SASKATCHEWAN HIV CASE MANAGEMENT GUIDING PRINCIPLES

October 2016

SK HIV COLLABORATIVE

HIV Case Management

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Saskatchewan HIV Case Management Guiding Principles

Purpose

The purpose of HIV Case Management is to aid clients to overcome individual barriers to achieve and maintain each level of care in the HIV Care Continuum. The ultimate goal of HIV Case Management is for clients to reach and maintain the final stage of the HIV Care Continuum, viral suppression, resulting in transition to discharge from HIV Case Management.

HIV Case Management utilizes the HIV Continuum of Care to identify gaps and challenges preventing clients from achieving and maintaining viral suppression.[1]

Each health authority (inclusive of Regional Health Authorities (RHAs), First Nations Inuit Health Branch (FNIHB) and Northern Inter-Tribal Health Authority (NITHA)) is encouraged to adapt these Guiding Principles to meet the individual needs of their clients. The available resources and services in various health authorities across the province with respect to staff and broader community resources must also be considered.

HIV Care Continuum

The HIV Care Continuum (also known as the HIV Cascade of Care or HIV Treatment Cascade) is a model that outlines the sequential steps, or stages of HIV medical care that people living with HIV will go through, from initial diagnosis to achieving the goal of viral suppression (an undetectable, or very low level of HIV in the blood) (See Figure 1)[1]. The HIV Care Continuum is recognized as a focal point for efforts to maximize individual and public health benefits of antiretroviral therapy.[2] A thorough understanding of the stages in the HIV Care Continuum where individuals are lost to care informs strategies to re-engage individuals to care and subsequently, treatment.

The ultimate goal of HIV Case Management is to support individuals living with HIV to achieve viral suppression, however it is recognized that for those who fail to adequately link to care or be retained in care, viral suppression may be unattainable.

Individuals must achieve and maintain each step as they progress through the continuum. It is possible to regress (drop back a step or more if, for example, a client who was once retained in care is subsequently 'lost to follow up').
Through the practical application of the HIV Care Continuum, HIV Case Management focuses on the stages of the continuum where barriers to care have the greatest negative effect on linkage and retention into care. Through targeted strategies aimed at mitigating barriers to care and treatment, individuals can be supported to move forward, through the Continuum of Care.

Figure 1[1]

HIV Case Management

HIV Case Management is an adaptable, collaborative, and client-driven process for the provision of quality health and support services through the effective and efficient use of resources. HIV Case Management supports the clients' achievement of safe, realistic, and reasonable goals within a complex health, social and fiscal environment.[3]

HIV Case Management can prevent morbidity, mortality and transmission of HIV. This model of care serves as a safety net for those most vulnerable and serves to link clients to care, to retain clients in care, to support adherence of clients to their care and treatment plan, and to ultimately achieve viral suppression. For the purposes of clarity, these outcomes of HIV Case Management are reflective of the stages of the HIV Care Continuum.

Principles of HIV Case Management [3]

1. **Case Management supports patient rights**
   The patient's right to confidentiality, privacy, dignity and respect is valued (e.g. Informed consent is required prior to any discussion at HIV Case Management meetings).

2. **Case Management is purposeful**
   The actions of Case Managers must address the specific needs of patients.

3. **Case Management is collaborative**
   An interdisciplinary team approach to HIV Case Management utilizing a collaborative clinical and community model will assist in removal of patient barriers to allow progression through the HIV Care Continuum and minimize regression.

4. **Case Management supports accountability**
   Case Managers facilitate and organize service delivery that is coordinated, timely and appropriate for each patient's optimal health care benefit, goal achievement and maximal self-care and independence.

5. **Case Management strives for cultural competency**
   Poverty, mental health, addictions, discrimination, social isolation, past trauma, homelessness, and other social inequalities may decrease patients' ability for engagement and retention in HIV care. Provision of care will be in a non-judgmental and non-coercive manner.

Core Components:

A standardized approach to HIV Case Management, based on evidence from literature, as well as good and current practices allows for a provincial approach that is adaptable and clear. This standard approach also reflects the goals identified as part of the Saskatchewan HIV Strategy 2010-14 and may be adapted to individual health authorities based on financial, human and community resources.[4] The core components should be consistent across health authorities.

1. **Client Eligibility and Identification**
   Individuals must be HIV-positive to be eligible for HIV Case Management and may be referred by any allied health care or service provider by completing the Referral Form (see Appendix B).

   Clients will be evaluated as to their stage within the HIV Care Continuum. In addition, clients will be assessed regarding the potential barriers to accessing care. Individual clients may have multiple barriers to care making case management an optimal means to address their needs.

   Clients at any stage of the HIV Care Continuum, other than 'viral suppression' (stage 5), will be considered eligible:

   Stages of the HIV Care Continuum:
   1 - Diagnosed, but not linked to care
   2 - Linked, but not retained in care
   3 - Retained in care, but not on HIV medication
   4 - On HIV medication, but not virally suppressed
   5 - Viral suppression achieved

As well as having any of the following factors:

1. Unmanaged HIV resulting in hospitalization
2. AIDS diagnosis
3. Starting/changing cART
4. <16 years of age
5. Pregnant
6. Newcomer/Immigrant/Refugee
7. Co infected with TB
8. Vulnerable housing (homeless, couch-surfing, etc.)
9. Addictions/substance abuse
10. Mental Health
11. Street-involved
12. Involvement with sex work/survival sex
13. History of incarceration
14. Inadequate family/social supports
15. Lack of Transportation

2. Consent

Once eligibility for HIV Case Management is determined, the consent must be completed and signed by the client. Client consent should be obtained as soon as possible upon receiving the referral. It is recognized that the consent and referral process must be an adaptable and flexible process.

Depending on the circumstances and which team member is linking to the client, consent may be obtained immediately after the client is referred to the HIV Case Management Team, or the referral is made and then consent is obtained (i.e. in the case of a referral from a community partner). Date consent is obtained should be documented.

For clients who may be considered to be mobile between health authorities or known to be moving from one health authority to another, an optional consent paragraph in the HIV Case Management Consent Form should be considered to facilitate ease of health information transfer to another health authority. Clients should be informed of the intent to share information with the receiving health authority and written consent (via an additional signature) should be obtained.

Clients and their health information may not be discussed at HIV Case Management prior to a signed consent.

3. Intake and Assessment

The intake and assessment form should be completed within one month of receiving referral/client signing consent. The stage of the Continuum of Care must be determined. The risks which may make linkage and retention into care more difficult, and the barriers to accessing care must also be identified.

Regardless of where the client resides, linkage to HIV-specific clinical care is required to assist clients in being able to achieve and be maintained in the HIV Continuum of Care, and to ultimately have the client be supported to achieve viral suppression. In light of geographical challenges, the linkage to HIV-specific care may be both episodic and consultative and will be based on the goals of HIV Case Management.

The stage of the HIV Continuum of Care for each client must be determined. The risks which may make linkage to and retention into care more difficult, and the barriers to accessing care must also be identified.

Client participation is key to the success of HIV Case Management. Clients must be aware of the Case Management processes and the team members. Clients must be involved in the plan related to the goals as part of the HIV Continuum of Care.

a. Assigning a Case Manager

Individual Health Authorities may or may not have the capacity to mobilize a team approach. For clarity of roles, Health Authorities may have one or more Primary Case Managers, Case Managers or other designated staff who are responsible to fulfill the role of HIV Case Manager.

Where there are Primary Case Managers, Case Managers and other supporting staff on the HIV Case Management Team, the Primary Case Manager is deemed the person responsible for the overall coordination of client care and the care plan.

The Primary Case Managers, or designate(s) will review referrals for HIV Case Management. The Primary Case Manager for each client will be determined incorporating flexibility and negotiation as needed, with consideration to current caseload, clients' needs, and the primary goals of HIV Case Management, as they relate to the Continuum of Care. Further, the ability to assign a Case Manager will be dependent on local health authority resources and in some instances; the Primary Case Manager and Case Manager may be one in the same. Additionally, the Case Manager in some health authorities may the HIV Strategy Coordinator or the CD Coordinator.

For health authorities with the ability to work with a larger interdisciplinary team:

- Optimal caseload in the HIV Case Management setting is dependent on the type of services available, the range of available community supports and the needs of the client. An average of 15-25 clients per full time Case Manager may be reasonable, however some negotiation and flexibility is required.

As much as possible, the Case Managers should communicate about their respective caseloads to ensure adequate coverage if urgent concerns arise or to cover scheduled time away.

b. Plan of Care and Goal Setting

The Primary Case Manager will:

- Determine the current stage within the Continuum of Care;
- Identify, with the client, factors to achieving and being maintained in each stage of the continuum;
- Identify with the client strategies to minimize/reduce and remove identified barriers;
- Identify and set reasonable goals with the client, to maintain and/or improve the client's overall health outcomes; and
- Present their clients/caseload at HIV Case Management meetings if a team approach is feasible.

The Comprehensive Needs Assessment, Goal Setting and Case Management plan is to be completed within a month of obtaining client consent for HIV Case Management (see Appendix B).

The Primary Case Manager or designate, will be responsible to complete these documents with the client.

c. Discharge from HIV Case Management

Discharge planning ideally begins when clients consent to HIV Case Management. Clients may be discharged from HIV Case Management as follows:

- Virally suppressed and not requiring HIV-related supports to be retained in the continuum for 6 months
- Deceased
- Moved out of Region
    - Consider referral to case management team in the health authority where client has moved to. Obtain client consent prior to referral and document to whom the referral was sent as well as the current plans for follow up in the referring health authority which may be considered in the receiving health authority.
        - If unable to obtain client consent to allow referral, consult with local Medical Health Officer regarding risk related to HIV transmission. Document same.
- Lost to follow up/unable to locate for a minimum of 6 months (i.e. no contact with any team member)
    - To ensure clients are not permanently lost to care, designated staff will be responsible to attempt contact every 3-6 months at minimum following the determination of a client being lost to follow up. Individual Health Authorities will determine who is best to be responsible for this task; for example, in some communities, it may be the HIV Strategy Coordinator, Public Health, the HIV Case Manager or other designate who is responsible. It is important that the responsibility for 'lost to follow up' is designated and clear in local Health Authorities.

4. Case Management Team

The HIV Case Management Team composition will vary, depending on the health authority, its resources and partners. Ideally, each client who is case managed should have an identified primary case manager or lead.

Other membership invited to participate or partner and provide support could include representation from those departments in the health authority who work with people living with HIV, and partner agencies who are funded via HIV-targeted funding to support community aspects including prevention and harm reduction, housing supports and social case management. Examples include, but are not limited to:

- Health Authority
  i. Infectious Diseases or HIV-specific clinic staff and physicians (as able)
  ii. Public Health, Communicable Disease (CD) High Risk/CD staff
  iii. Addictions (includes Outreach and/or Detox/Inpatient counsellors)
  iv. Mental Health counsellors
  v. Primary Health Care providers
  vi. Native Health Social Worker/other cultural support(s)
- Community Partners
  i. As determined by individual health authorities

In health authorities where HIV-specific care is not locally available or in the case where individual clients choose to seek HIV-specific care outside of their home RHA, the clinical team (outside the client's home health authority) is encouraged to share relevant information with those responsible for HIV Case Management in the client's home health authority. Consent from the person living with HIV participating in HIV Case Management must be in place under *The Health Information Protection Act* (HIPA) for this to occur, unless disease investigation supersedes, as per the Saskatchewan *Public Health Act*, i.e. in the case of clients' non-disclosure, recalcitrance, etc. Those responsible and/or participating in HIV Case Management in the home health authority will depend on whether a team approach is feasible and may include any combination or all of the following:

- the HIV Coordinator and/or the CD Coordinator
- the Medical Health Officer
- community-based organizations
- Addictions (includes Outreach and/or Detox/Inpatient counsellors)
- Mental Health
- Primary Health Care providers
- Native Health Social Worker/other cultural support(s)
- Community Partners - as determined by individual health regions

a. Role and Responsibilities

The roles and responsibilities for HIV Case Management are aimed at moving clients to the final stage of the HIV Care Continuum and as effectively as possible.

It is important to minimize redundant or duplicate services and working at cross purposes. Timely communication between disciplines is key to success and collaboration. For this reason, health and service providers involved in HIV Case Management in each individual health authority must clearly outline and document their individual roles and responsibilities.
Confidential information will be used and shared only as needed to perform legitimate duties as they relate to HIV Case Management.

Non-Health Authority partners who are invited to participate in HIV Case Management will submit their agency's confidentiality agreement to the HIV Strategy Coordinator or Primary Case Manager. Individual organizations who are not part of the health authority should also be encouraged to consider obtaining a 'release of information', signed by the mutual client to identify their role and the type of information to be shared as well as to facilitate access to information as needed.

b. Meetings

Where a team approach is feasible, HIV Case Management meetings will involve presenting clients and providing regular (as defined by individual Health Authority, ideally monthly or bi-monthly) updates, with respect to the HIV Continuum of Care.

Information regarding the case managed client, including an overview with respect to stage in Continuum, barriers to care, challenges which may make accessing HIV care difficult and goals for moving forward in the Continuum should be clearly documented.

In health authorities where a Case Management team is available, the first time an individual is presented at HIV Case Management, an overview with respect to the current stage in the Continuum; barriers to care, challenges which may make accessing HIV care difficult and goals for moving forward in the Continuum will be reviewed.

At subsequent meetings, the following should be addressed as much as possible by the Primary Case Manager or Lead:

i. State the client's current stage in the Continuum
   - Indicate how long the client has been in that stage and if relevant, indicate whether a recent change from previous stage (up or down) has occurred.
ii. Review the last, next, and missed appointments with ID or HIV-specific care provider
iii. Review of blood work results, including Viral Load and CD4, as necessary and relevant to stage in the Continuum
iv. Review the challenges which exist in preventing the client moving forward through the Continuum
v. Update the strategies to assisting the client to move through the Continuum – i.e. removing or mitigating barriers
   - May include the client goals related to the Continuum, including what is achieved or remains outstanding

During HIV Case Management meetings input regarding the client is expected from any/all involved members of the Team regarding their individual role(s) with the client(s). Communication from various team members regarding ability to locate, information on primary health care needs, antiretroviral readiness and adherence, etc. is needed to determine the stage of the Continuum.

5. Implementation

Case managed clients will be discussed with team members and/or partner organizations as required to meet HIV Case Management goals.

The Primary Case Manager with support from appropriate team members, as required, will work with the clients to maintain the plan of care, to assist clients to achieve and be maintained in appropriate stage(s) in the HIV Continuum of Care. Communication among relevant team members and the Primary Case Managers will occur as necessary.

6. Monitoring and Evaluation Framework

Data will be collected to monitor the HIV Continuum of Care. Data should be collected at minimum on a quarterly and annual basis. Health Authorities should determine how often reporting should occur beyond the quarterly and annual recommendation.

All health authorities must clearly identify and determine how and where data is collected, how and where client information is documented and where both the data and client documentation are stored. In a team setting, individual team members will have their own charting and documentation related to the client. The Case Manager(s) will be responsible to maintain chart notes related specifically to HIV Case Management which may be shared where a team approach is applied.

As examples, documentation and/or data may be kept with the Public Health team, the HIV Strategy Coordinator if involved in front-line care, etc.

Health Authorities may provide case management support to people living with HIV who reside within their own RHA or clients from other RHAs, depending on the client's individual choices regarding HIV-specific care providers and on what HIV-specific care is/is not available in each RHA. Data on all clients who are case managed will be maintained by each RHA providing case management services.

As much as possible, the proportion (number and percentage) of patients who are case managed will be reported on utilizing the Care Continuum

- **Number and percentage of people:** diagnosed with HIV, linked to HIV care, retained in care, on HIV treatment, with undetectable viral load/virally suppressed

General Case Management Considerations

a. Consistent and practical application of the *Saskatchewan Public Health Act.* [5]
Communication with the Medical Health Officer or designate is necessary for those clients who are not adequately able to achieve and maintain the stages of the Continuum of Care. This is of particular importance for those clients who:
   - Have been diagnosed with an STI;
   - Are named as a contact to HIV or another STI;
   - Are identified as not retained in care and not currently accessing ART; and/or
   - May be identified as high risk of transmitting HIV.

b. Immunization[6]
HIV Case Management plays a role in supporting the overall health of people living with HIV. As part of improving and maintaining adequate overall health and where applicable, clients will be offered immunizations as per the current publicly funded provincial program. The HIV Case Manager and/or members of the HIV Case Management team will work together to determine what immunizations are recommended for clients living with HIV and will work together to facilitate completion of the recommended immunizations. For information on the Saskatchewan Immunization program, go to:
http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx

c. Pregnant Contacts to HIV
To reduce the likelihood of undiagnosed HIV in a pregnant woman who is negative for HIV and identified as an intimate contact to HIV, and to reduce the potential for vertical transmission, these clients will be prioritized and included in alignment with the health authority's HIV Case Management process. The follow up in most instances will be coordinated by the local Public Health program, under the Saskatchewan *Public Health Act*. [5]
When required, communication between the Infectious Diseases Clinic/Clinical Team and Public Health staff and potentially other partners (i.e. primary health care, addictions, mental health, etc.) may occur to assist in minimizing the risk of diagnosis of HIV and potential risk of vertical transmission.

Appendix A: Cascade of Care

The largest cohort of data with respect to the HIV Cascade of Care comes from the USA; it is noted here (Figure 1). Canadian data is added for additional context (Figure 2).

Figure 1[7]

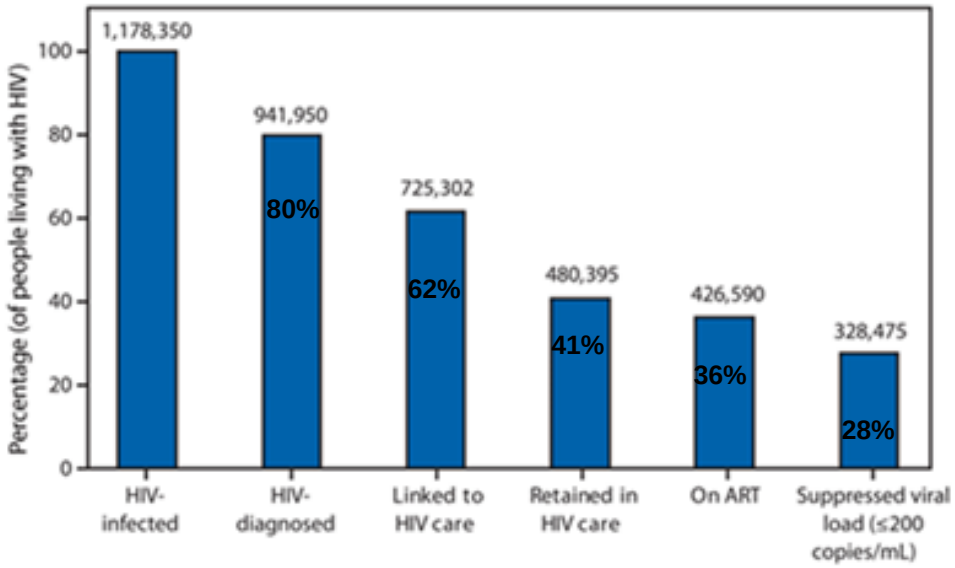
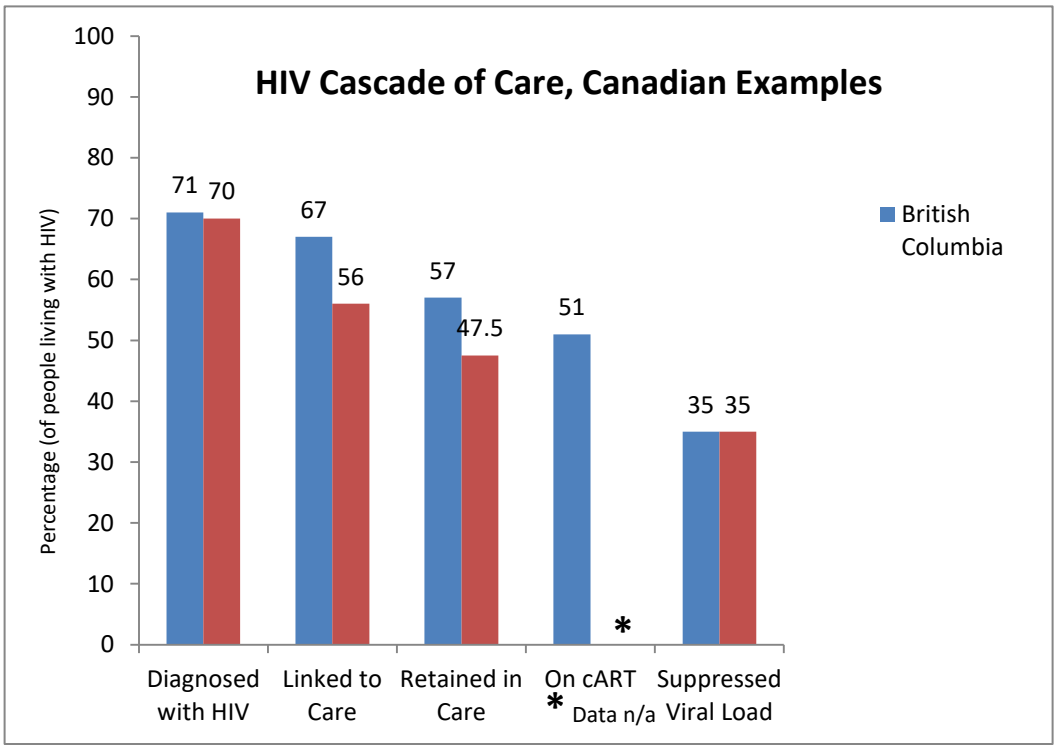


Figure 2 [8,9]



Interpretation of the HIV Care Continuum[7, 8]

A comprehensive continuum of care ensures that all persons living with HIV receive the support required to achieve viral suppression. By ensuring that individuals living with HIV are diagnosed and are then linked to and well-engaged in care, the percentage of people able to achieve viral suppression will be increased.

The model below outlines the sequential steps or stages of HIV care stages that people diagnosed with HIV move through. It is visual and clearly demonstrates the steps/stages. It is included here as a way to interpret the Continuum for health care professionals, non-health care professionals and people living with HIV.

It is recognized and accepted that any and all health authorities involved in the care of people living with HIV may define their own HIV Care Continuum in ways that suit the needs and purpose of the individual health authority. However, in the interest of being able to compare and contrast the continuum of care across jurisdictions and for the purposes of this document, the HIV Continuum of Care Indicators as noted in Figures 1 and 2 will be defined as they were in the Saskatchewan HIV Strategy Evaluation (2015).[10] They are defined and numbered below:

Stage		Definition
1	Diagnosed with HIV	confirmed HIV antibody indeterminate or positive and confirmed by laboratory test (positive)
2	Linked to Care	attended an HIV-specific medical visit within 3 months of diagnosis
3	Engaged or Retained in Care	attended at least two HIV-specific medical visits within the last year, at least 90 days apart
4	Prescribed Antiretroviral Therapy	prescribed at least one prescription for ARVs within the last calendar year
5	Achieved Viral Suppression	most recent viral load ≤200 copies/ml, or undetectable viral load, confirmed through laboratory test within the last calendar year

Dates which must be captured for all case managed clients are date diagnosed, date linked to care, date retained in care, date cART started and date viral suppression achieved. **For the purpose of measuring HIV Case Management outcomes, the date of consent being signed is central to demonstrating outcomes, i.e, Date of consent to date linked to care or date consent signed to date started on cART.**

Each step in the Continuum is significant. To be able to measure the impact of the Case Management process, the date for when the HIV Case Management consent is signed assists in determining the effectiveness of the Case Management interventions in being successful in moving clients through the steps of the Continuum.

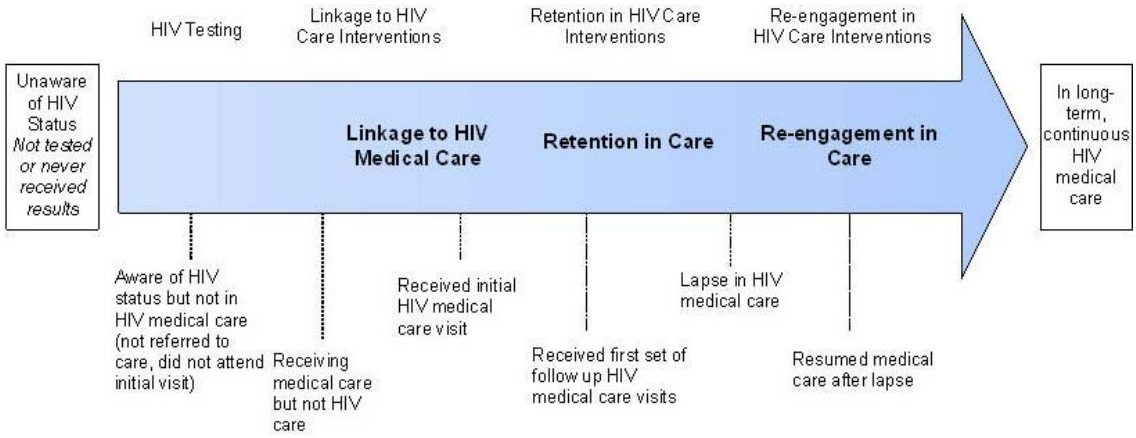
For example, if a client was diagnosed and linked to care, but was not able to be retained until they consented to and participated in HIV Case Management, those interventions may be measured as positively impacting Case Management and contributing to moving the client forward in the steps of the Continuum.

Time frames for clients to be involved with the HIV Case Management processes may vary. Clients ideally should move through the Continuum and be able to be discharged within a defined period of time. General guidelines which incorporate the metrics from consent/referral and assessment for HIV Case Management include:

- Time from date of diagnosis to linkage to care
  - 3 months maximum
- Time to adequate retention in care (from time linked to care)
  - 6 -12 months
  - Clients who are deemed 'lost to follow up' by the local HIV Case Management team are those clients who are unable to be located by team members for 3 months or more.
    - To ensure clients are not permanently lost to care, designated staff will be responsible to attempt contact every 3-6 months at minimum after being deemed "lost to follow up". Individual Health Authorities will determine who is best to be responsible for this task; for example, in some communities, it may be the HIV Strategy Coordinator, Public Health, the HIV Case Manager or other designate who is responsible. It is important that the responsibility for 'lost to follow up' is designated and clear in local Health Authorities.
- Time to cART
  - Client dependent, based on assessment of treatment readiness by the HIV-provider, responsible to prescribe and manage ART
- Time to viral suppression
  - Client dependent, based on assessment of treatment readiness by the HIV-provider, responsible to prescribe and manage ART
- Time to discharge from HIV Case Management
  - Viral suppression x ≥6 months
  - Clients may be discharged from Case Management for other reasons:
    - Virally suppressed <u>for 6 months</u> and not requiring HIV-related supports to be retained in cascade
    - Deceased
    - Moved out of Region
    - Lost to follow up/unable to locate for <u>minimum 3-6 months</u> (i.e. no contact with any team member). See above re: follow up to avoid client being permanently lost to care.

Dates to be captured for all case managed clients relate to date diagnosed, date linked to care, date retained in care, date cART started and date viral suppression achieved.

<u>Example, Linkage and Retention in HIV Medical Care</u>[11]
To assist in clients being able to achieve and be maintained in the HIV Continuum, clinicians, public health and community can refer to the figure below which outlines care from diagnosis to being fully engaged in HIV care.
http://www.cdc.gov/hiv/prevention/programs/pwp/linkage.html



HIV Care Continuum Data Collection

HIV Case Management will also collect the following data (total numbers and percentage of total) on Case Managed clients:

- Demographics (age, gender, ethnicity)
- Reason for CM referral:
  - Stage in HIV Continuum
  - Barriers to care: 1-<16 years of age 2-Pregnant 3-(new) immigrant 4-Co infected with TB 5-Vulnerable housing 6-Addictions/substance use 7-Mental Health 8-Street-involved 9-Involvement with sex work/survival sex 10-History of incarceration 11-Inadequate family/social supports
- Date started Case Management (i.e. date consent signed) and stage in HIV Continuum at start
  - Will also collect data on clients who may have been discharged from Case Management and who have reconsented; start date and reason for reconsent
- Date(s) of movement to next stage(s) in HIV Continuum (include time to reach this), or possible regression within the stages of the Continuum
- Date discharged from HIV Case Management (to calculate total time – from consent to discharge). Discharge may occur for clients who are:
  - Virally suppressed and not requiring HIV-related supports to be retained in HIV Continuum
  - Deceased
  - Moved out of Region
  - Lost to follow up/unable to locate
    (refer to Appendix A)
- Number and percentage of clients retained in Case Management
  - Number and percent 'active'
  - Number and percent discharged from case management, including reason for discharge (suppressed, deceased, moved, lost to care)
- Include stage in Continuum at time of discharge from HIV Case Management
- Include those agencies involved in supporting client to be linked to and retained in care (i.e. CBOs, regional partners, etc.)

Appendix B: Documents – Examples

These examples of documents may be altered and adapted to suit individual health authority requirements. Local privacy officers, Medical Health Officers, CD Coordinators and other related-HIV specific care providers/allied partners are encouraged to be consulted.

B-1 Consent
B-2 Referral
B-3 Intake & Assessment
B-4 Comprehensive Needs Assessment
B-5 HIV Case Management Service Plan
B-6 HIV Case Management Discharge Summary

Insert logo

Case Management Contacts:

insert RHA-specific info

Release of Information Consent
HIV/AIDS Health Services

The ***[Case Management Team/Case Manager, etc. – RHA specific]*** provides a wide variety of services to care for, treat and support the health and well-being of clients. These services include: screening/testing services, assessment, case management, nurse/case manager/outreach worker supports, medication support, counselling (individual and family), advocacy medical care, information and referral, and prevention/education services.

In order to provide such services, we work with and help you deal with different people and organizations which may also provide services to you or assist in your care. For example, we may help you apply for income assistance from the Ministry of Social Services, or assist you to find supported housing through a housing agency. We may help you understand how to comply with legal requirements of different government agencies. We may also speak with your family doctor/primary care provider or members of your family to help us provide better care to you.

In order for us to work with or help you deal with these different people and organizations, we may need to obtain information from them about you and the services that you may be receiving from them and help you share the necessary information with them about you so that you can receive appropriate services, assistance or care from them.

Under the *Health Information Protection Act*, we are required to obtain your consent before we can share your information with other people or organizations as described above.

By signing below, you are authorizing us to obtain from and share information about you with such people and organizations in the manner set out in this consent. The ***[Regional Health Authority]*** collects uses and discloses personal information only in accordance with the *Health Information Protection Act*.

You may revoke your consent at any time by speaking to one of our program staff. If you have any privacy questions, please contact the Health Authority Privacy Office at _____.

_____	_____
Client Signature	Witness Signature
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

I am choosing to revoke my consent, as of today _____, 20___, to the involvement of **the *[Case Management Team, etc. as per RHA]***, as previously agreed to above. I understand I am still able to obtain/access individual service(s) from the providers above now or in the future by contacting the program staff.

_____	_____
(Client Signature)	(Witness Signature)
_____	_____
(Date)	(Date)

Insert logo

Case Management Contacts:
Insert RHA-specific info

HIV CASE MANAGER REFERRAL FORM

The Case Manager's role is to assist people who are at risk and HIV positive in addressing barriers to medical care and improve utilization of medical and social resources, as well as to facilitate access to and adherence with treatment. Please complete form to the best of your knowledge.

Referrals may be called or faxed to any one of the Case Management Contacts:

Referred by: _____ Date: _____
□ Infectious Disease Clinical/Team: _____
□ Public Health: _____ □ Primary Health Care: _____
□ Mental Health: _____ □ Native Health Services: _____
□ Addictions Services: _____ □ CBO: _____
□ Other(Incl. Home Care): _____

Client Name: _____
Date of Birth (dd/mm/yyyy): _____ HSN: _____
□ Male □ Female □ Other _____

Address: _____
Phone (or contact numbers): _____
Person with whom a message may be left if unable to reach client (per client), and contact number:
_____

Criteria for referral to case management (please check as appropriate):
Stage in HIV Care Continuum (if known/assessed):
□ Diagnosed; not linked to HIV Clinical Care
□ Linked to care; not retained
□ Retained in care; not on HIV medications
□ Medications concerns, i.e. adherence

Indicate factors contributing to Case Management support if present:
□ Pregnant
□ Immigrant
□ Vulnerable housing (homeless, couch surfing, etc.)
□ Addictions/substance use
□ Street-involved
□ History of incarceration
□ Other: _____
□ < 16 years of age
□ Co-infected TB
□ Inadequate family/social supports
□ Mental health issues
□ Involvement in sex work/survival sex
□ Transportation challenges

Additional Comments/Client Situation (incl. next ID appointment if known): _____
_____
_____
_____
_____
_____

Intake/Assessment Form

Referral Date:

Demographics			**Page 1 of 2**
Last Name:		**First Name:**	**MRN or Other RHA Identifier:**
Gender: **F❒** T❒ M❒ Other❒	**Date of Birth:** **(dd/mmm/yyyy)**	**Ethnicity :**	**HSN:**
Permanent Address: **❒Unknown**		**Phone #:**	**Language Details:**
Current Location and Contact Details: **❒Unknown**			**Stage of HIV Continuum of Care:** 1 ❒ Diagnosed with HIV 2 ❒ Linked to care 3 ❒ Retained in care 4 ❒ Prescribed antiretroviral therapy 5 ❒ Achieved viral suppression

Reason for Referral

1. **Individual is diagnosed with HIV and consent to Case Management (Date of consent:_____)**
2. **Individual is not adequately linked/retained in HIV care, on cART or virally suppressed. Stage noted above.**
3. **Individual has one or more of the following:**

❒ Pregnant
❒ Immigrant
❒ Vulnerable housing (homeless, couch surfing, etc.)
❒ Mental health
❒ Involvement with sex work/survival sex
❒ Inadequate family/social supports
❒ Other - Specify:

❒ < 16 years of age
❒ Co infected with TB
❒ Addictions/substance use
❒ Street-involved
❒ History of incarceration
❒ Transportation

	Date	**Comment**	
Primary Care Provider (GP or NP):	**Date of last visit**		
Infectious Diseases Specialist:			
CD4 # and % (if available):			
HIV VL # (if available):			
On ARVs? Yes ❒ No ❒	**Adherence Issues?** Yes ❒ No ❒	**Date on ARV's:**	**Enhanced Adherence:** No ❒ Yes ❒ (Provide location)

Social & Community Supports: (Name/Organization)

❒ Mental health
❒ Addictions
❒ Primary health care
❒ Other _____
❒ Native health/elder
❒ Community based organizations
❒ Methadone
❒ Home care
❒ Harm reduction/NEP

Presenting Issues			
	In Treatment?	**Medication / Dose**	**Referral required?**
Mental Health - Comments:	❒ Yes ❒ No		❒ Yes ❒ No Referral details:
Addiction - Comments: **(Drug of choice and frequency of use)**	❒ Yes ❒ No		❒ Yes ❒ No Referral details
Behavioural - Comments:	❒ Yes ❒ No		❒ Yes ❒ No Referral details
Health - Comments	❒ Yes ❒ No		❒ Yes ❒ No Referral details
Other:	❒ Yes ❒ No		

Finances and Income		
Receiving Special Diet Supplement? **❒ Yes ❒ No**		
❒ No Income ❒ Social Assistance ❒ SAID Program ❒ Other _____	❒ Other Disability Income (EI/CPP/WCB/Employer) ❒ Other (Pension/Old Age Security) ❒ GIS – Guaranteed Income Supplement	❒ Employment Income ❒ PT ❒ FT ❒ Casual/Not Reliable ❒ Other Income:_____

Housing				
Stable Housing? Yes ❒ No ❒	**Safe Housing?** Yes ❒ No ❒	**Referral for Housing?** Yes ❒ No ❒	**Referral to:** **Date:**	**Waitlist** Yes ❒ No ❒
❒ Homeless/NFA/Couch Surfing ❒ Staying w/ Friends/Family ❒ Temporary Accommodations (e.g. Shelter/Recovery or Treatment Centre)		❒ **Apartment or House** Specify rent or own: ❒ **Other** Specify:_____		

Nutrition	
Food Security: ❒ Yes ❒ No Please describe:	**Need immediate referral to access food?** ❒ Yes ❒ No

Assessment Completed By: **(Staff Name)**	**Signature**	**Date** **(dd/mmm/yyyy)**

Final Disposition: ❒**Allocated** ❒**Discharged**	
Allocated to : (Key Provider) (Secondary Provider)	**If Discharged,** indicate organization or provider taking on care of this client

Adapted from Vancouver Coastal Health/RQHR Intake/Assessment Forms

Comprehensive Needs Assessment Form

Date	Last Name	First Name	DOB	Client HSN

History of Hospitalizations in past 12 months (*Include Psychiatric & Substance Abuse*)

Illness	Date	Where

For pregnant clients

EDC:_____ **Pre-natal Care:** ☐ **Yes** ☐ **No** **Date of last appointment:** _____

Provider/Obstetrician: _____

Immunization Status

	Yes	No	Date (if known):
Hep A	☐	☐	
Hep B	☐	☐	
Pneumo 23	☐	☐	
Hib	☐	☐	
TDaP	☐	☐	
Influenza	☐	☐	
Meningococcal	☐	☐	
Other:			

Current Health Status

Do you know your latest CD4 count?		Date	
Do you know your latest Viral load?		Date	

Current Medications including antiretrovirals and over the counter (*OTC)*

Medication:	Dosage:	Frequency:
Any known drug allergies? ☐ Y ☐ N Describe:		

Pharmaceutical Providers

Name/Address:	Phone:	Fax:

Medical Care Providers

Name/Address	Phone	Specialty	Last Seen	Next Appt.

Medication Adherence (if on CRVs):	Yes	No	Comments:
Are you able to take medications as prescribed?	☐	☐	
Do you require assistance taking your medications?	☐	☐	
Do you require assistance to get to your medical/other appointments?	☐	☐	
Describe any problems or assistance you need with medications.			

Mental Health/Substance Abuse History & Treatment:	Yes	No	Comments:
Are you currently using any substances? If so, list substances.	☐	☐	
Do you feel you have control over your substance use?	☐	☐	
Do you want to speak to someone about substance abuse support/treatment?	☐	☐	
Do you want to speak with someone about mental health counseling/ support?	☐	☐	

Nutrition	Yes	No	Comments:	
Do you have a good appetite?	☐	☐	Current weight	
Have you lost or gained weight in the last 6 months? (>/<10lbs)	☐	☐	How much?	
Do you need assistance to access food?	☐	☐		

Housing Arrangements:

Status:	*Structure:*	Home and safety concerns :
☐ Homeless NFA/Couch surfing ☐ Staying with Friends/Family ☐ Temporary Accommodations ☐ Rent	☐ House ☐ Mobile Home ☐ Apartment ☐ Room(s) ☐ Shelter ☐ Other	

☐ Own ☐ Other ☐ Government Subsidized		

Household:	Yes	No	Comments:
How long at current residence?			Do we need this?
How many adults there?			
How many children live there?			

Education:	Yes	No	Comments:
What is the highest level of education completed?			

Source of Income:

☐ Employed
☐ Social Services
☐ SAID ☐ Other _____

Activities of Daily Living you require help with:	Yes	No	Comments: (How much, how often, who helps)	Referral Needed. Yes	No
Personal care: Dressing	☐	☐		☐	☐
Personal care: Bathing	☐	☐		☐	☐
Personal care: Eating	☐	☐		☐	☐
Personal care: Toileting	☐	☐		☐	☐
Mobility	☐	☐		☐	☐
Transportation	☐	☐		☐	☐
Using the telephone	☐	☐		☐	☐
Shopping for groceries? Other?	☐	☐		☐	☐
Preparing meals	☐	☐		☐	☐
Laundry	☐	☐		☐	☐
Light housekeeping	☐	☐		☐	☐
Heavy chores	☐	☐		☐	☐
Managing personal finances	☐	☐		☐	☐
Keeping track of appointments	☐	☐		☐	☐

Persons/agency currently most responsible to assist with health & social needs:	

Health Coverage Information

- ☐ FNIHB
- ☐ Sask Health
- ☐ Other _____

Service Referrals

Service Need	Date Need Identified	Referral Needed Yes	Referral Needed No	Referral Details
HIV Medical Management		☐	☐	
Primary Medical Care		☐	☐	
Specialty Medical		☐	☐	
Treatment Adherence		☐	☐	
Labs		☐	☐	
Medications		☐	☐	
Dental Care		☐	☐	
Mental Health Counseling/ Support		☐	☐	
Substance Abuse Counseling/Treatment		☐	☐	
Pre-Natal Care		☐	☐	
Transportation		☐	☐	
Food		☐	☐	
Housing Assistance		☐	☐	
Spiritual/Religion/Cultural		☐	☐	
Community Social Service Resource		☐	☐	

Need for information – Check all that applies:

Client & Provider Identified Need Date Need Identified	Referral Needed Yes	Referral Needed No	Referral Details
General HIV/AIDS Educational Materials	☐	☐	
Treatment Information	☐	☐	
Harm Reduction	☐	☐	
Living with HIV/AIDS	☐	☐	
Social Services and other Public Assistance	☐	☐	
Family Planning/Women's Health	☐	☐	
Legal Issues	☐	☐	
Spiritual Care/Cultural Support	☐	☐	
Other	☐	☐	

Case Manager (Print) **Case Manager Signature** **Date Completed**

HIV CASE MANAGEMENT PLAN

Client Name: _____

Case Manager: _____ **Date Completed:**

Plan of Care/Goals (List 3-5 goals identified with client):

Identified issue/Goal	Action Required	Individual Responsible for Action Needed	Referral (Yes or No)	Completion Date
Example: Unstable/unsafe housing	*Assistance with securing safe and stable housing* *Emergency shelter*	*Housing Coordinator* *Case Manager*	*Social Services*	*1 week* *Immediate*

_____ _____

Case Manager Signature **Client Signature**

_____

Date Signed

_____

Review Date

COMPLETE NEW SERVICE PLAN FORM UPON REASSESSMENT

HIV Case Management
Case Discharge Summary

Name: _____ Case Manager:_____

Date Case Management Consent Signed: _____

Case Discharge Date _____

Reasons for Discharge

❒ Virally suppressed and no longer requires supports

❒ Deceased
Date: _____

❒ Moved out of region
Moved to: _____ Referred to: _____

❒ Lost to follow-up/unable to locate for minimum of 6 months
List person responsible to attempt contact every 3-6 months minimum:
_____

❒ Other _____

Ongoing Continued Services:

Agency	Service	Contact name/Phone

Discharge Date _____

Case Manager: _____ Date: _____

Appendix C: Roles and Responsibilities

For the purpose of a broad, provincial document, only the Primary Case Manager role is defined. It is recognized that each individual Health Authority will have its own unique staffing and community partnership resources. Wherever possible, the HIV Case Management model should include at minimum:

- Primary Case Manager/Case Manager/Designate
  The role of a HIV Case Manager is dynamic because it is both proactive in assessing and planning and responsive to the changing abilities and needs of the client. Case Managers work to ensure equitable access to healthcare services and use of healthcare resources that is ethically responsible and fiscally reasonable. The Case Managers should communicate about their respective caseloads to ensure adequate coverage if urgent concerns arise, or to cover scheduled time away.
  In health authorities where HIV-specific care is not locally available, the Case Manager is encouraged to share relevant information with those responsible for HIV-specific care. Consent from the person living with HIV participating in HIV Case Management must be in place for this to occur. The Case Manager responsible for HIV Case Management in the home health authority may be the HIV Coordinator and/or the CD Coordinator, or the Medical Health Officer in some instances.

- Public Health Staff (i.e. Medical Health Officer, public health nurse, social worker, CD Coordinator, etc.)
  With respect to HIV Case Management and where Public Health is involved with Case Management, Public Health is primarily responsible for the stages in the HIV Care Continuum from diagnosis through to retention in care (stages 1-3) but may also provide support as needed with respect to stages 4- 5 in the Continuum.
  Public Health staff, under the guidance of the Medical Health Officer assist in ensuring legislative functions as per the *Public Health Act* .

- Infectious Diseases Specialist/HIV-provider/Clinical Team
  While not all regions will have an Infectious Diseases specialist or an experienced HIV-provider locally accessible, each region must have an identified link to an Infectious Diseases specialist or experienced HIV-provider. In general, the Clinical Team is responsible primarily for stages 4-5 of the HIV Continuum, but also assist in clients being liked to and retained in care.

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