. Enter a progress note as needed.
Communicate	Send a Communicate to the supervisor or Case Manager on duty or Intake Worker (depending on region) to advise them of the new Intake for their agency, any pertinent information that occurred during Intake and next steps to be taken.

All Modules need to be verified in the electronic database at the time of enrollment.

APPENDIX B – RAPID ENROLLMENT WORKFLOW

B. RAPID ENROLLMENT WORKFLOW:

Module	Rapid Enrollment Workflow Pop Up Screen
Search Client	Search for the client in the database. Search SEPARATELY by first name, last name, SS#, and date of birth. Check for duplicate client.
Diagnosis	Enter HIV Diagnosis Information.
Income	Document all income, including spousal and dependent income, per Section 5 of Case Management Manual. Enter a progress note as needed.
Housing	Enter the physical and mailing address information provided.
Demographics	Verify and/or update demographic information, as appropriate.
Documents	Upload required documentation per section 5 of Case Management Manual.
Service Referral	After client attests to eligibility, enter a 30-day regional Case Management Service Referral in 2PEN stats. Enter other appropriate Core Medical service referrals based on client need.
Encounters	Enter Rapid Enrollment update encounter with progress note that utilizes Rapid Enrollment clipping.

APPENDIX C – ENROLLMENT WORKFLOW

C. ENROLLMENT WORKFLOW

Module	Enrollment Workflow Pop Up Screen
Search Client	Search for the client in the database. Search SEPARATELY by first name, last name, SS#, and date of birth. Check for duplicate client.
Case Status	Verify and/or enter the appropriate case status for the client (open or re-open) and start date.
Housing	Enter the physical and mailing address information provided.
Demographics	Verify and/or update demographic information, as appropriate.
Social Support	Enter spouse and/or dependents in module. Enter any other social supports provided by client, as needed.
Professional Contacts	Enter Ryan White Case Manager and HIV Provider. Enter any other professional contacts, as needed.
Documents	Upload all required documents to the module, per section 9 of manual.
Assessment Interview	Record Missouri Case Management Assessment Tool results in the module.
Service Plan	Enter the Areas of Assessments that were developed in collaboration with the client. Add a minimum of one progress note utilizing the MO CM Service Plan clipping.
Service Referral	After determining eligibility, enter a twelve month regional Case Management Service Referral including a six month follow-up date. Enter all other appropriate service referrals based on client need.
Encounters	Enter enrollment update encounter with progress note that utilizes MO CM Enrollment/Annual update clipping.
Health Coverage	Record all sources of current Health Coverage. Enter a progress note as needed.
Income	Document all income, including spousal and dependent income, per Section 3 of Case Management Manual. Enter a progress note as needed.
Employment	Enter employment information, if known.
Diagnosis	Enter HIV Diagnosis Information.
Verified Medical Care	Review and record the client's most recent verification of medical visit, CD4, or Viral Load.

APPENDIX D –ANNUAL UPDATE WORKFLOW

D. ANNUAL UPDATE WORKFLOW

Module	Annual Update Workflow Pop Up Screen
Search Client	Search for the client in the database. Search SEPARATELY by first name, last name, SS#, and date of birth. Check for duplicate client.
Case Status	Verify the appropriate case status for the client (open or re-open) and start date.
Housing	Verify and update housing. Change/add any new housing. Close any expired housing.
Demographics	Verify and/or update demographic information, as needed.
Social Support	Verify and update emergency contacts, dependents, and household members. Close any expired social supports.
Professional Contacts	Verify and update professional contact information as needed. Close any expired professional contacts.
Documents	Upload all required documents to the module, per section 9 of manual.
Assessment Interview	Record Missouri Case Management Assessment Tool results in the module.
Service Plan	Verify and/or update the service plan. Enter progress notes utilizing the MO CM Service Plan clipping, as needed.
Service Referral	After determining eligibility, enter a twelve month regional Case Management Service Referral including a six month follow-up date. Enter all other appropriate service referrals based on client need.
Encounters	Enter annual update encounter with progress note that utilizes MO CM Enrollment/Annual Update clipping.
Health Coverage	Verify and update any changes in health coverage. Enter a progress note as needed. Close any expired entries listings.
Income	Verify and update all income, including spousal and dependent income, per Section 3 of Case Management Manual. Enter a progress note as needed.
Employment	Verify and update any changes in employment. Close any expired listings.
Diagnosis	If there is any new diagnosis (i.e., from HIV progressed to AIDS), add a new entry for diagnosis.
Labs	Review module to verify engagement in care.
Verified Medical Care	Review and record the client's most recent verification of medical visit, CD4, or Viral Load.

APPENDIX E – SIX MONTH CHECK-IN WORKFLOW

E. SIX MONTH CHECK-IN WORKFLOW:

Module	Six-Month Check-In Workflow Pop Up Screen
Demographics	Verify and/or update demographics, as needed.
Social Supports	Verify and update emergency contacts, dependents, and household members. Close any expired social supports.
Professional Contacts	Verify and update professional contact information as needed. Close any expired professional contacts.
Service Plan	Verify and/or update the service plan. Enter progress notes utilizing the MO CM Service Plan clipping, as needed.
Encounters	Enter Six Month Check-In Encounter(s). Enter a progress note Utilizing the Six Month Check-In clipping.
Health Coverage	Verify and update any changes in health coverage. Enter a progress note as needed. Close any expired entries.
Labs	Review module to verify engagement in care.
Verified Medical Care	Review and record the client's most recent verification of medical visit, CD4, or Viral Load, if not in Labs module.

APPENDIX F – MO CASE TRANSFER WORKFLOW

F. MO TRANSFER WORKFLOW:

Module	Case Transfer Workflow Pop Up Screen
Housing	Confirm current address and last verified date.
Demographics	Confirm current data listed in this module.
Social Support	Confirm that the social support list is up to date and verified.
Professional Contacts	Confirm that Ryan White Case Manager and client HIV Provider are listed in professional contacts and verified.
Documents	Confirm that there is a scanned verification of HIV+ status, verification of income, verification of residence, and health coverage/payer of last resort documentation.
Assessment Interview	Assure there is a current MCMAT completed.
Service Plan	Assure there is a current service plan completed and last verified date(s).
Service Referrals	Confirm there is a current case management service referral and other support service referrals as needed.
Encounters	Enter a "Transfer" Encounter with a progress note detailing transfer and any other pertinent information, issues or pending items. Transfer codes are as follows: J. 10.50 = Transfer in Region; J. 10.53 = Transfer Out of Region.
Health Coverage	Confirm current coverage and last verified date.
Income	Confirm current income sources and last verified date.
Labs	Review module to verify engagement in care.
Verified Medical Care	Confirm most recent labs and verified medical care visits, if not in Labs module.
Communicate	Send communicate to receiving HIV Case Manager/agency supervisor/intake coordinator regarding the official transfer of the client's case. Additionally, a message needs to be sent to any other user who needs knowledge of the transfer, including all programs to which a referral has been made.

APPENDIX G – CASE CLOSURE OPEN TO OTHER SERVICES WORKFLOW

G. MO CASE CLOSURE WORKFLOW:

Module	MO Case Closure Workflow Pop Up Screen
Case Status	Enter an end date and select an option from the "why closed" drop down. Enter circumstances surrounding closure. Include reasoning for any suspension or permanent closure. See Case Management Manual subsection 8 for details
Demographics	Review client's demographic profile (if client is deceased, enter date of death and selected cause) and change the Active button to "no". Remove your name from the CM drop-down menu by selecting blank/null selection at the top of the drop-down menu.
Professional Contacts	Enter the end date, verified date, and change the ACTIVE status to NO for only the Case Manager's entry in professional contacts.
Documents	Scan any remaining documents, letters, or other communication sent to the client or on behalf of the client before or during the closure process.
Service Referrals	Close the CM referral and any specialty CM (SPPC, etc.) by changing ACTIVE status to NO, change end date to date of closure for all CM referrals, and change referral status to 7 CLS. Only change CM and CM specialty referrals.
Encounter	Enter a "Case Closure" encounter and corresponding progress note detailing the reason for closure. Document circumstances surrounding case closure. Include reasoning for suspension or permanent closure.
Communicate	Send a message to other users who need to know of the change of status and all programs to which a referral has been made, advising them of the closure to Ryan White CM.

APPENDIX H – ABBREVIATIONS AND ACRONYMS

H. ABBREVIATIONS & ACRONYMS:

PURPOSE:

To assure consistent use and understanding of abbreviations and acronyms commonly used.

POLICY:

Only approved abbreviations and acronyms will be used in documentation.

Acquired Immune Deficiency Syndrome	AIDS
Activities of Daily Living	ADL
Adult Expansion Group (Expanded Medicaid)	AEG
Affordable Care Act	ACA
Agency Supervisor	AS
AIDS Drug Assistant Program	ADAP
Also Known As	AKA
Americans With Disabilities Act	ADA
Antiretroviral Therapy	ART
Apartment	APT
Appointment	APPT
Area of Assessment	AOA
As Necessary	PRN
Assistant	ASST
Blood Pressure	BP
Cut down, Annoyed, Guilty, Eye-opener (CAGE) Assessment	CAGE
Case Manager	CM
Case Management Educator	CME
Case Management Supervisor	CMS
Center for Disease Control	CDC
Client	CLT
Care Of or Complains Of	C/O
Consolidated Omnibus Budget Reconciliation Act	COBRA
Date of Birth	DOB
Date of Death	DOD
Date of Service	DOS
Department of Corrections	DOC
Department of Health and Senior Services	DHSS
Department of Mental Health	DMH
Department of Social Services	DSS
Departmental Client Number	DCN

APPENDIX H – ABBREVIATIONS AND ACRONYMS

Diagnosis	DX
Direct Enrollment Services	DES
Disease Intervention Specialist	DIS
Doctor	DR
Doctor of Osteopathy	DO
Eligible Metropolitan Area	EMA
Emergency Department	ED
Emergency Preparedness and Response Limited Access Attestation Form	EPRF
Emergency Room	ER
Estimated Day of Confinement (Due Date)	EDC
Expiration	EXP
Explanation of Benefits	EOB
Face to Face	F/F; F2F
Family Case Manager	FCM
Family Services Division	FSD
Federal Poverty Level	FPL
Female to Male	FTM
Follow Up	F/U
For Your Information	FYI
Gender Nonconforming	GNC
Health Insurance Portability and Accountability Act	HIPAA
Health Insurance Premium Program	HIPP
Health Resources and Services Administration	HRSA
Health Strategic Initiatives	HSI
Hepatitis A Virus	HAV
Hepatitis B Virus	HBV
Hepatitis C Virus	HCV
Highly Active Antiretroviral Therapy	HAART
Hispanic	HISP
History	HX
Home Visit	HV
Housing and Urban Development	HUD
Housing Assistance Notification Form	HAN
Housing Assistance Verification Form	HAV
Housing Opportunities for Persons with AIDS	HOPWA
Human Immunodeficiency Virus	HIV

APPENDIX H – ABBREVIATIONS AND ACRONYMS

Human Papilloma Virus	HPV
Individual Service Plan	ISP
Income Attestation Form	IAF
Income Determination Form	IDF
Infectious Disease	ID
Injection Drug User	IDU
Lead Case Manager	LCM
Level of Care	LOC
Linkage to Care	LTC
Low-Income Subsidy	LIS
Male to Female	MTF
Medical Doctor	MD
Men Having Sex with Men	MSM
Mental Health	MH
Message	MSG
Midwest AIDS Training and Education Center	MATEC
Missouri Health Net	MHN
Missouri High-Risk Insurance Pool	MHIP
Missouri Case Management Assessment Tool	MCMAT
Negative	NEG
Non-binary	NB
Not Applicable	N/A
Nurse Practitioner	NP
Office Visit	OV
Opportunistic Infection	OI
Oral Contraceptives	OC
Outpatient	OP
Over the Counter	OTC
Payer of Last Resort	POLR
Persons Living with HIV/AIDS	PLWHA
Person with Aids	PWA
Phone Call	PC
Prescription	RX
Quality Service Manager	QSM
Rapid Enrollment Attestation Form	REAF
Regarding	RE
Regional Case Management Supervisor	RCMS

APPENDIX H – ABBREVIATIONS AND ACRONYMS

Registered Nurse	RN
Related To	R/T
Residential Care Facility	RCF
Resource and Referral	R&R
Rule Out	RO
Ryan White	RW
Securing Client Outcomes Using Technology	SCOUT
Sexually Transmitted Infection	STI (STD)
Signs and Symptoms	S/S
Single, Married, Divorced, Widowed	S, M, D, W
Social Security Administration	SSA
Social Security Disability	SSD
Social Security Disability Income	SSDI
Social Security Income	SSI
Social Security Number	SSN
Spenddown	SD
State Plan Personal Care	SPPC
Substance Use Disorder	SUD
Substance Abuse and Mental Health Services Administration	SAMHSA
Telephone Call	TC
Temporary Aid for Needy Families	TANF
Transgender	TG
Transitional Case Manager	TCM
Transitional Grant Area	TGA
Treatment	TX
True Out of Pocket	TROOP
Verified Medical Care	VMC
Viral Load	VL
Voicemail	VM
Waiver Personal Care	WPC
Within Normal Limits	WNL
Women, Infants, and Children Supplemental Feeding Program	WIC
Women who have sex with Women	WSW
Youth Case Manager	YCM

APPENDIX I – HIV CASE MANAGEMENT DOCUMENTATION SCHEDULE

I. HIV CASE MANAGEMENT DOCUMENTATION SCHEDULE:

Items to be Documented for each Process	Enrollment	Six Month Check-in	Annual Update	With Status Change
Intake				
1. Intake/Data Form	Optional	Optional	Optional	
2. Complete modules contained in the Ryan White Case Intake Workflow	Required			
Enrollment/Annual Update				
1. Client Signature Form	Required		Required	
a. Rights and Responsibilities	Required		Required	
b. Policies for Removal and Re-admission	Required		Required	
c. Complaint, Grievance, and Appeal	Required		Required	
d. FAQs	Optional		Optional	
e. Notice of Privacy Policy	Required		Required	
f. Healthy for Life	Optional		Optional	
2. Income Determination Form	Reference Only			
3. MCMAT 2.0	Required		Required	Required
4. ISP	Required	Update Required	Update Required	Update Required
5. Client Personal Medical/Health Information Form (PHI)	Required		Required	Required
6. Medical Information Request Form (MIRF)	Optional	Optional	Optional	Optional
7. Agency and Medical Case Manager Contact Information	Required	Optional	Required	Required
8. Complete Modules listed Ryan White Enrollment/Update Workflow	Required		Required	Required
9. Encounter/Duration	Required at Each Contact	Required at Each Contact	Required at Each Contact	Required at Each Contact

APPENDIX I – HIV CASE MANAGEMENT DOCUMENTATION SCHEDULE

10. Progress Notes	Required at Each Contact	Required at Each Contact	Required at Each Contact	Required at Each Contact
11. Viral Load (may or may not include a CD4)			Expectation: 2x per Year	
12. HIV Medical Visits			Expectation: 2x per Year	
13. Required Eligibility Documentation (Refer to MO HIV CM Manual, Section 3.0)	Required		Required	Required in certain circumstances; see Policy on self-reported income (3.4)

APPENDIX J – CASE MANAGEMENT ENCOUNTER CODES AND GLOSSARY

J. CASE MANAGEMENT ENCOUNTER CODES AND GLOSSARY

The following codes are used to identify the type of encounter being recorded:

J10.03	Initial Contact
J10.05	Agency Assignment
J10.07	Case Manager Assignment
J10.0R	Rapid Enrollment
J10.11	Home Visit
J10.2	Office Visit
J10.26	Six Month Update
J10.27	Six Month Check-In Phone Call
J10.28	Six Month Check-In Home Visit
J10.29	Six Month Check-In Office Visit
J10.2B	Hospital Visit
J10.2E	Home Visit- Enrollment
J10.2F	Office Visit- Enrollment
J10.2H	Home Visit- Annual Update
J10.2M	Medical Visit (Accompanied Client)
J10.2O	Office Visit Annual Update (letter O, not zero)
J10.2P	Annual Update Phone Call
J10.3O	Outreach/Marketing (letter O, not zero)
J10.4	Document (when not included in another encounter)
J10.43	Phone call with client
J10.46	Phone calls on behalf of client (advocacy, information gathering, etc.)
J10.47	Electronic Communication
J10.48	Support Groups
J10.50	Transfer to Case Manager in Region
J10.51	Transfer to DES
J10.53	Transfer to Case Manager out of Region

APPENDIX J – CASE MANAGEMENT ENCOUNTER CODES AND GLOSSARY

J10.56	Risk Reduction/Prevention with Positives
J10.57	Transfer to Resource and Referral in Region
J10.58	Supervision
J10.60	Clinical/Case Conference
J10.61	Clinical Conference-Adherence/Risk Reduction
J10.63	Chart Audit
J10.66	Case Closure
J10.7	Intake
J10.84	Labs Request
J10.85	Labs Review
J10.9A	Administration Time
J10.9T	Time Not Worked (Sick, Vacation)

Encounter Codes Glossary

1. J10.03 - **Initial Contact:** The purpose of the Initial Contact Encounter Policy and Procedure is to describe the process for documenting a case manager's first attempt to contact a newly assigned client.
2. J10.05 - **Agency Assignment**: used when a client is assigned to an agency, but not yet to a specific Case Manager.
3. J10.07 - **Case Manager Assignment**: used when a client is assigned to a specific Case Manager.
4. J10.0R – **Rapid Enrollment**: office/clinic visit, home visit, or phone call to complete Rapid Enrollment process with a client
5. J10.11 – **Home Visit**: this code is used for an interaction/visit with a client in any place other than the Medical Case Manager's office or clinic site and for a *purpose other than Enrollment, Six Month Check-In, or Annual Update.* This can include such venues as an in-patient hospital room, nursing home, restaurant, institutions, or other neutral sites. Choices made from the "Service Outcomes" drop-down can further identify the type of encounter and activities or counseling that occurred.

APPENDIX J – CASE MANAGEMENT ENCOUNTER CODES AND GLOSSARY

6. J10.2 – **Office Visit**: meeting with a client for any purpose other than enrollment or annual update in the office/clinic setting, including physician office and/or emergency room.
7. J10.26 – **Six-Month Update**: office/clinic visit, home visit, or phone call to complete six-month update with a client (used prior to 1/1/2023)
8. J10.27 - **Six Month Check In Phone Call**: phone call to complete Six Month Check-In with a client (used after 1/1/2023).
9. J10.28 - **Six Month Check In Home Visit**: home visit (setting outside the office or clinic site) to complete six month check-in with a client (used after 1/1/2023).
10. J10.29 - **Six Month Check In Office Visit**: office /clinic visit to complete six month check-in with a client (used after 1/1/2023).
11. J10.2B – **Hospital Visit**: Case Manager visits client while inpatient at a medical facility. This encounter should not be used by a Hospital Liaison to document visiting an inpatient client.
12. J10.2E – **Home Visit – Enrollment**: home visit (setting outside the office or clinic site) to enroll a client in case management services. The recording of this encounter is vital to accurately reflect the time from intake to enrollment for federal reporting.
13. J10.2F – **Office Visit – Enrollment**: office /clinic visit to enroll a client in case management services. The recording of this encounter is vital to accurately reflect the time from intake to enrollment for federal reporting.
14. J10.2H – **Home Visit – Annual Update**: home visit (setting outside the office or clinic) To complete an annual update and re-assessment of a client.
15. J10.2M – **Medical Visit (Accompanied Client) –** to document a case manager attending a medical appointment with a client.
16. J10.2O – **Office Visit – Annual Update**: office/clinic visit to complete an annual update and re-assessment with a client. (The last character is the letter O.)
17. J10.2P – **Annual Update Phone Call**: phone call to complete an annual update and re-assessment of a client.
18. J10.3O – **Outreach/Marketing**: time spent on outreach with a client and marketing of the case management system to providers and collaborative partners in the community. (The last character is the letter O.) See your Grantee for use.

APPENDIX J – CASE MANAGEMENT ENCOUNTER CODES AND GLOSSARY

19. J10.4 – **Document** (when not included in another encounter): to record the time spent receiving and processing documents not associated with another encounter. For example, the time needed to process medical records received from a physician, including faxes.
20. J10.43 – **Phone call with client:** when Medical Case Manager makes a phone call to or receives a phone call from a client. Multiple calls about a single subject in a single day may be bundled into one encounter representing the total time spent.
21. J10.46 **- Phone call on behalf of client:** when a Medical Case Manager makes or receives a phone call regarding a client with someone other than the client (advocacy, information gathering, etc.) Multiple calls about a single subject in a single day may be bundled into one encounter representing the total time spent.
22. J10.47 - **Electronic Communication:** when a Medical Case Manager makes or receives a text or email from/to/on behalf of a client.
23. J10.48 – **Support Groups:** time Medical Case Manager spent facilitating program funded support groups. See your Grantee for use.
24. J10.50 – **Transfer to Case Manager IN Region:** time spent preparing and transmitting information for a client transferring between Case Managers in the same region
25. J10.51 - **Transfer to DES**: time spent preparing and transmitting information for a client transferring to a Direct Enrollment Services (DES) program
26. J10.53 – **Transfer to Case Manager OUT OF Region:** time spent preparing and transmitting information for a client transferring between Case Managers in different regions.
27. J10.56 - **Risk Reduction/Prevention with Positives**: to document risk reduction activities including referral to formal programs, conversations and counseling with client, condom distribution, etc.
28. J10.57 - **Transfer to Resource and Referral in Region**: time spent preparing and transmitting information for a client transferring to a Resource and Referral program in the same region.
29. J10.58 **– Supervision**: discussion/meeting held between a supervisor and a Ryan White Medical Case Manager, in accordance with the Ryan White agency contract. See your Grantee for use.

APPENDIX J – CASE MANAGEMENT ENCOUNTER CODES AND GLOSSARY

30. J10.60 – **Clinical/Case Conference**: discussion of issues around a client with peers, supervisors, Case Management Supervisor, Quality Service Manager, physician, physician office staff, or others.
31. J10.61-**Clinical Conference-Adherence/Risk Reduction:** used to record a discussion of issues regarding the importance of 100% adherence to medication schedule or the importance of risk reduction in daily activities. Activities do not have to occur at the same time.
32. J10.63 – **Chart Audit**: to be used by **supervisory** personnel to record time spent conducting electronic or paper record reviews to assure the quality of care and record-keeping. Medical Case Managers will use this designation for time spent doing peer chart audits within their agency.
33. J10.66 – **Case Closure:** to be used when completing a case closure
34. J10.7 – **Intake:** to be used by any person completing an intake on a client, whether the client will be assigned to another Medical Case Manager or their enrollment will immediately follow Intake. Reporting of the time interval between Intake and Enrollment is a HRSA requirement.
35. J10.84 - **Lab Request:** to be used when requesting HIV labs (via fax, email, or phone) from a client's provider.
36. J10.85 - **Labs Review**: time spent by Case Manager reviewing HIV labs in a clinic/provider's Electronic Medical Records (EMR) system.
37. J10.9A – **Administration Time:** time spent on duties related to the conduct of the business of the agency or region as opposed to time spent on behalf of a particular client. Indicate the activity in the notes box in the encounter log or choose one from the outcomes drop-down. See your Grantee for use.
38. J10.9T – **Time Not Worked (Sick, Vacation):** time a Case Manager is out of the office and not working. See your Grantee for use.

APPENDIX K – DOCUMENT DESCRIPTION WITH CATEGORY

K. Document Description with Category:

ACA-AE pre-application with signature
ACA - Documentation
Additional Assessment Data
Agency Client Service Request Form
Case Consultation
Client Doc - Birth Certificate
Client Doc - Driver's License/ State ID
Client Doc - Healthcare Directives/Durable POA
Client Doc - Immigration Documentation
Client Doc - Medical Records **(includes MIRF)**
Client Doc - Social Security Card
Client Doc - Will
Client File Sharing Consent
CM Service Agreement (Data Sheet)
Community Referrals
Copy of Birth Certificate if bill in minor chds nm
Correspondence
Documentation of Medical Visit
Exception Request
Grievance Policy
Health Coverage – Change Release Form/EFT Term
Health Coverage - HSI Card
Health Coverage - HSI Release for Insurance (2)
Health Coverage - Insurance Cont./COBRA
Health Coverage - Insurance Eligibility letter
Health Coverage - Letter of Creditable Coverage
Health Coverage - Medicaid Card
Health Coverage - Medical Bills/EOBs
Health Coverage - Medicare A & B
Health Coverage - Medicare Part A
Health Coverage - Medicare Part B
Health Coverage - Medicare Part C
Health Coverage - Medicare Part D
Health Coverage - Private Insurance Documentation
HICP Client Refund(s)
HIPAA Release
HOPWA Enrollment Form
Housing - Assistance Notification Form
Housing - Assistance Verification Form
Housing - Community Housing App./ Verification
Housing - Criminal Background Check
Housing – Family Verification of Demonstrated Need
Housing - HOPWA Inspection Form
Housing – Lead-Based Paint Disclosure Form
Housing Lease
Housing – Mortgage Payment/Verification
Housing - Other

APPENDIX K – DOCUMENT DESCRIPTION WITH CATEGORY

Housing - Physician Verification of Demonstrated Need
Housing- Rent Reasonableness Checklist
Housing – Rights and Responsibilities
Housing - Utility Asst. Calculation Worksheet
Housing - Utility Bill
Housing- VAWA Domestic Violence Certification
Housing – VAWA Lease Addendum
Housing – VAWA Notice of Occupancy Rights
Housing - W-9 Taxpayer ID Number
HSI Client Correspondence
HSI Employer Insurance Verification Form
LTC Data Sheet
KS - Health Insurance Continuation Enrollment
KS – Signature Page
KS - Medicaid Screening Tool
Marriage Certificate
MCM - Budget Planner
MCM – Emergency Preparedness Response Form
MCM – Income Determination Form
MCM - Intake Form
MCM – Release of PHI (Enter description in Name field)
MCM - Release - Other (Enter description in Name field)
MCM - Signature Page
Missouri Medicaid Screening Tool
MO ADAP Affidavit of Declined Insurance form
OMO Award Letter
Positive Start - attachment
Positive Start - CMS Referral Form
Positive Start - What You Need to Know MO Law
Proof of Food Stamps
Rapid Enrollment Attestation
Resource/Care Plan
SPPC Waiver Client Choice Statement
SPPC Waiver Emergency Plan
SPPC Waiver HIVLOC
SPPC Waiver Medicaid Authorization Deter. Letter
SPPC Waiver Notification of Change Letter
SPPC Waiver Personal Goal Plan
SPPC Waiver QSM Plan Approval
SPPC Waiver Service Activity Instructions
SPPC Waiver Service Plan
SPPC Waiver Supervisory Monitoring Log
TCM STEP documents
Transportation
Treatment Adherence – Care Plan
Treatment Adherence - Intake
Treatment Adherence – Notes/Discharge
Treatment Education Certificate
Verification Medigap Supplemental Insurance
Verification of Community Housing Application

APPENDIX K – DOCUMENT DESCRIPTION WITH CATEGORY

Verification of HIV+ Status
Verification of Incarceration
Verification of Income
Verification of Income/Residency
Verification of Legal Name Change
Verification of Medicaid Application
Verification of Medicaid Denial
Verification of Medical Status
Verification of Preliminary Positive
Verification of Residency
X Other (Enter description in Name Field)

APPENDIX L- SUPERVISION AND SUPPORT

L. Supervision and Support:

HIV Medical case management agencies will provide competent oversight, information, education, training, clinical support, resources, and advocacy to ensure quality HIV Case Management.

Policy:

1. Each local HIV Case Management agency and system will provide its Case Managers with guidance and supervision to include the following:
    a. Clear reporting hierarchy and designated mentor during orientation.
    b. Job description; delineation of roles, responsibilities, and expectations; benefits package; agency orientation and evaluation criteria.
    c. Materials and resources necessary to carry out the roles, responsibilities, and expectations of the job.
    d. Annual Evaluation of job performance or per agency guidelines.
    e. Orientation to the agency, region, and Missouri Department of Health and Senior Services HIV/AIDS Case Management policies and procedures.
    f. Continuing education and training opportunities including access to educational resources at the agency, local community, regional, or DHSS level.
        i. Ensure completion of annual cultural competency training at a statewide, regional, agency, or individual level to serve clients in a culturally sensitive manner. Translation services should be available to each client and each case manager will be trained on the use of the translation service.
    g. Participation/attendance at all case management meetings/conferences within the agency and/or region, unless the regional/agency supervisor is notified of a reason for absence.
    h. Ensure caseload coverage is provided for clients either through an internal process or with the assistance of a temporary/ PRN service when the Case Manager is on vacation or absent for an extended period or when a Case Management position is vacant.
    i. DHSS approved Confidentiality Agreement form must be signed annually.
2. Agencies will have a designated supervisor that will have the additional duties of:
    a. Providing leadership and mentorship to Case Managers.
    b. Ensuring new case managers complete the on-line orientation modules within 30 days of hire.
    c. OR as per action plan for performance improvement.

APPENDIX L- SUPERVISION AND SUPPORT

d. Providing a communication channel between Case Managers, Regional Supervisor, Quality Service Manager, Director of Case Management, and the Department of Health and Senior Services.

e. Ensuring Case Managers are knowledgeable of and capable of implementing any new or changes in existing policies and procedures that affect the eligibility for and/or delivery of case-managed services.

f. Providing continual quality assurance and performance information from quarterly standard reports to Case Managers to meet regional quality improvement programs/goals.

g. Collaborating with regional and statewide management teams.

h. Attending agency, regional, and statewide meetings as required and complete continuing education and training activities.

i. Ensuring that all Case Managers attend agency, regional, and statewide meetings as required and complete continuing education and training activities.

j. Participating in activities and providing support as requested by Regional Supervisors, Quality Service Managers, Grantees, or the Department of Health and Senior Service.

APPENDIX M – 2023 CASE MANAGEMENT MANUAL UPDATES

2023 HIV Case Management Manual Changes and Updates

Section 1.0 – Program Overview

- Updated header and fixed formatting
- Defined "Core Medical Services" as referenced in Section 5.

Section 2.0 – Access Standard

- Updated header and fixed formatting
- Removed language referencing eligibility at the Six-Month Update

Section 3.0 - Eligibility Requirements for HIV Case Management

- Updated section title; previously titled "Engagement in HIV Case Management Standard"
- Moved Inquiry, Intake, and Case Assignment to Section 5
- 3.1 HIV+ Documentation
  - Added Rapid-Rapid Form as acceptable documentation
  - Removed Requirement for EMR/EHR name to be included on flowsheets
- 3.2 Residency Documentation:
  - Updated section header
  - Added definition of "current" documentation to the top of section
  - Added 2 new acceptable residency documents
    - Rapid Enrollment Attestation Form
    - RW Institutional Release Form
  - Added language for how to document clients who self-report a change of residency during the 12-month referral timeframe.
- 3.3 Income Documentation:
  - Updated section header and re-formatted subsections
  - Added No Income and Working for Cash to the Income Table
  - Included unemployment debit card in income table
  - Removed language requiring consecutive pay stubs and extended timeframe from 31 to 60 days
  - Added language in policy for how to document clients who self-report a change of income during the 12-month referral timeframe

  - Added language that reimbursements (i.e. adoption/foster subsidies, mileage, or per diems) are not counted toward a client's gross income.
  - Updated language re: notifying HSI by changing referral to 2SRR, no longer requiring a communicate.
- 3.4 Self-Reported Eligibility Changes (NEW SUBSECTION)
  - Residency
    - Documentation not required for residency changes within a service area
    - CM will end existing housing entry, then add a new entry with current address
    - Verified date is not updated until new documentation is provided by client
  - Income
    - New documentation/Income module update only required if client's FPL increases
    - New documentation must be provided within 60 days or services may be impacted
- CM Exception Requests (NEW SUBSECTION)
  - Added the procedure for submitting an exception request for Part B Case Management services; refers to regional policy when appropriate

Section 4.0 – HIV Case Management Activities

- Update section title; previously called "Intake, Enrollment, and Update Procedures"
- Updated list of optional forms that are used at Enrollment/Annual Update
- Listed the different modules in the Enrollment/Annual Update workflow and refer to specific sections for policy/procedure
- Added policy on referring clients to SPCC/Waiver, if client scores 1 or above on the ADL AOA in MCMAT
- Language added for CMs to use the "Follow Up Date" field on the 12-month service referral to indicate when the 6M Check In is due
- Added service referral table for annual updates, included the follow up date
- Add language about completing, at minimum, one face-to-face encounter during 12-month certification period
- Separated encounters and progress notes into separate subsections
- Included face-to-face contact language: "The required forms listed below must be given and explained to the client, and any subsequent questions must be addressed. Documents requiring a direct signature must be signed and dated or verbally attested to by the client."

APPENDIX M – 2023 CASE MANAGEMENT MANUAL UPDATES

- Added language re: clients receiving MCM services are required to have at least 1 active AOA on their ISP
- Removed "All encounters/notes addressing ISP item must be attached to the appropriate Area of Assessment."

Section 5.0 - Engagement and Retention in HIV Case Management

- Changed section title; previously called "Enrollment and Update Standard"
- Added Inquiry, Intake, and Case Assignment to section, previously in Section 3
- Removed language about clients providing documentation of application/denial for MO HealthNet (current systemic barrier makes this incredibly challenging; SwMM suggested to remove from audit tool as well)
- Updated intake extension policy: CMs must notify supervisors of extension, but no longer need supervisor approval prior to extension
- Clarified which encounters need to be done in-person (Enrollments and Annual Updates for clients not virally suppressed)
- Added Rapid Enrollment (Section 5.5)
    - For clients who need immediate access to ADAP, Outpatient Ambulatory Health Services, and/or LTC/MCM and cannot immediately provide income and/or residency verification
    - Added language about using new Rapid Enrollment Attestation Form and *Rapid Enrollment* encounter & clipping
    - Service referrals entered for 30-days in 2PEN status
    - 30-day window to gather all eligibility documentation and complete full, face-to-face Enrollment
    - Refers to regional Exception Request policy if additional 30-day window is needed after initial period of Rapid Enrollment
- Annual Updates (Section 5.6)
    - Added subsection about process for completing Annual Updates early
    - Clients who are virally suppressed may completed Annual Update over the phone, but clients who are not yet suppressed must completed Annual Update in person
- Six Month Check In (previously Six Month Update)
    - Required 6M Check In topics: changes to health coverage, treatment adherence/engagement in care, risk reduction, and ISP progress
    - New encounters (Phone, Home Visit, & Office Visit) and clipping created
    - If 6M Check-In is not completed after 3 attempts, clients will not be closed from services

APPENDIX M – 2023 CASE MANAGEMENT MANUAL UPDATES

- Clients who are virally suppressed- CM attempts contact again when Annual Update is due
- Clients who are not virally suppressed- CM attempts contact 2x/month until Annual Update is due or overdue 6M Check In is completed

Section 6.0 – Monitoring Engagement in Care Standard

- Changed section title; previously called "Monitoring Client Engagement in HIV Care Standard
- Defined engagement in care (per current version of Manual), clarified the policy, and expanded procedure steps to reduce confusion
    - Added language that the ISP is for clients who are not virally suppressed OR do not have evidence of care in the last 12 months
- Added *Labs Review* encounter to document CM time spent reviewing EMR/EHR for client labs; clarified *Labs Request* is when a CM requests labs via phone/fax from an outside provider

Section 7.0 –Client Transfer Standard (NEW SECTION)

- Separated into own section (previously Subsection 7.3)
- Updated/removed Six Month Update language

Section 8.0 - Removal, Readmission, and Case Closure Standards

- Previously Section 7.0; removed Section 7.3 (Client Transfer Policy and Procedure) to create its own section
- Added language, per HSI, for service Referrals: "If the service referral is already expired or closed this step is not needed. To close a referral, change the "Active" status to "No", and change the end date to the date of closure for all Case Management service referrals (including specialty Case Management). The referral status must be changed to 7CLS. For non- Case Management referrals made to HSI (ADAP, Insurance Continuation, Outpatient/Ambulatory, etc.), please change the status to 2SRR and place a note in the field indicating reason for Case Closure."
- Updated subsection names

Section 9.0 – Record and Documentation Standard

- Previously Section 8.0
- Update Legal Name change policy to note requirement of TWO (previously one) form of documented name change

APPENDIX M – 2023 CASE MANAGEMENT MANUAL UPDATES

Section 10.0 -- Emergency Preparedness Guidance (NEW SECTION)

- Formalized protocols for any potential state of emergency or natural disaster

Section 11.0 – Quality Management

- Formally Section 10.0
- No additional policy changes at this time

Appendices

- A – Intake Workflow
    - Clarified language to include in workflow pop-up screens (not yet changed in SCOUT)
    - Added Documents module
- B – Rapid Enrollment Workflow
    - Newly created
- C – Enrollment Workflow
    - Separated from Annual Update Workflow
    - Updated order of modules
    - Removed unnecessary modules
- D- Annual Update Workflow
    - Clarified language to include in workflow pop-up screens (not yet changed in SCOUT)
    - Removed Communicate module
    - Added Labs, Documents module
    - Updated order of modules
- E – Six Month Check In Workflow
    - Updated name (previously Six Month Update)
    - Clarified language to include in workflow pop-up screens (not yet changed in SCOUT)
    - Removed following modules: Housing, Documents, Service Referral, Income, Employment, Diagnosis
    - Added Labs module
- F – MO Case Transfer Workflow
    - Added Labs module

APPENDIX M – 2023 CASE MANAGEMENT MANUAL UPDATES

- G – MO Case Closure Workflow
    - Renamed from "MO Case Closure OPEN to Other Services Workflow"
    - Clarified language to include in workflow pop-up screens (not yet changed in SCOUT)
    - Information from old "MO Case Closure NOT OPEN to Other Services Workflow" included in this workflow
- H – Abbreviations & Acronyms
    - Previously Appendix G
    - Added the following: Adult Eligible Group (AEG), Area of Assessment (AOA), Case Management Supervisor (CMS), Emergency Preparedness and Response Limited Access Attestation Form (EPRF), Gender Nonconforming (GNC), Income Attestation Form (IAF), Non-binary (NB), Rapid Enrollment Attestation Form (REAF), and Women who have sex with Women (WSW)
    - Changed Substance Use Disease to Substance Use Disorder
- I – HIV Case Management Documentation Schedule
    - Previously Appendix H
    - Changed from Six Month Update column to Six Month Check In
    - Updated Required Eligibility Documentation row to refer to Section 3.4: Self-Reported Changes
- J – Case Management Encounter Codes and Glossary
    - Previously Appendix I
    - Added new encounter options: Rapid Enrollment, Six Month Check In- Phone Call, Six Month Check In- Home Visit, Six Month Check In- Office Visit, Annual Update- Phone Call, Labs Review, and Hospital Visit
    - Updated glossary for all newly created encounters
    - Removed Outcome Drop-down list. List will be moved to CM Data Rules
- K – Document Description with Category
    - Previously Appendix J
    - Updated to reflect current new document types in SCOUT
    - Added new options: Rapid Enrollment Attestation Form, Institutional Release Form, Housing Program Property Checklist, Verification of Active Medicaid
- L – Supervision and Support
    - Previously Appendix K
- M – HIV Case Management Manual Changes

APPENDIX M – 2023 CASE MANAGEMENT MANUAL UPDATES

  - Previously Appendix M
  - Replaced with this list of January 2023 updates/changes
- N – Data Rules
  - Previously included “Know Your Numbers”, which was removed from the manual
  - Updated CM Data Rules will be added as an appendix once updated, creating space for them here