2020

Georgia
Ryan White Part B
Case Management
Standard Operating Procedures
Contents

Introduction

Georgia Ryan White Part B Case Management Standard Operating Procedures (SOP) provide case management guidance based upon the changing needs of enrolled clients. Medical and Non-Medical Case Management in Georgia is available statewide through Ryan White HIV/AIDS Programs that receive federal funds from the Health Resources and Services Administration (HRSA). Funded case managers in the state also provide referrals to support services such as transportation, housing, food banks, etc. clients who receive any Ryan White Part B Program funded services must be enrolled in case management.

The purpose of the Georgia Ryan White Part B Case Management SOP is to provide guidance to sub-recipients and case managers that will assist in fulfilling the programs minimum expectations for case management. These Standard Operating Procedures are not meant to replace or override existing, more detailed standards agencies may have in place. If any agency is unable to meet case management standards, there must be documentation explaining why they were unable to meet the standards. The Standards are intended to assist the agency and case managers in fulfilling the following goals of case management:

- To increase the quality of care and quality of life for persons living with HIV/AIDS
- To improve service coordination, access, and delivery
- To provide coordinated services which reduce the cost of care from preventable emergency room, urgent care center and hospital visits
- To provide client advocacy and crisis intervention services
- To annually retain clients in care
- To achieve improve health outcomes

Background

The HIV services system provides several types of coordination, referral, and follow-up services that eliminate barriers and help people with HIV get connected and stay in care. Medical Case Management (MCM) is the backbone of the HIV services delivery system and the primary way of ensuring that people with HIV access, receive, and stay in primary medical care. MCM functions include, but are not limited to, assessment of primary and immediate needs of people living with HIV, coordination of referrals and follow-up with critical core medical and support services to ensure people with HIV remain in medical care. The services provided are in alignment with the National HIV/AIDS Strategy and focus on entry into care, retention in care and viral load suppression.

HRSA strongly encourages Ryan White HIV/AIDS Program (RWHAP) recipients, subrecipients, planning bodies, and providers to leverage their expertise and RWHAP infrastructure to incorporate viral suppression messages in service delivery settings where PLWH are engaged (e.g., outpatient ambulatory health services, medical and non-medical case management, health literacy, early intervention services, and treatment adherence discussion). To do this, providers should:

1) Involve PLWH in the decision-making process of their HIV treatment and their sexual health
2) Develop a trusting relationship with their patients
3) Assess barriers to treatment adherence
4) Support PLWH to achieve and maintain healthy outcomes

The continuum of HIV/ AIDS interventions is generally referred to as the HIV Care Continuum or the HIV Treatment Cascade. The HIV Care Continuum includes the diagnosis of HIV, linkage to primary care, lifelong retention in primary care, appropriate prescription of antiretroviral therapy (ART), and ultimately HIV viral load suppression.

Sub-recipients are encouraged to assess the outcomes of their programs along the HIV Care Continuum. Sub-recipients should work with their community and public health partners to improve outcomes across the continuum. This is to ensure that People living with HIV(PLWH) are linked to care, engaged in care, and encouraged to begin ART based on readiness of medical adherence.

Section 1: Case Management Defined (Medical and Non-Medical)

Case management is a directed program of care and social service coordination. Typically, PLWH are enrolled into case management to ensure a comprehensive continuum of care. PLWH are also enrolled into case management to eliminate barriers to accessing care with the goal to improve health outcomes. Case managers should assist with coordination of support services and follow-up to medical treatment. There are many definitions that vary among agencies; however, the definition of case management used will be that from HRSA PCN #16-02 for Ryan White Programs:

Medical Case Management, including Treatment Adherence Services

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities under this service may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 3 to 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for the adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- Coordination of Prenatal Care

Medical case management services should collaborate with Ryan White Medical providers and referred OB-GYN office to maintain care for pregnant women living with HIV and improve communication between prenatal and HIV care providers. Case managers must conduct monthly phone consultations with OB-GYN office to collect information on the patient's prenatal care. All case managers are expected to document consultation notes into their prospective electronic medical record or client paper chart.

Additional information regarding a Prenatal Operating Procedure can be found on pages 54-56 in Appendix F.

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurances plans through the health insurance Marketplace/Exchanges).

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

The objective to activities provided under **Medical Case Management is to improve health care outcomes**.

Non-Medical Case Management Services

Non-Medical Case Management Services (NMCM) is the provision of a range of client centered support services focused on improving access and retention in medical services. NMCM provides coordination, guidance, and assistance navigating through healthcare and support services. Non-medical case managers educate and guide PLWH in accessing medical, housing, linguistic, legal, financial, vocational, and other support services to eliminate barriers to care. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. Programs such as Medicaid, Children's Health Insurance Program (CHIP), private health insurance, Medicare Part D, State Pharmacy Assistance Programs, Patient Assistance Programs (PAP), Department of Labor, Housing Authority, Educational services, other state, or local healthcare and/ support services.

Non-medical case management services include all types of encounters including face-to-face, telehealth, electronic mail (e-mail), and any other form of communication. Non-medical case management services are provided for PLWH who have a lower acuity score ranging from one to three. Acuity Scoring is described in greater detail later in the Case Management Standard

Operating Procedures. Non-Medical Case Management services provide support for PLWH who are self-sufficient with non-urgent circumstances. Generally providing structured guidance for PLWH to develop client centered goals

Key activities for Non-Medical Case Management Services include

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Key NMCM activities are not intensive and case management encounters are less frequent than medical case management activities. PLWH enrolled in non-medical case management are self-sufficient and able to manage life situations independently. Self-management allows case managers the opportunity to serve more clients and provide intensive support to those identified with a higher acuity score. Case Managers must ensure the following activities are completed for new and establish clients.

Non-Medical Case Management Process:

- Assessment of service needs
- Complete the Acuity Scale and develop a comprehensive ISP within 30 days of beginning the Intake
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the ISP
- Re-evaluation of the ISP at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- All clients should have documented evidence of coordination of services required to implement the ISP during service provision, referrals, and follow-up area.

Non-Medical Case Management service category objective is to provide guidance and assistance to **improve access** to support services.

The Medical and Non-Medical Case Manager

Roles of a Case Manager

The roles of the case manager are varied and require that case managers assist clients in addressing problems in all facets of their lives. Case managers often act in, but are not limited to the following roles:

- Advocate
- Counselor
- Problem Solver
- Coordinator with Service Providers/Planners
- Prudent Purchaser

Skill Set of a Case Manager

In addition to requiring that staff be knowledgeable in all areas listed above, case managers must possess a wide range of skills in order to carry out job functions. The case manager must have considerable skills to locate, develop, and coordinate the provision of support services in the community. In addition, a case manager must coordinate and follow-up medical treatment and adherence counseling. Case managers can benefit from training in the following areas regardless of their educational background:

- Motivational Interviewing
    - Oral, written, and communication skills
    - Establish rapport and maintain relationships
- Knowledge of eligibility requirements of applicable local, state, and federal programs
- Community Based Organizations (CBO's)
- Consultation strategies
- Basic working knowledge of HIV/AIDS
- Basic understanding of highly active antiretroviral therapy (HAART) including treatment adherence
- Record keeping and documentation
- Knowledge regarding the current standards of HIV/AIDS care and case management procedures

All staff should be provided opportunities for training to become familiar with the aspects of HIV/AIDS to better understand the needs of the clients served. Case managers should be provided an opportunity for training in all aspects of the disease including coordination and follow-up of medical treatments and the provision of treatment adherence counseling.

Publications and newsletters relating to HIV/AIDS can provide informative reading material for case managers. All case managers need to be trained in the use of state approved forms and methods of documentation.

Caseload Size

Caseload size is one of the most important factors affecting job performance. Generally, a caseload of up to 1:75 is considered optimum for the reasons stated above. However, only a ~~but~~ few case management agencies have caseloads at this level. RW agencies are encouraged to have caseloads below 75. Unfortunately, caseloads are generally higher than 75; caseload size greater than 75 clients, the nature of the case manager's role may change in the following ways:

- Interactions with clients can become reactive rather than proactive
- More demanding clients may receive the greatest amount of attention from the case manager
- Case managers may not have enough time to develop a suitable rapport with the client
- To save time, case managers may do more for clients rather than working with the clients to foster their independence
- Lastly, more time will be spent on documentation requirements, data collection and reporting
- Staff turnover may increase secondary to burnout

Caseload size alone is not necessarily indicative of the case manager's workload. The stage of the client's illness and/or the emergency circumstances which a client may or may not have (i.e., housing needs) often dictates how a case manager's time is spent. Case managers should be assigned caseloads in several ways including the number of PLWH already assigned per case manager, distance from service provider, available funding criteria used to assign cases. Case management programs should establish a method of assigning caseloads based on the service organization population.

Table 1. Case Management Personnel	
Standard	**Measure**
1.1 Newly hired HIV case managers will have the following minimum qualifications: • The appropriate skill set and relevant experience to provide effective case management, as well as be knowledgeable about HIV/AIDS and current resources available. • The ability to complete documentation required by the case management position. • Have a bachelor's degree in a Social Science or be a Registered Nurse with at least one year of Case Management experience. One year of full-time (or equivalent part-time) work experience in social services delivery (case management, outreach, prevention/education, etc.).	Resume in personnel file.
1.2 Newly hired or promoted HIV Case Manager Supervisors will have at least the minimum qualifications described above for case managers plus two years of case management experience, or other experience relevant to the position (e.g., volunteer management experience).	Resume in personnel file.
1.3 Case management provider organizations will give a written job description to all case managers and all case manager supervisors.	Written job description on file
1.4 Case managers will comply with the Georgia HIV/AIDS Case Management Standards.	Review of case management records.
1.5 Case managers will receive at least two hours of supervision per month to include client care, case manager job performance, and skill development.	Documentation in personnel file of case manager job performance.
1.6 The optimum caseload per case manager is up to 75 active clients.	Observations during site visit and self-report by case manager.
1.7 Case managers will receive training on the Case Management Standards and standardized forms.	Documentation in training records/personnel file.
1.8 Case managers will participate in at least six (6) hours of education/training annually.	Documentation in training records/personnel file.

1.9 Each agency will have a case management supervision policy.	Written policy on file at provider agency.
1.10 Each agency must maintain the Case Managers credentials and/or evidence of training of health care staff providing case management services.	Documentation of credentials in records/personnel file.

Agency Policy and Procedures

The objective of the policies and procedures standard is to ensure that agencies have policies and procedures. These policies establish eligibility, guarantee client confidentiality, define client rights and responsibilities, outline a process to address client grievances and uphold Health Insurance Portability and Accountability Act (HIPAA) policy. Policy and procedures must be displayed within the agency and accessible to all staff and those receiving services.

Eligibility Policy

Agencies must establish client eligibility policies that comply with state and federal regulations. These include screenings of clients to determine eligibility for services within 15-30 days of Intake. Agencies must have documentation of eligibility in client's records including:

- proof of HIV/AIDS positive medical diagnosis
- must be a Georgia resident
- have income at or below 400% of the Federal Poverty Level (FPL)
- must have no other payer source for the services provided.

Confidentiality Policy A confidentiality policy protects client's personal and medical information such as HIV status, behavioral risk factors, and use of services. The confidentiality policy must:

- include consent for release of medical information
- include how medical records are securely stored for privacy

Client Right and Responsibilities Policy

Active participation in one's health care and sharing in health care decisions maximizes the quality of care and quality of life for people living with HIV/AIDS. Case Managers should encourage clients to be actively participate in their own care. Case manager must explain options available to them regarding their rights and responsibilities to create a better health outcome. A signed copy of the rights and responsibility policy must be provided to the client and the agency is required to follow and maintain the original signed copy within the client chart record.

Grievance Policy

An agency's grievance policy must outline the process to report unfair treatment or lack of providing quality services. The grievance policy procedure must be posted and visible to everyone provided services. The policy should be specific detailing personnel to contact and the process to file a complaint.

Health Insurance Portability and Accountability Act (HIPAA)

An agency must provide the client with the agency's Notice of Privacy Practices on the first date of service delivery as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Obtain a signed copy of the patient acknowledgement of Notice of Privacy Statement (HIPAA form). Provide the client with a copy of the signed statement.

Table 2. Agency Policy and Procedures

Standard	Measure
2.1 Each agency must have an eligibility policy and procedure that comply with state and federal regulations (i.e., linguistically appropriate for the population being served)	Written policy on file at provider agency.
2.2 Each agency must have a client confidentiality policy (i.e., linguistically appropriate for the population being served). Every employee must sign a confidentiality agreement.	Written policy on file at provider agency. Copy of signed confidentiality agreement in personnel file.
2.3 Each agency must have grievance policies and procedures; and client's rights and responsibilities (i.e., linguistically appropriate for the population being served). Each agency must implement, maintain, and display documentation regarding client's grievance procedures and client's rights and responsibilities.	Written policy on file at provider agency. Grievance procedures and client's rights and responsibilities displayed in public areas of the agency.
2.4 Inform the client of the client confidentiality policy, grievance policies and procedures, and client's rights and responsibilities at Intake and annually. The case manager and client will sign documentation of the above. The case manager will provide the client with copies of the signed documents.	Documentation in the client's record indicating that the client has been informed of the confidentiality policy, grievance policies and procedures and client's rights and responsibilities. Signed documentation in client's record.
2.5 Obtain written authorization to release information for each specific request. Each request must be signed by the client or legal guardian. (e.g., linguistically appropriate for the population being served)	Release of information forms signed by client in case management record.

Note: If releasing AIDS Confidential Information (ACI), the client must sign an authorization for release of information, which specifically allows release of ACI. (See Georgia Code Section 24-9-47 for medical release of ACI.)	
2.6 Provide the client with the agency's Notice of Privacy Practices on the first date of service delivery as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Obtain a signed copy of the patient acknowledgement of Notice of Privacy Statement (HIPAA form). Provide the client with a copy of the signed statement.	Signed acknowledgement of Notice of Privacy Statement (HIPAA form) in the client's record.

Section 2: Intake Overview

The purpose of the Intake process is to ensure PLWH understand the purpose of case management and that screen if the client is currently receiving Ryan White Case Management service at another agency. It is extremely important to provide mandated information and obtain required consents, releases, and disclosure. An Intake is also a time to gather and provide basic information from PLWH with care and compassion. It is also a pivotal moment to establish trust, confidence, and rapport between both parties. If there is an indication that the client may be facing an imminent loss of medication or other forms of medical crisis at intake, the process should be expedited, and appropriate intervention take place prior to formal enrollment.

Five steps must be completed for every client who is new or re-enrolling into case management: Client Intake, Income/Expense Spreadsheet, Acuity Scale, Individualized Service Plan (ISP), and case note documentation. The above-mentioned forms will be discussed in further detail throughout this document.

1) Intake

The first step in the enrollment process is to complete Client Intake form. Upon completing this form, the case manager will review the document to ensure that the requested information is complete and accurate. The intake form should be signed by both the person receiving services and case manager. All supporting documents provided should be reviewed for accuracy. Case Management intake must be completed within 15-30 days of beginning the initial services based on the client's level of acuity. **Additional information regarding a Client Intake Form can be found on pages 13-15 and a Client Intake Form is in Appendix A.**

2) Income/Expense Spreadsheet

The second document to be completed is the Income/ Expense Spreadsheet. This document will tabulate as numbers are entered into the cells. The purpose of this form is to obtain information regarding a client's financial expenses/resources. The Income/Expense Spreadsheet must be completed within 15-30 days of beginning the initial Intake assessment based on the client's level of acuity. The spreadsheet is in Appendix B.

3) Acuity Scale

The third step is to complete the Acuity Scale assessment. It is not necessary for a client to sign this document, only the case manager. The scale is a tool for case managers that can be used in conjunction with the initial Intake to develop an ISP. The Acuity Scale translates the assessment into a level of support designed to provide appropriate aid to the client's assessed level of functioning. This document must be completed within 15-30 days of assessment based on the level of acuity. **Additional information regarding the Acuity Scale can be found on pages 15-18 and the Case Management Acuity Scale is in Appendix C.**

4) Individualized Service Plan (ISP)

The fourth step is to develop the initial comprehensive ISP, which constitutes another essential function of case management. The ISP is the "bridge" from the assessment phase to the actual delivery of services. The primary goal of the ISP is to ensure client's access, retention, and adherence to primary medical care by removing barriers to care. A comprehensive assessment is developed using information gathered while completing the Intake and Acuity Scale to determine the level of client's needs and personal support systems. The information is then used to develop a mutually agreed upon comprehensive ISP with specific goals and action steps to address barriers to care.

The ISP's should be developed using SMART objectives. Smart objectives are as follows; **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime Specific. A comprehensive ISP must be signed by both the client and case manager within 15-30 days of beginning the initial services based on the client's level of acuity. **Additional information regarding the ISP can be found on pages 16-21 and in Appendix D.**

5) Case Note Documentation

The final step is to complete a case note that contains specific details to explain information gathered during the Intake process as well as other relevant information. Case note documentation, regardless of complexity, must be comprehensive enough to support the design and implementation of the ISP and the nature of case management services provided. A client's history is usually reflective of trends and may offer valuable insight about what to expect in the future. It is important that the case managers documentation reflects the following: subjective (what you hear) and objective (what you see) observations (e.g. changes in health status or feelings of anxiety or depression). Document any actions done in response to the observations and the client's response to the actions.

To provide a more complete picture of the client's situation, the case manager may document the client's, family member or significant other's actual response (verbal or non-verbal) to any aspect of care provided. A verbal response may be documented using quotations (e.g. "response" marks). Non-verbal responses should be described in as much detail as possible. This case note documentation must be completed within 15-30 days of beginning the initial Intake. **Additional information regarding the case note documentation can be found on pages 22-25.**

Section 3: Initial Intake

An Initial Intake is the formal process of collecting information to determine the client's eligibility for services and his/her immediate service needs. The case manager become familiar with the eligibility requirements of numerous assistance programs to provide appropriate referrals to address client barriers to care. The Ryan White HIV/AIDS Program requires that funds be utilized as the payer of last resort. The following eligibility documents must be provided during intake:

1. HIV/AIDS positive medical diagnosis
2. Georgia residency
3. Income at or below 400% of the Federal Poverty Level (FPL)
4. Having no other payer source for the services provided.

During the Intake, clients should be informed of the case management services available that can assist with improving health outcomes and gain self-sufficiency. The information collected during the Intake process provides the basis to obtain informed consent for case management services and conducting the comprehensive needs assessment. The following are the objectives of an Intake process:

1. Establish rapport and trust between the client and case manager
2. Determine the client's immediate needs assessment and link them to the appropriate resources
3. Inform the client of the scope of services offered by the Ryan White program which includes.
    a. Benefits and limitations~~,~~
    b. Rights and responsibilities as a participant in the program
    c. Case managers should allow the interactions with the client to evolve in such a way that the client feels free to express needs openly and for those needs to be acknowledged by the case manager.

An Intake must be completed for new or re-enrolling case management clients. The client should serve as the primary source of information; a case manager should actively engage the client in the assessment process avoiding yes/no questions, utilize open ended questions and enhance communication between the two parties.

Clients may be asked to identify their own strengths/weaknesses and to assist in identifying support services that will be needed for independent living. The healthcare team may be contacted for more information regarding the client's medical condition and support services. Additional sources of information might include hospital or social service agency records, family, friends, and therapists. These sources of information must be utilized only with the knowledge and consent of the client. Six major areas of a client's life for consideration when conducting an Intake include the following:

1. Clinical/Medical – This includes discussion of the client's health status, diagnosis, possible treatments, the client's right to refuse care or insist upon a different approach and access to primary care.

2. Psychosocial – This includes discussion of the client's level of coping or functioning and past coping strategies that were tried. A review of available resources for client support, an assessment of the client's strengths/weaknesses, support groups and barriers to care should also be addressed.

3. Social – This includes discussion of the client's family structure, significant others, and cultural background. The case manager should meet with the client's family members and significant others only when deemed appropriate for continuum of care and treatment and at the agreement of the client wishes. The client's history of family, friends, spouses, domestic partners, and others are essential to the client's well-being. This network can provide a range and depth of services which can only be enhanced.

4. Economic – This includes the current financial resources and insurance coverage, and financial assistance that has not been explored (i.e., food, housing, transportation, etc.). Budget counseling and debt management should be provided as an option. All resources including but not limited to employment and disability coverage vigorously be explored continuously documented in chart records. The client and family should be educated about insurance and terminology. (See Appendix 2. Income/Expenses Form.)

5. Cultural – This includes assessing culturally specific needs of the client and ensuring that case management services are provided in the preferred language of the client. Please note that it is not encouraged to rely on children or family to interpret for the client.

6. Linguistic - Language assistance must be provided by the agency when an interpreter is required to communicate effectively with staff to translate key information including, but not limited to, the consent for services, consent for release of medical/psychosocial information, grievance policy and any other similar documents that a provider might typically use during service provision to clients.

Typically, the initial Intake interaction with the client regarding case management services will occur via face-to-face encounter. However, the Intake can be conducted in other locations such as: office, hospital, clinic, home, or shelters. The Intake is necessary to determine whether the client is experiencing a crisis and/or requires an immediate referral. The case manager and client will discuss services offered, the expectation from both client and case manager, and requirements to access case management services. It is during this interaction that the case manager and client establish the basis for developing rapport and trust, which are essential elements of case management. This information must be discussed during the Intake in order to avoid future miscommunication and inappropriate expectations.

If it is determined that the client is eligible for HIV/AIDS services, the case manager or another staff member proceed with the following:

- Obtain consent for services based on agency's policies
- Explain medical and support services available and other case management procedures
- Explain the agency's regular, after-hours, weekend, and holiday policies (if applicable)
- Explain the agency's grievance policy, policies/procedures and client rights and responsibilities
- Advise client of his/her rights to confidentiality as specified by state statutes and obtain authorization to release confidential information as needed
- Initiate a client file/record to be maintained throughout the duration of the client's involvement with the case management agency

Note: The client must sign an authorization for release of information, which specifically allows release of AIDS Confidential Information (ACI). (See Georgia Code Section 24-9-47 for medical release of ACI.)

Table 3. Intake

Standard	Measure
3.1 Determine Ryan White Part B Program eligibility for services.	Documentation of eligibility in client's records including proof of HIV/AIDS positive medical diagnosis, proof of Georgia residency, income at or below 400% of the Federal Poverty Level (FPL) and must have no other payer source for the services provided.
3.2 Obtain client's authorization to obtain and/or release information if there is an immediate need to release or request information.	Signed Release (or No-Release) of Information in client's record.
3.3 Complete the Initial Intake, Income/Expense Spreadsheet, Acuity Scale, initial ISP, and case note within 15-30 days of beginning the initial Intake assessment.	Completed Intake, Income/Expense Spreadsheet, Acuity Scale, initial ISP, and case note in client's record.

Section 4: Acuity Scale

All new and re-enrolling clients must have an Acuity Scale completed. The scale is a tool for the case managers to use in conjunction with the initial Intake to develop an Individualized Service Plan (ISP). The intent is to provide a framework for documenting important assessment elements and standardizing the key questions that should be asked as part of an assessment. This scale also translates the assessment into a level of programmatic support designed to provide the client assistance appropriate to their assessed need and function.

The case manager can at his/her discretion increase the acuity level based upon his/her assessment and client needs, i.e., there are circumstances which indicate the client may benefit from additional services or support.

*Please note: *The acuity level can only be decreased after completing a new Acuity Scale, which indicates a lower level of acuity than the previously dated Acuity Scale.*

Acuity Levels

Level 1 and 2 clients are lower levels of acuity, which require less intensive case management services. Most case management services provided for level 1 and 2 clients are non-medical vs. medical, the objective is to provide coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services.

Level 3 clients are at a higher acuity level which require more case management services.

Level 4 clients are at the highest acuity level which require intensive case management services. Most case management services provided for level 3 and 4 clients will be medical vs. non-medical, as the objective is to improve health care outcomes. Appropriate case management activities are assigned in accordance with the Activities by Acuity Level document according to the indicated acuity scale levels. Below are the Acuity Levels, point values and a brief description of a client who has been assigned that level of acuity.

Level 1 Self-Management 16-17 points

Self-management is appropriate for clients who are adherent to medical care and treatment, are independent, and can advocate for themselves. Clients may need occasional assistance from the case manager to update eligibility forms. These clients have demonstrated capability of managing self and disease, are independent, medically stable, virally suppressed and have no problem getting access to HIV care. Additionally, their housing and income source(s) should be stable. If clients have a mental health diagnosis, they should be in the care of a mental health provider and adherent to their treatment plan. If clients have a history of substance abuse, they should have more than 12 months of sobriety and should preferably be accessing continued support services to maintain their sobriety. Most case management services provided will be non-medical vs. medical. Re-evaluation of the acuity scale and ISP must occur at least every 6 months with adaptations, as necessary.

Level 2 Supportive 18-22 points

Supportive case management is appropriate for clients with needs that can be addressed in the short term. Clients should be adherent to their medical care and treatment, independent, and able to advocate for themselves. Additionally, these clients require minimal assistance and their housing and income source(s) should be stable. Clients may require service provision assistance no more that 2-3 times a year. If the clients have a mental health diagnosis, they should be in the care of a mental health provider and adherent to their treatment plan. If clients have a history of

substance abuse, they should have no less than 6-12 months of sobriety and should preferably be accessing continued support services to maintain their sobriety. This includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Most case management services provided will be non-medical vs. medical. Re-evaluation of the acuity scale and ISP must occur at least every 6 months with adaptations, as necessary.

Level 3 Intermediate 23-37 points

Intermediate case management is appropriate for clients who are considered medically case managed. Coordination and follow-up of medical treatment is a component of medical case management. These clients require assistance to access and/or remain in care and are at risk of medication and appointment non-compliance. They may have opportunistic infections and other co-morbidities that are not being treated or addressed and have no support system in place to address related issues. The case manager should ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Key activities include but are not limited to completing initial Intake within 15-30 days of beginning the Intake, development of an individualized service plan (ISP) within 15-30 days of beginning the Intake, and re-evaluation of the acuity scale and ISP with a revision at least every 6 months. Most case management services provided will be medical vs. non-medical. Documentation should be reflective of goals, activities, and outcomes in the case notes. Consultation with a multi-disciplinary team, case management supervisor and/or others as needed should be documented.

Level 4 Intensive 38-56 points

Intensive case management is appropriate for clients who are considered medically case managed. These clients require assistance to access and/or remain in care. The clients are at risk of becoming lost to care and are considered medically unstable without MCM assistance to ensure access and participation in the continuum of care. The case manager should ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Key activities include but are not limited to completing initial Intake within *15 days* of beginning the Intake, development of an individualized service plan (ISP) within 15-30 days of beginning the Intake, and re-evaluation of the acuity scale and ISP with a revision at least every 3 months. Most case management services provided are for medical services rather than non-medical. Documentation be reflective of goals, activities, and outcomes in the case notes. Consultation with a multi-disciplinary team, case management supervisor All services provided must be documented any service provided without documentation will not be acknowledged.

Upon completing and scoring the Acuity Scale, the Activities by Acuity Level document in Appendix 5 provides timelines and activities that must be followed depending on the acuity level score.

Information obtained while completing the Acuity Scale can be used to develop the ISP.

After the initial documents have been completed for a new or re-enrolling client, the next step is to *determine when the Acuity Scale and ISP will need to be revised.*

For level 4 clients, this will be at least every 3 months.

Level 1-3 clients will require revision at least every 6 months. However, the ISP and Acuity scale can be updated more frequently if needed.

Table 4. Acuity Scale

Standard	Measure
4.1 All new or re-enrolling case management client charts will have a completed Acuity Scale within 15-30 days of initial assessment.	Acuity Scale must be assessed, and a score assigned and in the client chart.
4.2 All case managed client charts containing a completed Acuity Scale will have a level of acuity assigned.	Every Acuity Scale must contain the Total Score and Assigned Acuity Level reflective on each completed Acuity Scale Assessment and in the client chart.
4.3 All Acuity Scale assessments will be updated in accordance with the Activities by Acuity Level document. (see Appendix 5)	At a minimum, the Acuity Scale should be revised as follows: Level 4 – Every 3 months. Level 1-3 – Every 6 months.

Section 5: Individualized Service Plan (ISP)

The development of the ISP consists of the translation of information acquired during Intake and completion of the acuity scale into short and long-term objectives for the maintenance and independence of the client. The service plan includes:

- identification of all services currently needed by the client
- identification of agencies that have the capacity to provide needed services to the client
- specification of how the client will acquire those services
- the procedure that will be followed to assure the client has successfully procured needed services
- develop a plan for how the various services the client receives will be coordinated while specifically defining the role of the case manager.
    - Client participation in the development of the service plan is fully required as is possible.
    - Client feedback should be obtained on each element of the service plan before it is implemented and signed by case managers and PLWH.

Every new or re-enrolling case management client must have an ISP completed and signed by both the case manager and PLWH. Additionally, there must be an ISP completed for every new and re-certifying Ryan White Part B Program ADAP/HICP client at least every 6 months. If an ADAP/HICP client already has a case manager, the same ISP can be utilized for the ADAP/HICP client charts and documented to include ADAP/HICP service screenings and current enrollment status of all applicable client. Any client who only receives ADAP/HICP must be informed of the additional services offered by the Ryan White Part B Program. If the client decides to decline these additional services except for ADAP/HICP, the client must sign a Declination of Services except ADAP/HICP form. The declination form must be updated accordingly to the RW Eligibility guidelines and remain within the chart record. See Appendix G.

The primary goal of the ISP is to ensure clients access, retention, coordination of care and follow-up, and medical/treatment adherence to primary medical care by removing barriers to care. A medical, psychosocial, and financial portrait of the client is created using information gathered during the Intake and acuity scale process. The information is then utilized to develop a mutually agreed upon comprehensive ISP with specific goals and action steps to address barriers to care.

The ISP is the "bridge" from the assessment phase to the actual delivery of services and constitutes another essential function of case management. It is developed based on the information obtained from the client assessment and pinpoints the individualized needs of the client and links the appropriate services with the needs. The ISP is a map of actions that documents the interventions, actions, responsibilities, and timeframes needed to meet the identified goals. Interventions and actions may be immediate, short term or future focused. Future focused interventions anticipate a persons' changing life circumstances and recognize the role of prevention. The realistic needs of the client be reflected in the development of the plan. The ISP must include coordination and follow-up of medical treatments, referrals for outside medical treatments, and treatment adherence.

The client is involved with the planning of the ISP, but it is the responsibility of the case manager to write the plan. The client's primary physician, mental health provider, caregiver, and other appropriate individuals should be contacted for additional information if deemed appropriate. It is important that the case manager have a comprehensive knowledge of the community resources to address the needs of the client during the development of the ISP. ISP's should be developed using SMART objectives; **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime Specific. Information documented on the ISP can be brief statements that explain the client's situation. The document contains a set of goals and activities that help client's access and maintain access to services, particularly primary medical care, gain or maintain medication adherence, and move towards self-sufficiency. Short term goals address immediate needs, especially those required to stabilize the client or to deal with a crisis. These are goals that the client can realize soon, such as in a day, within the week or even a few months. Long term goals are achieved over a longer period. These goals are usually those that are meaningful, thus giving the client a sense of greater importance. It is important to prioritize goals and help clients decide what is most important right now. The ISP documents the resources readily available to help the client make immediate improvements in his/her situation.

After completing the assessment, case managers should be able to answer basic questions about the new client and his/her care needs. Information collected should be used as a baseline from which to update the client's health status and change in service needs over time. Both the case manager and client must sign and date the ISP; however, agencies using EMRs may use an electronic signature for case managers. Additionally, the client must be offered a copy of his/her ISP and the ISP should be kept in the client's chart.

Implementation requires the case manager and the client to work together to achieve the goals and objectives of the ISP. Providing social support and encouragement to the client is as much a part of implementation as the actual brokerage and coordination of services. In order to make the ISP work, the case manager and client need to determine how much autonomy the client can exercise on his/her own behalf and how much assistance he/she needs in order to acquire the services. Implementation of the ISP includes careful documentation in the case notes of each encounter with the client, dates of contact, information on who initiated contact and any action that resulted from the contact be included in the case notes.

When to revise the ISP

The ISP should be completed for all case managed clients. Level 4 clients should have an ISP revised at least every 3 months and Level 1-3 revised at least every 6 months. The acuity scale be updated during this time as well. Upon revising the ISP, a case note must be completed. Case Managers must ensure that the following activities are completed for all new and established **Medical Case Management** clients:

- Assessment of service needs
- Complete the Acuity Scale and develop a comprehensive ISP within 30 days of beginning the Intake
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ISP
- Re-evaluation of the ISP at least every 3-6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- All clients should have documented evidence of coordination of services required to implement the ISP during service provision, referrals, and follow

Table 5. ISP Assessment

Standard	Measure
5.1 Conduct client eligibility evaluation every 6 months. The process to determine client eligibility must be completed in a time frame so that services are not delayed.	Eligibility assessment must include at a minimum: • Proof of income • Proof of residency • Proof of active participation in primary care or documentation of the client's plan to access primary care.
5.2 All newly enrolled or reactivated case managed clients must have an acuity scale and comprehensive ISP completed within 15 days for a Level 4 and 30 days for a Level 1-3 of beginning the initial Intake	At minimum, the initial assessment should cover the following areas: • Medical History/Physical Health Status • Medical Treatment and Adherence • Health Insurance
	• Family/Domestic Situation • Housing Status

5.3 All newly enrolled or re-certifying ADAP/HICP client must have an ISP completed within 30 days of beginning the application.	• Source of Income • Nutrition/Food • Mental Health • Substance Abuse • Personal and Community Support Systems • Disclosure • Risk Reduction • Legal Issues • Transportation • Cultural Beliefs and Practices/Languages • Dental • Emergency Financial Assistance • Additional Service Needs Ensure that documentation (case notes, initial assessment, or re-assessment) is in the client's record.

Coordination of Care and Re-Evaluating ISP

Coordination involves communication, information sharing, and collaborating regularly with case management and other agencies serving the client. The case manager and other agencies work together on a case-by-case basis to ensure that clients receive appropriate services without duplication. During coordination of services the case manager will focus on the clients' strength and accomplishments rather than focusing on short comings or relapses. Coordination activities may include directly arranging access, reducing barriers to obtaining services, establishing linkages, and other activities recorded in the case note.

Table 6. Coordination of Services

Standard	Measure
6.1 Implement client's ISP.	Documentation in client's record of progress toward resolution and outcome of each item in client's ISP.
6.2 Identify and communicate with other case managers with whom the client may be working with. Collaboratively determine with all parties and the client the person most appropriate to serve as the primary case manager.	Documentation in client's record of other case managers with whom the client may be working with and documentation of who is the most appropriate person to serve as the primary case manager.
6.3 With consent of the client, identify and communicate with other service providers with whom the client may be working. This	Documentation of communication in client's record.

can occur during team meetings to coordinate continuity of care.	Agenda or meeting notes.
6.4 Coordination and follow-up of primary medical care and treatment adherence. Clients should have one visit with their primary care provider (i.e., MD/DO, PA, and APRN) at least every six (6) months. For clients who have not had a visit with their primary care provider, the case manager should follow-up with the client within 30 days to determine barriers to care and adherence.	Attendance at medical visits. Documentation of referrals to primary care and follow-up within 30 days.

Re-evaluating the ISP

The case manager must complete an assessment of the client's needs in accordance with the Activities by Acuity document**.** It is critical that the ISP be updated in collaboration with the client, considering his/her priorities and perception of needs. The ISP should be revised at least every 6 months, including any new goals identified and completed. This includes a re-evaluation of health issues related to HIV and non-HIV, resources available to a client, as well as compliance with treatment adherence. The case manager will ensure that and not accessing or utilizing primary medical care still receive other supportive services if desired. Access to other HIV supportive services is *not* conditional upon access to or use of primary medical care.

Table 7. Re-Evaluating the ISP

Standard	Measure
7.1 ISPs for medical and non-medical case management clients should ensure that all areas of assessment have been completed and updated in accordance with the Activities by Acuity Level document. 7.2 ISPs for ADAP and HICP clients should ensure that all areas of assessment have been addressed and updated at least every 6 months.	At minimum, the assessment should cover the following areas: • Medical History/Physical Health Status • Medical Treatment and Adherence • Health Insurance • Family/Domestic Situation • Housing Status • Source of Income • Nutrition/Food • Mental Health • Substance Abuse • Personal and Community Support Systems • Disclosure • Risk Reduction • Legal Issues • Transportation • Cultural Beliefs and Practices/Languages • Dental • Emergency Financial Assistance

	• Additional Service Needs Ensure that documentation (case notes, initial assessment, or re-assessment) is in the client's record.
7.3 All medical and non-medical case management clients must have an Acuity Scale and ISP revised in accordance to the Activities by Acuity Level document.	The following information must be provided for each area assessed on the ISP: Identified Needs, Goals, Interventions/Timelines, and Outcomes. Documentation (case notes, initial assessment, or re-assessment) in client's record.

Termination of Case Management Services/Discharge Planning

Termination of Case Management Services/Discharge Planning is an important component of medical and non-medical case management. There are legitimate reasons for terminating medical case management services with a client, but keep in mind that termination never be assumed. A good faith effort must be attempted and clearly documented in the client's chart prior to discharge from case management.

Table 8. Discharge

Standard	Measure
8.1 Discharge a client from case management services if any of the following conditions apply: • Client is deceased • Client requests discharge and is no longer receiving RW Part B Program services (except ADAP/HICP only clients with completed declination form) • If a client's actions put the agency, case manager, or other clients at risk (i.e., terrorist threats, threatening or violent behavior, obscenities, harassment, or stalking behavior). • If client moves/re-locates out of service area • If after repeated and documented attempts, a case manager is unable to reach a client for six (6) months. • *If the client no longer meets Ryan White eligibility requirements.*	Reason for discharge must be documented. Upon re-enrolling in case management services, the prior documentation detailing the reason for discharge must remain in the chart for explanation of lapses in case management services.

Section 6: Documentation

Documentation is a key means of communication amongst team members. It contributes to a better understanding of PLWH and their family/caregiver's unique needs and allows for interdisciplinary service delivery to address those needs while reflecting the accountability and involvement of the case manager. Documentation is an important process that facilitates and explains what services were provided and what actions were taken. Documentation will facilitate communication between service providers and ensure coordinated, rather than fragmented service provision. It is important to be able to provide relevant client information at any given time. This is necessary for the legal protection of both the agency and the case manager. *Remember "if it's not documented, it never happened".*

Documentation runs concurrently throughout the entire case management process and should be objective, specific, descriptive, substantive, concise, accurate, up-to-date, meaningful, and consistent. The following information should be documented:

- history and needs of a client
- any services that were rendered
- outcomes achieved or not achieved during periodic review
- any additional information (e.g. case conferences, email exchanges, consultation with others, and any additional exchanges regarding the client).

Case note documentation should be complete so anyone reading the case notes can understand who this client is, what brought them to the office, what goals were established, what is the plan, what interventions were used, and what referral/follow-up will happen, if any (who, what, where, when, why and how). It is also useful to record contact and other details of agencies used, such as phone numbers and contact names of an interpreter service, or the hours of availability of a service provider for future reference. Language in case notes needs to be strengths based. Documentation must ensure that the following activities are being completed for all new and established case management clients:

New

- Standardized Case Management Intake
- Acuity Scale
- Acuity Scale completed and leveled in accordance with the Activities by Acuity Level document
- ISP
- Case note

Established Clients

- Acuity Scale updated every 3-6 months and leveled in accordance with the Activities by Acuity Level document

- The ISP updated every 3-6 months and leveled in accordance with the Activities by Acuity Level document
- Case notes documented in client's chart, in accordance with the Activities by Acuity Level document

To standardize documentation and be in alignment with federal guidelines, all case note documentation must be reflective of how healthcare outcomes are being improved as well as how providing guidance and assistance is improving access to services for clients. In 2017, the Georgia Ryan White Part B Program adopted two standardized formats for documenting case notes for charting: 1) APIE (Assessment, Plan, Intervention, and Evaluation); and 2) SOAP notes (Subjective, Objective, Assessment, and Plan). Medical and Non-Medical Case Management services are provided by both case managers and nurse case managers. The nurse case manager often functions in a dual capacity as both nurse and case manager, which means he/she is also expected to follow Georgia Case Management Standard Operating Procedures during service provision.

The case manager will have the option of using an APIE or SOAP note format. Nurse case managers can continue to use the SOAP note format for documentation in client charts. APIE is a format that condenses client statements by combining subjective and objective information into the Assessment section. APIE format combines the actions with the expected outcomes of client care into the Plan component.

The four phases of **APIE** are:

- **Assessment:** information about the client's presenting issues, gathering of the facts, some historical perspective, and assessment of the client's needs
- **Plan:** a plan is developed in order to address the identified need of the client
- **Implementation:** specific tasks or action steps that need to be taken in order to fulfill the plan
- **Evaluation:** provides a means for accountability in ensuring that the plan is being worked on and progress is updated. It should include timelines and specific measurable outcomes

A **SOAP** note is another documentation format used to document in a client's chart.
The four parts of SOAP note documentation are:

- **Subjective:** describes the client's perception of their condition in narrative form
- **Objective:** documents your perception of the client's physical state or status
- **Assessment:** details the assessment or presenting reason for the visit
- **Plan:** describes the plan for managing the client's concern/condition

Regardless of the documentation format utilized APIE or SOAP, the content must detail the following: Reason for the interaction with the client, client's needs, if any, unique circumstances or changes since the last assessment/encounter, current medical status, if any changes and actions taken to address the needs and/or interventions performed on behalf of the client. The strength of case management services provided depends on good documentation in the client's records. Charts should include:

- Important enrollment forms and information such as Intake forms, consent for enrollment forms, release of information forms, etc.
- Client information used to develop the initial assessment and the individualized service plan (ISP), monitoring activities, and revisions to the ISP
- Medical information and service provider information, and confirmation of diagnosis

- Benefits/entitlement counseling and referral services provided. Documentation should include assistance in obtaining access to both public and private programs, such as but not limited to, Medicaid, Medicare Part D, Patient Assistance Programs (PAP), co-pay cards, AIDS Drug Assistance Programs (ADAP), other state and local healthcare documents and supportive services
- The nature, content, units of case management services provided and whether the goals specified in the care plan have been achieved and/ next steps to achieve goal
- Whether the client has declined services at any time while being an active client in case management
- Timelines for providing services and re-evaluations
- Clear documentation of the need and coordination with case managers of other programs
- Entries should be documented in chronological order. Do not skip lines or leave spaces
- Be specific, use time frames, and quotations if indicated. Avoid generalizations with documentation
- Avoid labeling or judging a client, family, or visitor in the documentation
- Use a problem-oriented approach: identify the problem, state what was done to solve it, and document any follow-up instructions including timelines as well as the outcome
- Document all interactions with the client, outside organizations and other consulting disciplines

General Documentation Principles

Follow general documentation principles including:

- Document in ink only or typed notes for electronic medical record (EMR)
- Record the PLWH name and identifiers (e.g., date of birth or clinic ID number) on every page
- Record date on all entries
- Document the duration of the encounter (i.e., 15 minutes, 30 minutes, 1 hour etc.)
- Ensure the type of encounter is identified (face-to-face, telephone contact, consult, etc.)
- Personnel must sign all entries with full name and professional title.
- Ensure that entries are legible
- All entries should be made in a timely manner (i.e., the same day).
- Late entries should be clearly indicated as such (i.e., document as Late entry for (date of encounter
- If an error is made, then make one strike through, initial and date the error, ***do not use white out under any circumstances***
- Thoroughly complete all forms, applications, and other documents with the most accurate information available
- **Do not** alter forms, applications, or other documents
- **Do not** forge signatures (i.e., do not sign for the provider (MD/DO, APRN, PA), client, etc.)
- Things staff must avoid
  - Casual abbreviations
  - Taking shortcuts at the cost of clarity (re-read out loud)
  - Generalizations or over-interpretations
  - Grammatical errors
  - Negative, biased, and prejudicial language.

- Use of medical diagnoses that have not been verified by a medical provider (i.e., rather than "the client is depressed", say, "client states that PLWH is having feelings of sadness or depressed mood" or "describes seeing hallucinations or feeling sad daily"

Note: Submission of incomplete, inaccurate, or altered applications may result in delays in client services. Submission of incomplete ADAP applications will result in the delay of medications to the client.

Table 9. Documentation	
Standard	**Measure**
9.1 Each agency must have a documentation policy.	Written policy on file at provider agency.
9.2 Case Managers must participate in documentation training	Training records in personnel file
9.3 Case managers must ensure that appropriate signatures are on all applicable documents	Documents maintained in client's charts
9.4 Case Managers must document all interactions or collaborations which occurred on client's behalf.	Documents maintained in client's charts
9.5 Each client's case management record must be complete and include all relevant forms and documentation	Client chart contains all relevant forms, proof of eligibility, ISP, case notes, and other pertinent documents

Appendix A

CLIENT INTAKE

☐ New Client ☐ Updated ☐ Reactivated Client

Date: Social Security #: Client #:

PERSONAL INFORMATION

PRIMARY LANGUAGE ______________________ NEED INTERPRETER ☐ YES ☐ NO

STREET ADDRESS ______________ CITY/STATE ______________ ZIP ______

ALTERNATE ADDRESS ______________ CITY/STATE ______________ ZIP ______

______________ COUNTY Preferred Method of Contact ☐PHONE ☐ MAIL ☐EMAIL

Consent to Send Mail ☐ YES ☐ NO Consent to Send Email ☐ YES ☐ NO Email ______________________

Anonymous return address requested ☐ YES ☐ NO

(____)__________ May we leave message? ☐ YES ☐ NO Message/Day Phone (____)__________

HOME PHONE

Discreet message only: ☐ YES ☐ NO May we contact you at work? ☐ YES ☐ NO PHONE (____)__________

ETHNICITY: ☐ HISPANIC/LATINO ☐NON -HISPANIC/NON-LATINO

RACE: ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE HAWAIIAN /PACIFIC ISLANDER

☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ OTHER

KEY CONTACTS

EMERGENCY CONTACT ______________ RELATIONSHIP ______________ PHONE NUMBER (__)__________

AWARE OF STATUS? ☐ YES ☐ NO

HIV /AIDS PROVIDER______________________________ (____)__________

PRIMARY CARE PROVIDER ______________________________ (____)__________

DENTAL PROVIDER_ ______________________________ (___)__ __________

BEHAVIORAL HEALTH PROVIDER______________________________ (__)__________

REFERRAL AGENCIES ______________________________ (__)__________

EDUCATION

Do you have difficulty reading? ☐ YES ☐ NO Do you have difficulty writing? ☐ YES ☐ NO

Highest level of education completed? ______________

Place Client Label Here

Case Managers Initials:______________

Date:______________________

1 of 5 Case Management Intake 4/1/19

HIV STATUS
☐ HIV positive not AIDS ☐ HIV positive, AIDS status unknown ☐ CDC-defined AIDS
Date tested positive____________ Date of AIDS Dx: ____________

Risk Category (Check One)
☐ MSM ☐ MSM/IDU ☐ Heterosexual ☐ Unknown ☐ Occupational Exposure
☐ IDU ☐ Maternal/Child ☐ Undisclosed ☐ Blood Products ☐ Other

NON-HIV RELATED CONDITIONS

____

____

MEDICATIONS - Including all current medication, prescriptions, over the counter & experimental

MEDICATION	PURPOSE	DOSE	FREQUENCY	BEGAN/REFILL

Do you need help obtaining medications? ☐ YES ☐ NO

____

HOUSING SITUATION

☐ Permanently Housed (Stable) ☐ Temporary Housing (hotel, family, friend, college dorm, etc.)
☐ Transitional Housing (Substance Abuse Treatment Program, Transitional Housing Program) ☐ HUD/Section 8
☐ Emergency Housing (Shelter, Salvation Army, Etc.) ☐ Medical Facility (Adult Foster Care, Personal Care Home, Skil Nursing Facility, Hospice, Etc.) ☐ Homeless ☐ Other
Describe current situation (Stability, safety, affordability)

____

____

HOUSEHOLD MEMBERS
MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCE ☐ WIDOWER ☐ PARTNER

NAME	RELATIONSHIP TO CLIENT	PHONE #	AWARE OF HIV STATUS
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

FAMILY MEMBER(S) WHO ASSIST WITH YOUR CARE

			☐ YES ☐ NO
			☐ YES ☐ NO

HOUSEHOLD MEMBERS LIVING WITH HIV ☐ YES ☐ NO WHO? __________________________
FAMILY DEPENDENT CHILDREN
Do you have dependent children? ☐ YES ☐ NO
Names/Ages ____________________ ____________________ ____________________________
____________________________ ________________________
If yes, do they live with you? ☐ YES ☐ NO

Place Client Label Here

Case Managers Initials:_______

Date:_________________________

PREVENTION SCREENING TOOL

1) Are you in a relationship now? ☐ YES ☐ NO
Are you sexually active currently? ☐ YES ☐ NO
If yes, tell me about the relationship?____

2) What do you do/use to protect yourself from getting an STD, a resistant strain of HIV or infecting others?____

3) Have you ever been infected with a STD or Hepatitis? ☐ YES ☐ NO
If yes, please explain (i.e. type of STD or Hepatitis, treatment date and/or date of completion)?

4) When was your last TB skin test (PPD), and what were the results? ____________________

5) Are you currently or have you ever used drugs or alcohol? ☐ YES ☐ NO
If, yes when did you last use and what was your drug of choice? ____________________

6) Have you ever attended a drug and/or alcohol treatment/recovery program? ☐ YES ☐ NO
If yes, tell me about the program? ____

7) Do you feel that there are other factors or issues in your life that put you at risk for transmitting HIV/AIDS? ☐ YES ☐ NO
If yes, what are they? ____

8) Have you ever had or are you currently having thoughts of hurting yourself or someone else within the past 12 months? ☐ YES ☐ NO
If yes, please explain? ____

9) Have you ever been hurt physically by anyone within the past 12 months? ☐ YES ☐ NO
Have you ever been hurt by a partner, or been afraid you might be hurt within the past 12 months? ☐ YES ☐ NO
If yes, to either question tell me about incident? ____________________________________

CM Signature:____________________________

Place Client Label Here

Case Managers Initials:____________________

Date:________________________________

Acuity Level: ________________

INTAKE CHECK LIST
☐ Client Rights and Responsibilities
☐ Authorization to Release Information
☐ Grievance Policy
☐ HIPAA Form
☐ ISP Complete/Care Plan

DOCUMENTATION PROVIDED FOR:
☐ Proof of residence
☐ HIV Status
☐ Primary Care Provider
☐ Insurance
☐ Photo ID
☐ Income

DOCUMENTATION ATTACHED: (Checklist) **Federal** Poverty Level: _____% of poverty
☐ Bank statements showing deposits
☐ Copy of Social Security Check
☐ Year end 1099 form
☐ W-2 tax form from employer
☐ Income/Expense form
☐ Social Security award letter
☐ Pay Stubs
☐ Accounting Paperwork
☐ Federal income tax return

Place Client Label Here

CM Signature: ______________________________

Case Managers Initials: ______________________

Date: _____________________________________

Acuity Level: __________________

Appendix B

2020 Income Expense Spreadsheet

Is client's income enough to cover monthly expenses? Yes ___ No ___

INCOME		EXPENSES	
SOURCE	**AMOUNT**	**ITEMIZATION**	**AMOUNT**
Salary		RENT/Mortgage	
Spouse's Salary		Property Tax	
Short-Term Disability		Insurance (renters/house)	
Long-Term Disability		Phone (cell/home)	
SSI		Utilities (Electric)	
SSDI		Utilities (Gas)	
TANF		Utilities (Water)	
Pension		Cable/Internet	
Child Support		Garbage Collection	
Alimony		Car Payment	
General Assistance		Car insurance	
Food Stamps		Car maintenance	
Rental Income		Gasoline	
Unemployment		Transportation (Taxi/public transportation/ other)	
Retirement Benefits		CARE Assist Cost Share	
Family Support		Food (grocery, lunch, eating out)	
Savings/Investments		Day Care	
Children SSI		Child Support	
Annuity		Alimony	
Military Income		Medical Insurance	
Other Support		Medical Expense/Co-Pay	
		Medical Equipment	
		Prescription Meds/ Co-Pays	
		Over The Counter Meds	
		Life insurance	
		Personal Hygiene and Toiletries	
		Household and Laundry	.
		Recreation/ Leisure (movies, books, activities)	
		Substance Use (Tobacco products, Alcohol, Drugs)	
		Pet expenses (vet, food, maintenance)	
		Monthly Dues (Tithes, probation, memberships)	
		Credit Card	
		Other:	
TOTAL	$0.00	**TOTAL**	$0.00

			Date
Clients Name	________________________________	Acuity Level_____	_________
Client ID#	_____________________		Date
CM Name	____		_________

Appendix C

Case Management Acuity Scale

☐ New Client ☐ Updated ☐ Reactivated Client

Life Areas	1st 2nd Level 1	1st 2nd Level 2	1st 2nd Level 3	1st 2nd Level 4
Medical/ Physical Health 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Stable health with access to ongoing HIV medical care. ☐ ☐ Lab work periodically. ☐ ☐ Asymptomatic and in medical care.	☐ ☐ Needs primary care referral. ☐ ☐ HIV care referral needed – next available appt. ☐ ☐ Short-term acute condition; receiving medical care. ☐ ☐ Chronic non-HIV related condition under control with medication/treatment. ☐ ☐ HIV symptomatic with one or more conditions that impair overall health.	☐ ☐ Poor health. ☐ ☐ HIV care referral needed – appt. ASAP. ☐ ☐ Needs treatment or medication for non-HIV related conditions ☐ ☐ Pregnancy ☐ ☐ Debilitating HIV disease symptoms/infections. ☐ ☐ Multiple medical diagnoses. ☐ ☐ Home bound; home health needed.	☐ ☐ Medical emergency. ☐ ☐ End-stage of HIV disease. ☐ ☐ Intensive and or complicated home care required. ☐ ☐ Hospice services or placement indicated.
Medical Treatment and Adherence 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Adherent to medications as prescribed for more than 6 months without assistance. ☐ ☐ Currently understands medications. ☐ ☐ Able to maintain primary care. ☐ ☐ Keeps medical appointments as scheduled. ☐ ☐ Not currently prescribed medications. ☐ ☐ Express no issues with side effects or schedule. ☐ ☐ Can name or describe current medications. ☐ ☐ New to care	☐ ☐ Adherent to medications as prescribed less than 6 months/more than 3 months with minimal assistance. ☐ ☐ Keeps majority of medical appointments. ☐ ☐ New to care	☐ ☐ Adherent to medications and treatment plan with regular, ongoing assistance. ☐ ☐ Doesn't understand medications. ☐ ☐ Misses taking or giving several doses of scheduled meds weekly. ☐ ☐ Misses at least half of scheduled medical appointments. ☐ ☐ Takes long/extended "drug holidays" against medical advice. ☐ ☐ Takes non-HIV systemic therapies without MD knowledge. ☐ ☐ New to care	☐ ☐ Resistance/minimal adherence to medications and treatment plan even with assistance. ☐ ☐ Refuses/declines to take medications against medical advice. ☐ ☐ Medical care sporadic due to many missed appointments. ☐ ☐ Uses ER only for primary care. ☐ ☐ Inability to take/give meds as scheduled; requires professional assistance to take/give meds and keep appointments. ☐ ☐ Cannot describe or name current medications. ☐ ☐ New to care

Page **1** of **6**

Revised 3/19/18 Client Name ______________________________ Client ID# _______________________

Life Areas	1st 2nd Level 1	1st 2nd Level 2	1st 2nd Level 3	1st 2nd Level 4
Health Insurance 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Has insurance and or medical care coverage. ☐ ☐ Has ability to pay for care on own. ☐ ☐ Is enrolled in assistance (Ryan White, ADAP, Pap etc.)	☐ ☐ Needs information and referral to insurance or other coverage for medical cost.	☐ ☐ Case management assistance needed to enroll in accessing insurance (Ryan White, ADAP, Pap etc.) ☐ ☐ Assistance needed to enroll in other coverage for medical cost.	☐ ☐ Needs immediate assistance in accessing insurance or other coverage for medical cost due to medical crisis. ☐ ☐ Not currently eligible for insurance or public benefits. ☐ ☐Unable to access care. ☐ ☐ Needs referral to benefits assistance program.
Domestic/Trauma 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Emotionally dependable and physically available relatives and friends to support client. ☐ ☐ No history of abuse or domestic violence.	☐ ☐ Family and/or significant others often unavailable when crises occur. ☐ ☐ History of past relationship with violence.	☐ ☐ Agency(ies) involved due to signs of potential abuse (emotional, sexual, and physical). ☐ ☐ Violent episodes currently occurring. ☐ ☐ Pregnancy	☐ ☐ Acute situation where client is unable to cope without professional support within a particular situation/time frame. ☐ ☐ Medical and/or legal intervention has occurred. ☐ ☐ Life-threatening violence and/or abuse chronically and presently occurring. ☐ ☐ Unsafe home environment.
Housing 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Living in housing of choice: clean, habitable apartment or housing. ☐ ☐ Living situation stable; not in jeopardy.	☐ ☐ Living in stable subsidized housing. ☐ ☐ Safe & secure non-subsidized housing. ☐ ☐ Housing is in jeopardy due to projected financial strain; needs assistance with rent/utilities to maintain housing. ☐ ☐ Living in long-term transitional rental housing.	☐ ☐ Formerly independent person temporarily residing with family or friends. ☐ ☐ Eviction imminent. ☐ ☐ Living in temporary transitional shelter. ☐ ☐ Pregnancy	☐ ☐ Needs assisted living facility; unable to live independently. ☐ ☐ Home uninhabitable due to health and/or safety hazards. ☐ ☐ Recently evicted from rental or residential program. ☐ ☐ Homeless, (living in emergency shelter, car, or street/camping, etc.). ☐ ☐ Arrangements to stay with friends have fallen through.

Page **2** of **6**

Revised 3/19/18 Client Name ______________________________ Client ID# _______________________

Life Areas	1st 2nd Level 1	1st 2nd Level 2	1st 2nd Level 3	1st 2nd Level 4
Income 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Steady source of income which is not in jeopardy. ☐ ☐ Has savings and/or resources. ☐ ☐ Able to meet monthly obligations. ☐ ☐ No financial planning or counseling required.	☐ ☐ Has steady source or income which is in jeopardy. ☐ ☐ Occasional need of financial assistance or awaiting outcome of benefits applications. ☐ ☐ Needs information about benefits, financial matters. ☐ ☐ Has short-term benefits.	☐ ☐ No income. ☐ ☐ Benefits denied. ☐ ☐ Unfamiliar with application process. ☐ ☐ Unable to apply without assistance. ☐ ☐ Need financial planning and counseling.	☐ ☐ Immediate need for emergency financial assistance. ☐ ☐ Needs referral to representative payee.
Nutrition/Food 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Client is eating at least two meals daily. ☐ ☐ No significant weight problems. ☐ ☐ No problems with eating. ☐ ☐ No nutritional needs at this time. ☐ ☐ No other chronic medical condition (e.g., diabetes, hypertension, hyperlipidemia) requiring changes in diet.	☐ ☐ Unplanned weight loss in the past 6 months. ☐ ☐ Requests assistance in improving nutrition. ☐ ☐ Changes in eating habits in the past 3 months. ☐ ☐ Occasional nausea, vomiting and/or diarrhea. ☐ ☐ Chronic medical condition requiring changes in diet – following recommended diet. ☐ ☐ Overweight.	☐ ☐ Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies. ☐ ☐ Moderate problems eating (e.g. dental problems, thrush). ☐ ☐ Abdominal problems reported. ☐ ☐ Requests assistance in obtaining food. ☐ ☐ Chronic medical condition requiring changes in diet – difficulty following recommended diet. ☐ ☐ Obese ☐ ☐ Pregnancy	☐ ☐ Persistent nausea, vomiting and/or diarrhea. ☐ ☐ Severe problems eating (e.g. difficulty swallowing or chewing). ☐ ☐ Significant weight loss in past 3 months. ☐ ☐ Difficulty obtaining food to meet caloric needs. ☐ ☐ Needs referral to registered dietitian for nutritional therapy related to a chronic medical condition ☐ ☐ Obesity impairing activities.

Revised 3/19/18 Client Name ______________________________ Client ID# ______________________ Page **3** of **6**

Life Areas	1st 2nd Level 1	1st 2nd Level 2	1st 2nd Level 3	1st 2nd Level 4
Mental Health 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ No history of mental illness, psychological disorder or psychotropic medications. ☐ ☐ No need for counseling referral.	☐ ☐ History of mental health disorder/treatment in client and/or family. ☐ ☐ Level of client/family stress is high. Needs emotional support to avert crisis. ☐ ☐ Needs counseling referral. ☐ ☐ Depressed, functioning. ☐ ☐ Has some trouble getting along with others. ☐ ☐ In Mental Health Treatment and compliant	☐ ☐ Experiencing an acute episode and/or crises. ☐ ☐ Severe stress or family crisis; needs mental health assessment. ☐ ☐ Depression, not functioning. ☐ ☐ Requires significant emotional support. ☐ ☐ Significant trouble getting along with others. ☐ ☐ Recent Hospitalization ☐ ☐ In treatment but not adherent. ☐ ☐ Pregnancy	☐ ☐ Danger to self or others. ☐ ☐ Needs immediate psychiatric assessment/evaluation. ☐ ☐ Active chaos or problems due to violence or abuse. ☐ ☐ Requires therapy, not accessing it. ☐ ☐ Pregnant and not on Mental Health medication
Substance Abuse/ Addictions 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ No difficulties with addictions including: alcohol, drugs, sex, or gambling. ☐ ☐ Past problems with addiction; > 1yr. in recovery. ☐ ☐ No need for treatment referral.	☐ ☐ Past problems with addiction; <1 yr. in recovery.	☐ ☐ Current addiction but is willing to seek help in overcoming addiction. ☐ ☐ Major addiction impairment of significant other. ☐ ☐ Pregnancy	☐ ☐ Current addictions; not willing to seek or resume treatment. ☐ ☐ Fails to realize impact of addiction on life/indifference regarding consequences of substance use. ☐ ☐ Pregnant and actively using
Personal and Community Support 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Strong support from family, friends, and peers. ☐ ☐ No support needed.	☐ ☐ Strong support system, however client is requesting additional support. ☐ ☐ Has few family members/friends in local area. ☐ ☐ Gaps exist in support system. ☐ ☐ Family, friends, and peers often unavailable when crises occur.	☐ ☐ No stable support system in place. ☐ ☐ Only support is provided by professional caregivers. ☐ ☐ Pregnancy	☐ ☐ Imminent danger of being in crises. ☐ ☐ Acute situation where client is unable to cope without professional support within a particular situation/time frame.

Page **4** of **6**

Revised 2/22/17 Client Name ______________________________ Client ID# _______________________

Life Areas	1st 2nd Level 1	1st 2nd Level 2	1st 2nd Level 3	1st 2nd Level 4
Risk Reduction 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Abstaining from risky behavior by safer practices. ☐ ☐ Good understanding of risks. ☐ ☐ Understands the importance of preventing the spread of HIV. ☐ ☐Understands the importance of avoiding re-infection.	☐ ☐ Occasional risk behavior. ☐ ☐ Fair understanding of risks.	☐ ☐ Moderate risk behavior. ☐ ☐ Poor understanding of risks. ☐ ☐ Mild/moderate A&D, MH, or relationship barriers to safe behavior.	☐ ☐ Significant risk behavior. ☐ ☐ Little or no understanding of risks. ☐ ☐ Significant A&D, MH, or relationship barriers to safe behavior. ☐ ☐ No understanding of prevention methods or how to avoid re-infection.
Legal 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ No recent or current legal problems. ☐ ☐ Legal documents completed.	☐ ☐ Wants assistance completing standard legal documents. ☐ ☐ Possible recent or current legal problems	☐ ☐ Present involvement in civil or criminal matters. ☐ ☐ Incarcerated. ☐ ☐ Unaware of standard legal documents which may be necessary.	☐ ☐ Immediate crisis involving legal matters (e.g. legal altercation with landlord/employers, civil & criminal matters, immigration and family/spouse). ☐ ☐ Recent release from jail
Transportation 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Has own or other means of transportation consistently available. ☐ ☐ Can drive self. ☐ ☐ Can afford private or public transportation.	☐ ☐ Has minimal access to private transportation. ☐ ☐ Needs occasional assistance with finances for transportation.	☐ ☐ No means of private transportation. ☐ ☐ In area under or unserved by public transportation. ☐ ☐ Unaware of or needs help accessing transportation services.	☐ ☐ Lack of transportation is a serious contributing factor to current crisis. ☐ ☐ Lack of transportation is a serious contributing factor to lack of regular medical care.
Cultural Beliefs 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Understands service system and is able to navigate it. ☐ ☐ Language is not a barrier to accessing services (including sign language.) ☐ ☐ No cultural barriers to accessing services.	☐ ☐ Needs interpretation services for medical/case management services. ☐ ☐ Family needs education and/or interpretation to provide support to the client. ☐ ☐ Few cultural barriers to accessing services.	☐ ☐ Needs interpretation services to access additional services. ☐ ☐ Family's lack of understanding is barrier to care. ☐ ☐ Non-disclosure of HIV to family is barrier to care. ☐ ☐ Some cultural barriers to accessing services.	☐ ☐ Cultural factors significantly impair client and/or family's ability to effectively access and utilize services. ☐ ☐ Crisis intervention is necessary. ☐ ☐ Many cultural barriers to accessing services.

Page **5** of **6**

Revised 2/22/17 Client Name ______________________________ Client ID# ________________________

Life Areas	1st 2nd Level 1	1st 2nd Level 2	1st 2nd Level 3	1st 2nd Level 4
Dental 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Currently in dental care. ☐ ☐ Has seen a dentist within the past 6 months. ☐ ☐ No complaints of pain. ☐ ☐ Reports practicing daily oral hygiene.	☐ ☐ Has not seen a dentist within 6 months. ☐ ☐ Has dentures and requested dental follow-up. ☐ ☐ Reports not practicing daily oral hygiene.	☐ ☐ Reports problems with teeth, gums, and mouth. ☐ ☐ Episodic issues reported with the mouth and pain. ☐ ☐ Reports difficulty eating.	☐ ☐ Current or severe pain reported. ☐ ☐ Reports severe or major problems with teeth, gums, and mouth. ☐ ☐ Few or no teeth. ☐ ☐ Reports significant difficulty eating.
Emergency Financial Assistance 1st Date _____ 1st Score _____ 2nd Date _____ 2nd Score _____	☐ ☐ Never needs financial assistance ☐ ☐ Able to access services which they are eligible without assistance. ☐ ☐ Live within financial means.	☐ ☐ Financial assistance needed 1-2 times a year. ☐ ☐ Information needed to follow-up with applying for financial assistance.	☐ ☐ Financial assistance needed 3-6 times per year. ☐ ☐ Difficulty maintaining sufficient income to meet basic needs. ☐ ☐ Assistance needed with budgeting and financial planning	☐ ☐ Financial assistance needed 6+ times per year. ☐ ☐ Financial crisis, in need of immediate assistance.

1st Total Score _____ Assigned Acuity Level _____ Date _____

2nd Total Score _____ Assigned Acuity Level _____ Date _____

Level 1	Self-Management	16-17 points
Level 2	Supportive	18-22 points
Level 3	Intermediate	23-37 points
Level 4	Intensive	38-64 points

1st Case Managers Name ___________________________ CM Initials _____ Date ______________

2nd Case Managers Name ___________________________ CM Initials _____ Date ______________

Page **6** of **6**

Revised 2/22/17 Client Name _______________________________ Client ID# ________________________

Appendix D

Case Management Individualized Service Plan

Client Name | Client Identification Number | Date

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date What time frame ISP goals/objectives should be reviewed?
Medical History/ Physical Health Client Initial ______				
Medical Treatment and Adherence Client Initial ______				
Health Insurance Client Initial ______				
Domestic/Trauma Client Initial ______				

ISP Revised 2018 1

Client Name **Client Identification Number** **Date**

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date What time frame ISP goals/objectives should be reviewed?
Housing Client Initial ________				
Income Client Initial ________				
Nutrition/Food Client Initial ________				
Mental Health Client Initial ________				

ISP Revised 2018 **2**

Client Name **Client Identification Number** **Date**

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date What time frame ISP goals/objectives should be reviewed?
Substance Abuse/ Addictions Client Initial ________				
Personal, Social and Community Support Client Initial ________				
Risk Reduction Client Initial ________				
Disclosure Client Initial ________				

ISP Revised 2018 **3**

Client Name Client Identification Number Date

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date What time frame ISP goals/objectives should be reviewed?
Legal Client Initial ______				
Transportation Client Initial ______				
Cultural Beliefs Client Initial ______				
Dental Client Initial ______				

ISP Revised 2018 **4**

Client Name **Client Identification Number** **Date**

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date What time frame ISP goals/objectives should be reviewed?
Emergency Financial Assistance Client Initial ________				

Client ID # ________________________________ Acuity Level ___________

Client Name ______________________________

Client Signature ______________________________ Client Initials______ Date _________________________

Case Managers Name __________________________ CM Initials _______ Date _________________________

ISP Revised 2018 **5**

Appendix E

Activities by Acuity Levels

Level 4 (Intensive) 38-64 points

Intake

- Case Management Intake and assessment should be completed within 15 days of beginning intake.
- Complete the Acuity Scale assessment.
- Develop the initial ISP based on identified needs or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.
- An ISP should be completed upon Intake regardless of Acuity Level score.
- Additional goals, activities, and outcomes should be documented in the case notes.
- Newly diagnosed clients should automatically be assigned a Level 3 or 4.

Established Client

- Revise the Acuity Scale and ISP a minimum of every 3 months from the last date both documents were completed.
- Additional goals, activities, and outcomes should be documented in the case notes. A case note should be completed for every encounter with the client or consult regarding the client.
- Assist with referrals and follow-up as appropriate.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Continuous client monitoring to assess the efficacy of the ISP.
- Ongoing assessment of clients and other family members' needs and personal support systems.
- Treatment adherence counseling to ensure readiness and adherence to HIV treatments.
- Provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.
- Consult with multi-disciplinary team, case management supervisor and others as needed.
- The majority of case management services provided are medical vs. non-medical, the objective is to improve health care outcomes.
- Minimum contact (phone, face-to-face, or consult) every 30 days.

Level 3 (Intermediate) 23-37 points

Intake

- Case Management Intake and assessment should be completed within 30 days of beginning intake.
- Complete the Acuity Scale assessment.
- Develop the initial based on identified needs or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.
- An ISP should be completed upon Intake regardless of Acuity Level score.
- Additional goals, activities, and outcomes should be documented in the case notes.
- Newly diagnosed clients should automatically be assigned a Level 3 or 4.

Established Client

- Revise the Acuity Scale and ISP a minimum of every 6 months from the last date both documents were completed.
- Additional goals, activities, and outcomes should be documented in the case notes. A case note should be completed for every encounter with the client or consult regarding the client.
- Assist with referrals and follow-up as appropriate.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Continuous client monitoring to assess the efficacy of the ISP.
- Ongoing assessment of clients and other family members' needs and personal support systems.
- Treatment adherence counseling to ensure readiness and adherence to HIV treatments.
- Provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.
- Consult with multi-disciplinary team, case management supervisor and others as needed.
- The majority of case management services provided are medical vs. non-medical, the objective is to improve health care outcomes. minimum contact (phone, face-to-face, or consult) every 2-3 months.

Level 2 (Supportive)	18-22 points

Intake

- Case Management Intake and assessment should be completed within 30 days of beginning intake.
- Complete the Acuity Scale assessment.
- Develop the ISP based on identified needs or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.
- An ISP should be completed upon Intake regardless of Acuity Level score.
- Additional goals, activities, and outcomes should be documented in the case notes.
- Newly diagnosed clients should automatically be assigned a Level 3 or 4.

Established Client

- Revise the Acuity Scale and ISP a minimum of every 6 months from the last date both documents were completed.
- Continuous client monitoring to assess the efficacy of the care plan
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- A case note should be completed for every encounter with the client or consult regarding the client (phone, face-to-face, or consult).
- Assist with referrals and follow-up as appropriate.
- The majority of case management services provided are non-medical vs. medical, the objective is to provide guidance and assistance in improving access to needed services
- Minimum contact (phone or face-to-face) at least every 6 months with adaptations as necessary

Level 1 (Self-Management)	16-17 points

Intake

- Case Management Intake and assessment should be completed within 30 days of beginning intake.
- Complete the Acuity Scale assessment.
- Develop the ISP based on identified or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.
- An ISP should be completed upon Intake regardless of Acuity Level score.
- Additional goals, activities, and outcomes should be documented in the case notes.
- Newly diagnosed clients should automatically be assigned a Level 3 or 4.

Established Client

- Revise the Acuity Scale and ISP a minimum of every 6 months from the last date both
- Continuous client monitoring to assess the efficacy of the care plan
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- A case note should be completed for every encounter with the client or consult regarding the client (phone, face-to-face, or consult).
- Assist with referrals and follow-up as appropriate.
- The majority of case management services provided are non-medical vs. medical, the objective is to provide guidance and assistance in improving access to needed services.
- Minimum contact (phone or face-to-face) at least every 6 months with adaptations as necessary documents were completed.

Appendix F

Georgia Department of Public Health Office of HIV/AIDS Standard Operating Procedure (HIV Perinatal Program)	SOP Name: Ryan White Part A, B, C, D Coordination of Prenatal Care Revised Date: 6/21/2018 Implementation Date 2018	
Effective Original Date: 2017	Total Pages: 3	Revised Date: 2018
Approval Date: 2017	Date Reviewed: 2018	Approved By: Program Leadership

Standard Operating Procedure

1. **Purpose:** To strengthen collaboration between all Ryan White Part A, B, C, and D Case Managers, Ryan White Medical Providers, and the referred OB-GYN office(s) (including designated staff) to improve continuity of care for HIV positive pregnant women and increase seamless communication between prenatal and HIV Care providers.

2. **Scope:** The identified population is limited to Perinatal HIV/OB-GYN women receiving services.

3. **Prerequisites:** Electronic Medical Record and/or paper charts, telephone, call conference phone line, notepad, etc.

4. **Responsibilities:** All Ryan White Part A, B, C, and D case managers' responsibilities will be to conduct monthly phone consultations with OB-GYN office to collect information on the patient's prenatal care. All case managers are expected to document consultation notes into their prospective electronic medical record or client paper chart. Case managers are responsible for collecting/updating the following information during the call:

****** The following information should be collected from the OB-GYN office for all pregnant clients referred from Ryan White Clinics. ****

A. Scheduled prenatal appointment
- Attended prenatal appointment
- Missed prenatal appointment and provide a list of reason(s) for missed appointment
- Rescheduled prenatal appointment

B. Estimated date of delivery

C. Discussion on referral for Infectious Disease Pediatrician for infant after delivery

Georgia Department of Public Health Office of HIV/AIDS Standard Operating Procedure (HIV Perinatal Program)	SOP Name: Ryan White Part A, B, C, D Coordination of Prenatal Care Revised Date: 8/21/2018 Implementation Date 2018	
Effective Original Date: 2017	Total Pages: 3	Revised Date: 2018
Approval Date: 2017	Date Reviewed: 2018	Approved By: Program Leadership

D. Plan of delivery and reason why?
- Vaginal
- C-section

E. Treatment recommendations (Medication(s) and dosages)
- ARVs
- AZT for mother at delivery
- Newborn prophylaxis

F. Nutritional Recommendations
- Discussion of plan relating to formula feeding.
- Discussion of avoidance of pre-mastication of food for baby.

* Each month all case managers are to submit the **HIV Form 582 Perinatal Care Monthly Report to the State Office HIV Perinatal Coordinator.***

5. Procedure:

Who: Each month all Ryan White Part A, B, C, and D case managers will call OB-GYN office to discuss prenatal care services regarding their pregnant clients. *All case managers will designate a specific day and time each month with the OB-GYN office to conduct the phone consultation.*

What: Phone consultation and Quality Improvement.

When: Monthly

Where: Via phone consultation

Why: To improve communication amongst all case managers, medical providers, OB-GYN, Pharmacy, Hospital, Nutritionist, Social Workers, etc.

Georgia Department of Public Health Office of HIV/AIDS Standard Operating Procedure (HIV Perinatal Program)	SOP Name: Ryan White Part A, B, C, D Coordination of Prenatal Care	
	Revised Date: 8/21/2018	
	Implementation Date 2018	
Effective Original Date: 2017	Total Pages: 3	Revised Date: 2018
Approval Date: 2017	Date Reviewed: 2018	Approved By: Program Leadership

6. Follow up for baby: Highly encourage the Ryan White clinic to follow up with mother and the pediatrician concerning appropriate follow up, testing, and prophylaxis of baby to prevent seroconversion of HIV.

7. Acronyms:

Case manager-CM

Obstetrics and Gynecology- OB-GYN

Follow up- F/U

Electronic medical record-EMR

Cesarean Section- C- section

Zidovudine- AZT

Human Immunodeficiency Virus- HIV

Antiretroviral- ARV

7. Definitions:

Newly enrolled client: Client with initial referral to the OB-GYN for prenatal care and appointment has not yet been attended.

Currently enrolled client: Client has attended one or more prenatal care scheduled appointments.

3 | Page

Appendix G

Georgia Case Management Definitions

Medical Case Management

Medical Adherence Assessment
-- new to treatment or experienced
-- change in regimen
-- determine willingness to adhere
-- by RN in clinical setting

Individual Medication Adherence Counseling
-- new to treatment or experienced
-- change in regimen
-- ongoing regimen
-- by RN in clinical setting

Initial Enrollment
-- intake, assessment, and initiation of Individual Service Plan
-- coordination and follow-up of medical treatment
-- discussion of treatment adherence

Individual Service Plan (ISP)
-- face-to- face
-- review progress, identify additional needs, establish next steps, and set new goals
-- discuss medical treatment, adherence
-- initial or comprehensive updated
-- determine acuity level

Interim contacts
-- face-to-face or non face-to-face
-- must include coordination and follow-up of medical treatment and adherence
--follow-up on ISP goals and current needs

Discharge linkage
-- coordinate care for clients leaving hospital
-- link to clinic, access services and medication
-- education on enrollment
-- by RN or medical case manager in treatment setting

Georgia (Revised Version) 2018

Non-Medical Case Management

Initial Enrollment – Nonmedical
-- intensive enrollment visit for intake and assessment
--explanation of program, navigating health care system, discussion of needs, and collection of eligibility information (income, etc.)
-- may include assistance in obtaining medical, social, community, legal, financial, emergency assistance to self-managed client (housing, transportation, food, etc.) and other needed services.

Interim Contacts
-- face-to-face or non face-to-face
-- follow-up on ISP goals and current needs
-- including obtaining updates on needs and income.
-- may include assistance in obtaining medical, social, community, legal, financial, emergency assistance to self-managed client (housing, transportation, food, etc.) and other needed services.

Supportive/Self Management
-- face-to-face or non face-to-face
-- reevaluate and update
-- does **not** involve coordination or follow-up of medical treatment

Benefits/Financial Counseling
-- enrolling in ADAP, PAP, HICP and other entitlements
-- determining eligibility for Medicaid, Medicare, other payer
-- regardless of credential of staff performing activity

Peer Encounter
-- face-to-face or non face-to-face
-- by a peer advocate/educator
-- includes follow-up with clients lost to care, other client follow-up, and navigation
-- does not include benefit/financial counseling
-- does not include client education

Source: *Georgia Ryan White Parts A, B, D CAREWare Sub-services and Definitions,* 2018

Appendix H

Georgia Department of Public Health
Ryan White Part B Program
Request to Receive ADAP/HICP Only

Client Name: ____________________________

Client ID #: ____________________________

The Ryan White Part B/ADAP Program provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. All funded agencies provide primary care services, support services including ADAP and HICP, which provide medications and health insurance coverage. Please refer to HRSA PCN #16-02 for a complete list of service definitions. An example of the services offered are listed below:

Core Medical Services
Outpatient/Ambulatory Medical Care (OMAC)
Oral Health
AIDS Drug Assistance Program (ADAP)
Health Insurance Premium (HICP) and Cost Sharing Assistance
Mental Health
Medical Nutrition Therapy
Medical Case Management
Substance Abuse Outpatient Care

Support Service
Non-Medical Case Management
Emergency Financial Assistance
Food Bank/Home Delivered Meals
Health Education/Risk Reduction
Housing
Linguistic Services
Medical Transportation Services
Psychosocial Support Services

My signature below confirms that I was informed of all the services offered by the Ryan White Part B Program. I decline all additional services and request to only receive assistance with ADAP/HICP. I understand the process to obtain additional services if needed. If my circumstances change, I understand how to access Case Management Services to schedule an assessment.

Client Signature: ___________________________________ Date: _____________

Case Managers Signature: ____________________________ Date: _____________