

# Ryan White Part B

## Reporting & Documentation Changes

Case Manager Training  
Changes to take effect April 1, 2012



Paul R. LePage, Governor Mary C. Mayhew, Commissioner  
Training presented March 28, 2012

1

## Note



- This training is specific to the expectations of the Ryan White Part B program
- All new changes take effect April 1, 2012
- If you have questions about how to perform or document services reimbursed by MaineCare, you should consult your supervisor and/or contact MaineCare directly

2

# Policy and Contractual Changes



3

## Part B/Part C

**New!**

- Per HRSA, we must differentiate between Part B and C medical case management
  - Will only affect RMCL-funded agencies
  - Will not affect CAREWare entries
  - Directly related to acuity scale

4

## Service Area

**Review**

- Providers must ensure that clients are not receiving services at multiple agencies

5

## New & Revised Performance Measures

- New!** 90% of active clients have a completed semi-annual certification every six months, which is documented in CAREWare, during the year
- New!** 100% of active clients have an income date less than 1 year old entered in CAREWare
- Updated** 90% of active clients have a completed assessment, which is documented in CAREWare, during the year **(revised from 95%)**
- Updated** 90% of active clients have completed semi-annual care plans, which are documented in CAREWare, during the year **(revised from quarterly)**

6

## Unchanged Performance Measures

- 90% of client records audited during the contract year are complete
- 100% of clients have insurance and medical care documented in CAREWare
- 95% of clients report having both insurance and medical care
- 90% of active clients who reported no insurance and/or medical care during the prior reporting year report coverage during this reporting year
- 20 hours per year of training in core competency areas is documented in personnel files for all case managers
- Rate of satisfaction is at least 90% and not more than 2% less than previous rating

7

## Audits



8

## Note

- Any references to audits in this training refer to audits performed by the Ryan White Part B program
- MaineCare's Program Integrity Unit uses other criteria to audit records

9

## Changes



- Simplified form
- Part B program will do two site visits per year
  - One full site visit with chart review
  - One chart review only
- Part B program will perform “desk audits”
  - Reviewing CAREWare information in detail on randomized clients each quarter

10

# Client Rights & Responsibilities



## What?

**New!** New summary page

## Why?

- The Part B program wanted to be sure clients are aware of client-level data reporting
- Notify clients of new income limits

13

## New summary

To receive Ryan White HIV Medical Case Management in Maine you have to:

- Show proof that you have HIV
- Show proof of your income
  - Your income must be 500% of the federal poverty level or less

All Ryan White programs have to report individual info about clients to the federal government. **This info can't be used to identify you.** It is entered into a computer program by us. We send the info using a secure computer system. **Your privacy is protected.**

The following info is reported:

- Date of your first Ryan White service
- Year you were born
- Ethnicity and race
- Gender
- Your poverty level
- Type of housing you live in
- The first three digits of your zip code
- HIV status and date of AIDS diagnosis
- HIV risk factors
- The type of health insurance you have
- How often you use a Ryan White service (like case management)

This info has to be reported for anyone who gets Ryan White services.

If you want Ryan White HIV Medical Case Management, you have rights and responsibilities. They are described on the back of this paper.

14

# 6-Month Certifications



15

## Why?



- HRSA requires verification of eligibility every 6 months

**New!** Must be conducted face-to-face  
– To obtain appropriate documents and client signature

16



## HRSA-required processes

- Verification of household income
  - Document must be dated within last 12 months
  -  **New!** Household income cannot exceed 500% FPL
- Verification of HIV status
  -  **New!** Obtain most recent labs and complete Care Status section of certification form
- Verification of insurance status
  - Document insurance types and status
  - Copy insurance cards if client has insurance
- Verification of residence
  - Document any changes to address

17

## New form

- Modified version of former “Initial and Annual Review form” and “I have received info” form
- CAREWare fields highlighted in yellow – **make sure to update any changes!**

18

## Race/Ethnicity

**Review**

- HRSA is required to use the OMB reporting standard for race and ethnicity.
- Every client has an ethnicity and at least one race.

19

## Ethnicity

**Review**

- *Hispanic or Latino*—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be synonymous with “Hispanic or Latino.”
- *Not Hispanic or Latino*—A person who does not identify his or her ethnicity as “Hispanic or Latino.”

20

# Race



NOTE: Multiracial clients should select all categories that apply.

- *American Indian or Alaska Native*—A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- *Asian*—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- *Black or African American*—A person having origins in any of the black racial groups of Africa.
- *Native Hawaiian or Other Pacific Islander*—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- *White*—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

21

# Care Status tracking



- Obtain most recent labs from provider to complete form

**Care Status Tracking**

Date of last visit with HIV medical care provider: \_\_\_/\_\_\_/\_\_\_

Date of last Viral Load test: \_\_\_/\_\_\_/\_\_\_      Result: \_\_\_\_\_

Date of last CD4 test: \_\_\_/\_\_\_/\_\_\_      Result: \_\_\_\_\_

Has client been taking meds?

Taking meds

Refused/not taking prescribed meds

Not recommended at this time

Client meets the HRSA definition for "in care"?  yes  no

*Client is considered in care if*

- Client has seen his or her HIV medical provider in the last six months, OR
- Client has had labs drawn in the last six months, OR
- Client is taking HIV meds

22

# Care Status tracking



- Obtain most recent labs from provider to complete form
- Enter care status in CAREWare

**Care Status Tracking**

Date of last visit with HIV medical care provider: \_\_/\_\_/\_\_\_\_

Date of last Viral Load test: \_\_/\_\_/\_\_\_\_      Result: \_\_\_\_\_

Date of last CD4 test: \_\_/\_\_/\_\_\_\_      Result: \_\_\_\_\_

Has client been taking meds?

Taking meds

Refused/not taking prescribed meds

Not recommended at this time

Client meets the HRSA definition for "in care"?  yes  no

*Client is considered in care if*

- Client has seen his or her HIV medical provider in the last six months, OR
- Client has had labs drawn in the last six months, OR
- Client is taking HIV meds

Add/Edit Service Details

Date:	Service Name:	Contract:	Units:	Price:	Cost:
11/17/2011	1100 Client certification	test	6	\$0.00	\$0.00

Provider: \_\_\_\_\_ Care Status: **In Care** / Out of Care

# Entering labs in CAREWare



- Part B case managers are required to collect clients' CD4 and Viral Load test results during the SemiAnnual Certification process. These lab results must be entered into CAREWare through Encounters | Labs.

Demographics | Service | Annual Review | Encounters | Relations | QA | Medical and Insurance

Encounter Date: 02/17/2012 | Test      Create Encounter      Delete Encounter      Encounter Report      Sharing Options

Only show data for this provider

Labs | Case Note

**Labs**      Rapid Entry      Setup

Add/Edit

Current Test: \_\_\_\_\_      Result: \_\_\_\_\_      Save      Delete

Test	Date of Prior Test	Prior Result	Current Result (02/17/2012)	Provider	Comment

## Entering labs in CAREWare

**New!**

**Labs Rapid Entry**

Client: Testrecord, Test      From: 2/17/2011      Through: 2/17/2012       Show all Labs (no chart)

Primary Filter:      Secondary Filter:

Buttons: Setup, Report, Import, Close, View Expanded Chart

Test:      Date:      Result:      Comment:      Save      Cancel

Test	Date	Result	Provider	Comment	Data So...	Test Stat
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Buttons: Add, Edit, Delete, Image, HL7Source

## Housing/Living Arrangement

- There's a difference between *Nonpermanent Housing* and *Unstable Housing*

**Review**

- ***Nonpermanent Housing*** includes:
  - Transitional housing
  - Temporarily staying with friends or family (couch surfing)
  - Hotel or motel (not paid for with emergency shelter voucher)
  - Other temporary arrangement
- ***Unstable Housing Arrangements*** include:
  - Emergency shelter
  - Place not designed for, or ordinarily used as, a regular sleeping accommodation for people (vehicle, abandoned building, bus/train station/airport)
  - Hotel or motel paid for with emergency shelter voucher

26

# Institution



- Although there is an option for “institution” in the Housing/Living Arrangement in CAREWare, **you should not use this option**
- Instead use:
  - **Stable Permanent Housing** for institutional setting with greater support and continued residence expected (psychiatric hospital or other psychiatric facility, foster care home or foster care group home, or other residence or longterm care facility)
  - **Nonpermanent housing** for temporary placement in an institution (e.g., hospital, psychiatric hospital, or other psychiatric facility, substance abuse treatment facility, or detoxification center)
  - **Unstable Housing** for jail, prison, or a juvenile detention facility

27

# Income Verification

Household Size and Income – Annual Review/Annual screen in CAREWare

Legal household size: \_\_\_\_\_

Income must be verified for all members of the legal household.

Income Source	Annual Amount	Date of Verifying Document*
Earned Income (wages, salaries, overtime, commissions, fees, tips, severance and bonuses) before any payroll deductions; net income from self-employment, all regular pay, special pay and allowances for members of the Armed Forces.)		
Unemployment		
Supplemental Security Income (SSI)		
Social Security disability income (SSDI)		
Veteran's disability pay		
Private disability insurance		
Workers compensation		
Temporary Assistance for Needy Families (TANF)		
General assistance		
Social Security Retirement before deductions		
Veteran's pension before deductions		
Pension from a former job before deductions		
Child support		
Alimony or other spousal support		
Trust/annuity/investments		
Rental property		
Other:		
<b>Total Annual Household Income: \$</b>		

- \* Verifying documents **must** be attached. Acceptable forms of verification include:
- Social Security award letter
  - Copy of Social Security check
  - W2 tax forms
  - Year-end 1099 forms
  - Federal income tax return
  - Pay stubs (must be 4 consecutive weeks)
  - Bank statement
  - DHHHS statement

If client reports no income for household CM must complete box below:

Client has not received income since \_\_\_\_\_

Client does not expect to receive any income until \_\_\_\_\_

Client has applied for:

SSDI/SSI

Other assistance: \_\_\_\_\_

Client currently pays rent and/or utilities by: \_\_\_\_\_

Client gets food, hygiene items, and household supplies by: \_\_\_\_\_

28

## Income Verification

- Required even if the income amount hasn't changed
- Required for all members of the legal household
- Supporting documentation is required, not just the Income Verification form
  - Documents must be dated within the last 12 months
- Remember to update the Income Date in CAREWare

29

## Income Verification

- Note: Any client whose household income exceeds 500% of the Federal Poverty Level must be discharged due to ineligibility for services

30

## Household Size & Income

- A family of two or more people who live together and are related by
  - Birth,
  - Marriage,
  - Adoption, **OR**
  - A legally defined dependent relationship
- Otherwise, household size is 1
- This definition may be different from other programs, such as HAVEN and MaineCare
- “Household Income” should reflect the income for all of the people counted in “Household Size”

31

## Clients who report no income

**If client reports no income for household CM must complete box below:**

Client has not received income since _____
Client does not expect to receive any income until _____
Client has applied for:
<input type="checkbox"/> SSD/SSI
<input type="checkbox"/> Other assistance: _____
Client currently pays rent and/or utilities by: _____
Client gets food, hygiene items, and household supplies by: _____

- Blanks and NA are unacceptable
- Must demonstrate that Ryan White (including ADAP) is payer of last resort

32



# Client Agreement

**New!**

- Client must sign every six months to:
  - document understanding of income limits
  - assure income is accurately reported
  - consent to services

## Client agreement (initial each area and sign below)

\_\_\_\_\_ I understand that my case manager has to complete this form with me every six months for me to receive HIV medical case management services.

\_\_\_\_\_ I understand that some of this information is entered into a computer database. Information about me and the services I receive are entered into this secured database and reported to the federal government. I understand that my information has to be reported for me to receive HIV medical case management services funded by Ryan White.

\_\_\_\_\_ I understand the Client Rights and Responsibilities. I know my rights and responsibilities. I have a copy to take home.

\_\_\_\_\_ I understand the Notice of Privacy Practices. I know my privacy rights. I know when my information can be given to others. I have a copy to take home.

\_\_\_\_\_ I understand the Grievance Policy. I know how to file a complaint and what to expect. I have a copy to take home.

\_\_\_\_\_ I understand that my household income has to be less than 500% of the Federal Poverty Level for me to receive HIV medical case management services in Maine.

\_\_\_\_\_ I understand that the federal government requires proof of all income. I understand that I have to report any change in income, from any source, within 10 business days of the change.

\_\_\_\_\_ All information I shared with my case manager for this form is true.

I want to receive HIV medical case management services for the next six months.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

33

## How will this roll out?

- Run Last Assessment report in CAREWare
- If client's last assessment was between 4/1/2011 and 10/3/2011, do the first certification with the client's assessment and then every 6 months after that
- If the client's last assessment was between 10/4/2011 and 3/31/2012, do the first certification 6 months after the assessment and then every 6 months after that

34

## What we'll look for in chart audits

- Chart includes Semi-Annual Certification in last 6 months?
- Chart includes all required Semi-Annual Certifications for past year?
- Current Semi-Annual Certification signed by client?
- Current Semi-Annual Certification includes income verification?
- Current income verification present for all members of client's legal household?
- Current Semi-Annual Certification includes insurance verification?

35


## Assessment



36

## What?

- Changes to form

 Acuity assessment

37

## Why?

- HRSA strongly encouraged incorporating acuity scale during site visit
- Needed to move some things from former “initial and annual review” form to assessment with advent of certification form
- Some other changes to questions, based on client/CM feedback

38

# Acuity Assessment



Acuity Assessment					
Area	0 pts	1 pt	2 pts	3 pts	4 pts
	Client identifies no needs in this area	Client identifies low needs in this area	Client identifies moderate needs in this area	Client identifies high needs in this area	Client is in crisis in this area
1. Access					
2. Housing					
3. Food/Nutrition					
4. Transportation/Home Care					
5. Education/Employment/Financial Support					
6. Treatment Adherence					
7. Dental Care					
8. Mental Health/Social Support					
9. Substance Use					
10. Relationships					
11. Legal					
12. Other					

Total Acuity Score: \_\_\_\_\_

Agreed frequency of contact: \_\_\_\_\_

39

# Logging in CAREWare

Add/Edit Service Details

Date: 12/5/2011 Service Name: 1300 Comprehensive Assessment Contract: test Units: 6 Price: \$0.00 Cost: \$0.00

Provider: DB ADMIN Assessment Type: Annual Acuity Score: 12

Travel in Units: 2



40

## Assessment Update

- Two options to update assessment when client has new needs
  1. Revise original assessment form, documenting new need and acuity score for the area (initial and date all changes)
  2. Use the optional “Assessment Update” form
    - **STRONGLY encouraged**

41

## Assessment Update

Description of new need(s):

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Acuity Assessment of New Need(s)					
Area	0 pts	1 pt	2 pts	3 pts	4 pts
	Client identifies no needs in this area	Client identifies low needs in this area	Client identifies moderate needs in this area	Client identifies high needs in this area	Client is in crisis in this area
1. Access					
2. Housing					
3. Food/Nutrition					
4. Transportation/Home Care					
5. Education/Employment/Financial Support					
6. Treatment Adherence					
7. Dental Care					
8. Mental Health/Social Support					

42

## What we'll look for in chart audits

- We will compare the acuity assessment to the needs identified on the care plan to ensure they match
- We will check to make sure the assessment was completed in the last 12 months (either from audit date or discharge date)

43

## Care Plan



44




## What?



- Care plans will only be required by Part B program every 6 months
  - You will still need to do them quarterly for MaineCare clients
- Changes to form

45

## Why?

- HRSA only requires 6-month plan
- New form
  -  ties goals to treatment adherence
  -  helps identify barriers and reasons goals are not achieved
  -  includes client agreement

46

# Remember



- Care plan must still be signed once per year
- Care plan must be completed during face-to-face or phone contact with client

47

# New form



Client Name/ID:		Original Plan Date:		
<b>Problem Areas from Assessment (check all that apply)</b>				
1. Access	5. Education/Employment/Financial Support	9. Substance Use		
2. Housing	6. Treatment Adherence	10. Relationships		
3. Food/Nutrition	7. Dental Care	11. Legal		
4. Transportation/Home Care	8. Mental Health/Social Support	12. Other		
<b>Goals and Plan</b>				
Prioritized problem area:				
Relation to HIV treatment/care:				
Long-term goal:				
Goals for six months, including resources to be accessed:	Start Date	Target Date	Review	
			Outcome	If goal not achieved, indicate reasons
			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct
			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No





## Clients with Multiple Needs

- Clients may have too many needs to address in one quarter
- Client and CM should agree on prioritization of needs/goals
- CM should note which need areas were prioritized in the case note

49

## 6. Treatment Adherence

 Treatment Adherence (area 6) should only be checked if client has a specific need from this area of the assessment

 Every goal must support Treatment Adherence in some way

Prioritized problem area:  
Relation to HIV treatment/care:

50

## Care Plan Review

- New!** Care plan must be reviewed every six months for Ryan White
- MaineCare regulations still apply for MaineCare clients
  - Sections of form highlighted in yellow must be completed during review

Review		
Outcome	If goal not achieved, indicate reasons	Continued use of CM for this?
<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No

**New!**

51

## Care Plan Review **Review**

- Care plan must be reviewed with the client in person or by phone
- Review each need area to see if anything has changed
  - If so, amend assessment and add new goal area to care plan

52

# New form



**Client Agreement:** I have helped make this plan. I understand that I am responsible for parts of this plan. My case manager has explained this plan to me. I agree to follow this plan and to tell my case manager if anything changes. I agree to stay in contact with my case manager.

Client Signature		Date	
CM Signature		Date	
Date of Review		Reviewed: <input type="checkbox"/> in person <input type="checkbox"/> by phone	CM Review Signature

# Example

<b>Prioritized problem area: Housing</b>					
<b>Relation to HIV treatment/care: Client needs stable housing in order to store medications and receive appropriate care</b>					
<b>Long-term goal: Client will achieve stable housing</b>					
Goals for six months, including resources to be accessed:	Start Date	Target Date	Review		
			Outcome	If goal not achieved, indicate reasons	
Client will complete applications for housing subsidy with assistance as needed from CM			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Example

<b>Prioritized problem area: Treatment Adherence</b>					
<b>Relation to HIV treatment/care: Directly related</b>					
<b>Long-term goal: Client will achieve stable health status</b>					
Goals for six months, including resources to be accessed:	Start Date	Target Date	Review		
			Outcome	If goal not achieved, indicate reasons	Continued use of CM for this?
Client will discuss questions/concerns about recent labs with PCP and report back any barriers or concerns to CM.			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No

55

# Example

<b>Prioritized problem area: Dental</b>					
<b>Relation to HIV treatment/care: Dental health has an impact on overall health, particularly for people with HIV</b>					
<b>Long-term goal: Client will not suffer from acute dental pain</b>					
Goals for six months, including resources to be accessed:	Start Date	Target Date	Review		
			Outcome	If goal not achieved, indicate reasons	Continued use of CM for this?
Client will obtain dental estimate from provider and work with CM to apply for financial assistance to cover costs			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No

56

## Example

Prioritized problem area: Mental Health/Social Support					
Relation to HIV treatment/care: Client needs appropriate mental health services to maintain proper treatment of HIV					
Long-term goal: Client will regularly attend meetings with therapist as scheduled					
Goals for six months, including resources to be accessed:	Start Date	Target Date	Review		
			Outcome	If goal not achieved, indicate reasons	Continued use of CM for this?
Client will review list of available MH providers with CM, select provider, and schedule initial visit			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client will attend initial visit with MH provider and report back to CM on any barriers to continued access			<input type="checkbox"/> Achieved <input type="checkbox"/> Not Achieved <input type="checkbox"/> Unknown	<input type="checkbox"/> System barriers <input type="checkbox"/> Financial/economic barriers <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Active mental health issues <input type="checkbox"/> Active substance use issues <input type="checkbox"/> No longer prioritized by ct	<input type="checkbox"/> Yes <input type="checkbox"/> No

57

## What we'll look for in chart audits

- Chart includes Care Plan created/updated in last 6 months?
- Care Plan signed within the last year?
- Chart includes all required Care Plans for past year?
- Care Plans in chart are reviewed with client in person or by phone and signed by CM?
- Care Plan goals are needs identified on the Assessment?
- Client achieved at least 4 short-term goals in the past year?

58

## Note

- **We are NOT saying you only have to do care plans every 6 months**
- The Ryan White program will only be seeking evidence that clients' care plans are updated every six months
- If you bill MaineCare for services, you must still abide by MaineCare rules
  - Check in with your supervisor if you have questions/concerns

59

## Discharge



60

## What/why?

- Updated form and CAREWare process
  - Clearer
  - CAREWare and paperwork support each other

61

## Form



### Reason for Closure (select ONE):

- Referred/discharged: Client referred to another program, client is self-sufficient, client voluntarily leaves program, client refuses to participate
- Removed due to violation of rules
- Incarcerated
- Relocated/moved
- Deceased (select Inactive/Case Closed as enrollment status in CAREWare)
- Unknown/lost to care

62

# Form

- Logged service #1800 in CAREWare
- Updated CM assigned in CAREWare to "Discharged"



Case Manager Signature: \_\_\_\_\_

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

**If discharge initiated by agency, not client:**

Supervisor Signature: \_\_\_\_\_

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

63

## What we'll look for in chart audits

- Is the Discharge Summary form complete?

64



# Data Entry



65

## What?



- All quarterly data must be entered in CAREWare by 15 days after the close of the quarter
- **All** case notes must be entered in CAREWare
- Case notes must be entered within 15 days of the contact
- No longer tracking adherence, prevention, goal achievement, and discharge type in CAREWare services
- Case note template has space for relating contact to treatment adherence


66

## Why?

- Simplify data entry
- Simplify recordkeeping
- Faster reporting

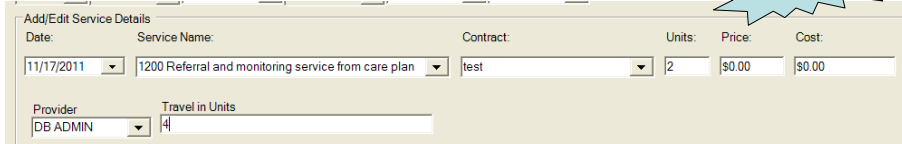
67

## Services

Code	Service Name	Units	Definition
1000	Care Plan	1 unit = 15 minutes	This service should be logged when a case manager completes a care plan with the client.
 1100	Client Certification	1 unit = 15 minutes	This service should be logged when a case manager completes a semi-annual certification with the client.
1200	Referral and monitoring service from care plan	1 unit = 15 minutes	This service should be logged when a case manager coordinates a referral for a client, facilitates the client's link to a service identified in the care plan, follows up to ensure that a client has received a service identified on the care plan, or screens for barriers related to accessing a service identified on the care plan. This includes collateral contacts.
1300	Comprehensive assessment	1 unit = 15 minutes	This service should be logged when a case manager completes an intake, re-intake, or annual assessment.
1400	Temporary coordination for institutionalized client	1 unit = 15 minutes	This service should be logged for time-limited assistance with coordinating a client's transition into or out of institutionalized care (including hospitals, assisted living, rehabilitation facilities, and correctional facilities) as long as these services relate to the client's care plan and needs identified on the assessment. This includes collateral contacts.
1800	Discharge	1 unit	This service should be logged when a client is discharged from Part B case management.

## One Service for Day-to-Day Contacts

**Review**



Date:	Service Name:	Contract:	Units:	Price:	Cost:
11/17/2011	1200 Referral and monitoring service from care plan	test	2	\$0.00	\$0.00

Provider: DB ADMIN  
Travel in Units: 4

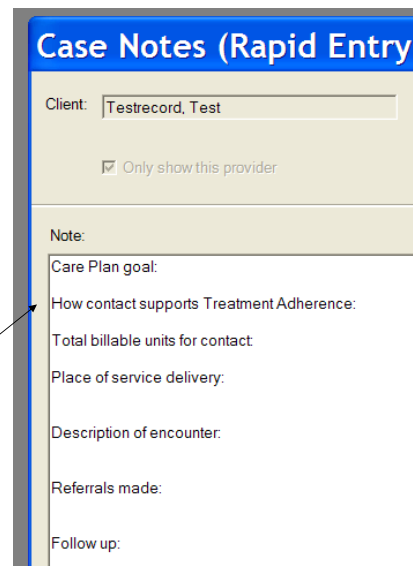
- No longer required to track adherence and prevention with any service
- No longer required to track goal achievement with care plan service

69

## Case Notes

**Review**

- All case notes must be entered in CAREWare
- Case notes must be entered within 15 days of the contact
- All case notes must indicate how the contact supported treatment adherence



**Case Notes (Rapid Entry)**

Client: Testrecord, Test

Only show this provider

Note:

Care Plan goal:

How contact supports Treatment Adherence:

Total billable units for contact:

Place of service delivery:

Description of encounter:

Referrals made:

Follow up:

## What we'll look for in desk audits

- Remote audit conducted by Part B program directly in CAREWare
  - All services logged as appropriate
  - All case notes entered as appropriate
  - Basic QM review of case notes
    - Provide one-on-one feedback for any identified issues
  - Required data elements are complete
  - Discharges are entered correctly

71

## What we'll look for in desk audits

Date:  
 Provider:  
 Client ID:  
 CM:

<b>Demographics Screen</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>
Client ID is entered in CAREWare?			
Demographic information is complete?			
Case notes for all services up to last 15 days entered?			
Case notes include all required information?			
<b>Services Screen</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>
Enrollment date is entered?			
Enrollment status is entered correctly?			
Temporary Coordination services do not exceed 45 days?			
All services entered (based on case notes available)?			
Minimum of quarterly contact?			
<b>Annual Review Screen</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>
Annual review information is complete?			
<b>QA Screen</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>
CM assigned in CAREWare is current?			
Client has income date within one-year entered in CAREWare?			
<b>Medical and Insurance Screen</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>
Information matches Annual Review?			
<b>Notes</b>			

## What we'll look for in chart audits

- Each Case Note entry includes date and case manager's name?
- Each Case Note indicates care plan goal that contact supports?
- Referrals are documented?
- Collateral contacts are documented?
- Case Notes indicate how contact supports treatment adherence?
- Prevention contacts are documented at least once per year?

73

**All revised forms are  
available online**

<http://go.usa.gov/Pzb>



74

# Questions?

