2025

Georgia Ryan White Part B Case Management Standards of Operating Procedures

For All Ryan White Part B Case Management Procedures

GEORGIA DEPARTMENT OF PUBLIC HEALTH

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INTRODUCTION

About this Document

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 services funded by RW Part B 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:

- Increase the quality of care and life for people living with HIV/AIDS
- Coordination of services to reduce preventable emergency room, urgent care center and hospital visits
- Provide client advocacy and crisis intervention services upon identified need
- Consistently retain clients in care
- Establish better health outcomes for all clients served

Background for Case Management Services

The HIV services system provides several types of coordination, referral, and follow-up services that aim to eliminate barriers to necessary medical and support services eligible persons are entitled to receive. To goal is to help people with HIV (PWH) get connected to needed services and stay in care.

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 PWH are engaged (e.g., outpatient ambulatory health services, medical and non-medical case management, health literacy, early intervention services, and treatment adherence discussion). Providers should:

1) Involve consumers in the decision-making process of their HIV treatment and sexual health

2) Develop a trusting relationship with their patients
3) Identify all barriers that could affect treatment adherence to medical care and support services
4) Support PWH 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, and continuing primary care, an 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 PWH are linked to care, engaged in care, and encouraged to begin ART based on readiness of medical adherence. Remember, we must meet the clients where they are in relation to the endurance of taking medications every day for life.

SECTION 1: SUB-RECIPIENT AGENCY RESPONSIBILITY

Any RW Part B funded subrecipient, also referred to as funded agencies, is required to provide both medical and non-medical case management services to all eligible PLWHA who reside in Georgia. Sub-recipients are responsible for maintaining appropriate relationships with entities in the area they serve that constitute key points of access to the health care system for individuals with HIV/AIDS (emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, and others) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care. **Services provided must meet all service standards set forth by the state**, and must align with HRSA's Ryan White Universal and Part B Programmatic and Fiscal National Monitoring Standards.

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). They should obtain a signed copy of the patient acknowledgement Notice of Privacy Statement (HIPAA form) and provide the client with a copy of the signed statement. **Signed acknowledgement of Notice of Privacy Statement (HIPAA form) in the client's record.**

Proof of Eligibility

Each agency must have an eligibility policy and procedure that complies with state and federal regulations (i.e., linguistically appropriate for the population being served). A written policy on

files at provider agency. All clients provided services at each subrecipient site must provide the necessary documentation required to receive care and treatment services funded through RW Part B dollars.

1. HIV Status
2. Low-Income
3. Residency
4. Payor of last Resort – have no other payor options

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

Client Confidentiality Agreement

Each agency must have a client confidentiality policy (i.e., linguistically appropriate for the population being served). Every employee must sign a confidentiality agreement.

Clients Rights and Responsibility 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 actively participate in their own care. Case managers 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.

The Grievance Policy

Each agency must have grievance policies and procedures; and client's rights and responsibilities (i.e., linguistically appropriate for the population being served). A written policy on file at provider agency. 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.

Grievance procedures and client's rights and responsibilities displayed in public areas of the agency.

Each agency must implement, maintain, and display documentation regarding client's grievance procedures and client's rights and responsibilities in public areas of the agency so all clients are aware of the process and how to file. Documentation of each must remain 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. These documents are completed and signed by the client and their respective case managers. 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.

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)

Agency Documentation Policy for Case Managers and Relative Staff

Each agency must have a written documentation policy on file at the service provider location. Case managers must participate in documentation training and these records must remain in the personnel file. Case managers must ensure that appropriate signatures are on all applicable documents. Case Managers must document all interactions or collaborations which occurred on the client's behalf. Each client's case management record must be complete and include all relevant forms and documentation such as proof of eligibility, ISP, case notes, and other pertinent documents.

SECTION 2: CASE MANAGEMENT DEFINED

Case Management Personnel Qualification

Newly hired HIV case managers will have the minimum qualifications, and their resume will remain in the personnel file. Required to have the appropriate skill set and relevant experience to provide effective case management, as well as be knowledgeable about HIV/AIDS and current resources available.

Possess the ability to complete documentation required by the case management position. Has achieved 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.)

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). Each agency will have a case management supervision policy.

Each subrecipient provider organization must have a written job description for all case managers and all case management supervisors. The job description is specific to the roles and responsibilities for each position providing a type of case management service to the client.

Case managers will receive training on the Case Management Standards and standardized forms. Case managers will participate in at least six (6) hours of education/training annually.

Each agency must maintain the Case Managers credentials and/or evidence of training of health care staff providing case management services. Case managers will comply with the Georgia HIV/AIDS Case Management Standards.

At subrecipient audits for case management services by the Clinical Quality Case Management Team will review staff qualifications and training documentation. This manual provides the definition of Georgia Case Management for Medical and Non-Case Managers (**Appendix A**).

SECTION 3: STYLES OF CASE MANAGEMENT

The Medical Case Manager

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, email and telehealth and any other forms of communication).

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. Other eligible services may include, Medicaid, Medicare enrollment and Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care, supportive services, and insurances plans through the health insurance Marketplace/Exchanges.

Visits to ensure treatment readiness 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.

Medical case management provides treatment guidance for clients who score higher on the Acuity Assessment Scoring tool. Clients scoring 3 or higher will be medically case managed. Clients in this area need more frequent contact with the case manager. The environment in which the client exists often lacks stable housing, homelessness, treatment adherence is more difficult, behavioral health needs often exist, the client undergoes more crisis or manic encounters due to their situation. Contact at the beginning of the case management can be weekly, bi-weekly, or monthly until such a time as the client begins to reach some sort of stability if possible.

This type of case management is a core medical service under Ryan White purposes for funding. Medical case managers are professionally trained, medically credentialed and can include team members who are health professionals in a joint team effort. These are client centered services which requires that the client has buy in to the process, participates in the creation of their treatment plan and is the focus of the process for completing goals and achieving a more stable environment through case management assistance and guidance. Case managers are the gate keepers for holding the client responsible for working towards the goals and outcomes of the treatment plan that the client helps establish. Documentation of each encounter with the client will be presented in the case management tab of the client medical record.

Medical case management services collaborate with Ryan White Medical providers and referred OB-GYN offices 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 the OB-GYN office to collect information on the patient's prenatal care. All case managers are required to document consultation

notes into their prospective electronic medical record or client paper chart (**Appendix B**).

Key activities for Medical Case Management services includes,

- Initial assessment of service needs
- Development of a comprehensive, ISP
- Continuous client monitoring to assess the efficacy of care plan
- Re-evaluation of the care plan at least every 3 months with adaptations as necessary for the client's medical care plan
- Ongoing assessment of the client 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 areas
- Timely and coordinated access to medically appropriate levels of health, support services and continuity of care
- 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 if applicable

The Medical Case Management service category's objective is to provide guidance and assistance to improve health care outcomes.

The NON- Medical Case Manager

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. Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. These include 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 applications and referrals, educational services, other state, or local healthcare and/ support services.

Complete the Acuity Scale and develop key NMCM activities that are not as intensive and less frequent encounters than those under the medical case management activities. PLWH enrolled in non-medical case management are more self-sufficient and able to manage life situations for themselves within their environment 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 established clients.

- A comprehensive ISP within 30 days of beginning intake
- Timely and coordinated access to medically appropriate levels of health, support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the ISP efficacy
- 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 services include all types of encounters including face-to-face, telehealth, electronic mail (e-mail), and any other form of communication. All encounters are documented in the client chart. 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 PWH who are self-sufficient with non-urgent circumstances that provides structured guidance for PWH to develop client centered goals

Key activities for NON-Medical Case Management services includes,

- Initial assessment of service needs for client acuity scores of 2 or below. Some clients scoring a 2 may need more encounters contact with the case manager due to a specific situation
- Development of a comprehensive, ISP
- Re-evaluation of the ISP at minimum every 6 months with adaptations as necessary
- 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 All clients should have documented evidence of coordination of services required to implement the ISP during service provision, referrals, and follow-up area

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

SECTION 4: Information Gathering

The Purpose of the Intake

To ensure PLWH understand the purpose of case management and to 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 to and from PLWH with care and compassion. It is 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.

The first step in the enrollment process is to complete the 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 the case manager. All supporting documents provided should be reviewed for accuracy.

A case manager completes a Client Intake form (**Appendix C)**, An initial intake can be much like a meet and greet with the client to get a basic understanding of the client's situation. 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.

During 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 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.

If the client declines Case Management services, the Request to Receive ADAP/HICP Only form (**Appendix D**) is required to be signed by the client and the case manager. This document will be filed in the client EMR.

SECTION 5: Performing the Intake

Acuity Scale and Assessment

The first step during the case management process after the intake 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 to use in conjunction 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. Acuity Scale must be assessed, and a score assigned and in the client chart. Additional information regarding the Case Management Acuity Scale (**Appendix E**).

Every Acuity Scale must contain the Total Score and Assigned Acuity Level reflective on each completed Acuity Scale Assessment. All Acuity Scale assessments will be updated in accordance with the Activities by Acuity Level document. (**Appendix F**). At a minimum, the Acuity Scale should be revised accordingly for Level 4 – Every 3 months and for Level 1-3 – Every 6 months.

The case manager can, at their discretion, increase the acuity level based upon the clients' needs and assessment where circumstances have changed 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.

Scoring the Client Acuity Level

Level 1 and 2 - Clients have 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 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 the 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 than 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- Clients are at a higher acuity level which requires more case management services.

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

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 case managed, 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 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 should be reflective of goals, activities, and outcomes in the case notes. All services provided must be documented and any service provided without documentation will not be acknowledged.
Upon completing and scoring the Acuity Scale, the Activities by Acuity Level document in Appendix D Page 35 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.*

Level 4 Scoring Clients will be at least every 3 months.

Development of Individualized Service Plan

The third step is to develop the initial comprehensive ISP (**Appendix G**), 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 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 should 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 has a comprehensive knowledge of the community resources to address the needs of the client during the development of the ISP.

The ISPs 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. 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 client currently needs
- identification of agencies with capacity to provide needed services to client
- specification of how client will acquire needed services
- the process identified to assure client has successfully obtains 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 PWH

At minimum, the initial ISP 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. 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 their situation.

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.

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 service needs over time. Both the case manager and client must sign and date the ISP. Agencies using electronic medical records (EMR) may use an electronic signature for case managers. 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.

Income and Expense Spreadsheet -Financial Assessment of income verses expenditure

The fourth step is to complete the Income and Expense document (**Appendix H)**. 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 document provides the case manager the insight into the clients' financial situation. Upon completion of this document, it can be determined if a client does or does not have the financial means of supporting themselves. It is at this juncture the client may need financial assistance, referral to a budget counselor and a crucial conversation about the disclosures of incoming finances versus the spending habits of the client. It is time to educate the client about the needs of necessary provisions versus luxury items. The case manager should be skillful at educating the client and teaching how to problem solve their own spending habits to better support themselves without relying on other sources.

SECTION 6: COORDINATION OF SERVICES

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 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. 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 should be updated during this time as well. Upon revising the ISP, a case note must be completed.

Implement client's ISP through documentation in client's record of progress toward resolution and outcomes of task listed on the client's ISP. Communicate with other case managers with whom the client may be receiving other services. Document the other providers of said services and if there is a specific other person whom the client wishes to utilize as a case manager in case there is some sort of issue with other persons.
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.

Documentation of referrals to primary care and follow-up must occur within 30 days of those appointments. This is necessary to maintain treatment adherence to needed medical services. 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. All medical and non-medical case management clients must have an Acuity Scale and ISP revised in accordance with the Activities by Acuity Level document. Ensure that documentation (case notes, initial assessment, or re-assessment) is in the client's record. 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).

Every new or re-enrolling case management client must have an ISP completed and signed by both the case manager and PWH. 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.

SECTION 7: TERMINATION OF CASE MANAGEMENT

Termination and/or Discharge of Case Management Service Provisions

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, staff, or other clients at risk (i.e., terrorist threats, threatening or violent behavior, obscenities, harassment, or stalking behavior)
- If client moves/relocates out of service area
- If after repeated and documented attempts, a case manager is unable to reach a client confirmed attempts have been established
- If the client no longer meets Ryan White eligibility requirements

Reason for discharge must be documented in the client chart under the case management section.

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. It is the responsibility of the case manager to ensure the client chart is correct, up-to-date and contains all the information pertaining to the Georgia RW Part B Case Management Standards.

SECTION 8: DOCUMENTATION

Documentation is a key means of communication between team members. It contributes to a clearer situation analysis for clients and their family/caregiver's unique needs. It 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 the services provided and the actions performed at each encounter with the client. 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 client
- any services that were rendered
- outcomes achieved or not 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 a timeline of care that has been established. It identifies who the client is, what brought them to the office, what goals were established, what is the plan of action forward, 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 information 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. Anyone reading the case note can clearly identify how a timeline of events has or will occur systematically. Documentation must ensure that the following activities are being completed for all new and established case management clients:

New Clients

- Standardized Case Management Intake
- Acuity Scale completed and scored in accordance with the activities by Acuity Level document
- ISP
- Case notes

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 Acuity scale and ISP.

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 Note:

- 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 to address the identified need of the client
- Implementation: specific tasks or action steps that need to be taken 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

The Four Phases of Soap Note:

- 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

APPENDICES

Appendix A: Definitions of Georgia Case Management

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 B: Perinatal Program

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: 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

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: 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

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.

Appendix C: Client Intake

CLIENT INTAKE

☐ New Client ☐ Annual Recert ☐ Re-Enroll

Date: Social Security #: Client #:

PERSONAL INFORMATION PRIMARY LANGUAGE_____

NAME: _____ NEED INTERPRETER ☐ YES ☐ NO

_____ _____ _____
STREET ADDRESS CITY/STATE ZIP

_____ _____ _____
ALTERNATE ADDRESS CITY/STATE ZIP

_____COUNTY SEXUAL IDENTITY:_____

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 a 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/ DISABILITY
Do you have a disability? ☐ YES ☐ NO
If yes, please explain.
_____
Highest level of education completed?

Case Managers Initials:_____
Date:_____

Place Client Label Here

1 of 1 Case Management Intake 4/1/21

Appendix D: Request to Remain on ADAP/HICP Only

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: _____

Appendix E: Acuity Assessment

2025 Georgia RW Part B Case Management Acuity Scale

Simply chose the best acuity level representing client's current situation and enter the Level number in the Life AREA below	Level 1 (1point)	Level 2 (2 points)	Level 3 (3 points)	Level 4 (4 points)
Medical/ Physical Health Please Select	Periodically has lab work, Asymptomatic, in medical care	Needs Primary care/referral Short-term acute condition treated Non-HIV related issue under control HIV symptomatic w/comorbidities impair overall health	Treatment/medication needed for non-HIV condition Pregnant Debilitating HIV condition Multiple medical diagnosis Home health/home bound services needed	In medical emergency End-stage HIV condition Intensive and/or complicate home care required Hospice services or placement
Medical Treatment/Adherence Please Select	Adheres to medication >6 Months w/o assistance/ n medication prescribed No issues w/medication side effects or schedule	Adherent to medication as prescribed <6 months or >3 months with minimal assistance Keeps majority of medical appointments	Adherent only with assistance Does not understand prescribed med Misses' doses consistently Misses ½ of scheduled medical appts Known to take drug holiday against medical advice	Resists medication & treatment plan adherence w/assistance Refuse/decline taking meds Uses ER for primary care Cannot take medication as directed or keep appointments w/o assistance Cannot name current medication New to care
Dental Care Please Select	Currently in Dental care Seen dentist <6 months w/o complaint Practice oral hygiene	No dental care >six months Has dentures requests follow-up No oral hygiene practiced daily	No dental care >1 year Episodic issues in mouth w/pain Problems w/teeth gums, and mouth Difficulty eating due to lack of dental care	Never seen a dentist Reports current/severe pain issue Severe or major problems w/teeth, gums, and mouth Few to no teeth Severe difficulty w/eating

2025 Georgia RW Part B Case Management Acuity Scale

Simply chose the best acuity level representing client's current situation and enter the Level number in the Life AREA	Level 1 (1point)	Level 2 (2 points)	Level 3 (3 points)	Level 4 (4 points)
Behavioral Health Please Select	No history of issues No referral needed for BH provider	Has history of BH issues for client/family background High stress level needed Functions w/depression Difficulty getting along w/others Current w/ treatment plan	Acute episodic & or in crisis Severely stressed referral needed Nonfunctional and depressed Not getting along w/others Recent hospitalization Requires significant emotional support Not adherent to plan	Is danger to self/others Needs immediate psychiatric assessment Active chaos from violence /abuse w/I situation Requires therapy but refuses Pregnant and not taking medication
Substance Abuse Please Select	No alcohol, drugs, sex, or gambling addiction History >1 year in recovery No referral needed	History of addiction <1 year in recovery No affect on paying bills or being medically adherent	Addiction issues current and willing to access treatment Impacts functionality Impaired by significant other	Refuses treatment Disregards the consequences on impact of life from substance abuse Pregnant and using
Support System Please Select	Support of family, friends, peers No additional support needed	Requests additional support Few to no friends in area Family, friends, peers not available when crisis occurs	Ha no stable support system Only support system available is Professional provider	Crisis is imminent In current acute situation unable to cope Requires professional assistance.
Violence and Trama Please Select	No history of violence/ abuse No intimate partner violence disclosed	History of past violence/abuse with family, friends, peers Has history of intimate partner violence but stable	Current abuse /violence occurs Professional services involved for abuse (emotional, sexual, and physical)	Chronic abuse/violence occurring now Medical/legal intervention needed or involved now Unsafe home environment
Legal Please Select	No current legal issues All legal documents needed are completed (HC-POA, living will, etc.)	Possible legal issues occurring Has not completed legal documents (HC-POA, living will, etc.) Requests assistance to complete	Current civil/criminal issues exist Unaware of standard legal documents for current situation and/or healthcare decisions Incarcerated	In crisis with legal situation (with landlord, employer, coworkers, civil/criminal) Needs legal assistance

Revised 04/01/2025

2025 Georgia RW Part B Case Management Acuity Scale

Simply chose the best acuity level representing client's current situation and enter the Level number in the Life AREA	Level 1 (1point)	Level 2 (2 points)	Level 3 (3 points)	Level 4 (4 points)
Culture and Language Please Select	No barriers to navigating the system No barriers to understanding language (includes signing)	Needs language interpreter for services Family/others needs education interpretation to provide support Few cultural barriers accessing services	Interpreter required to access additional services Family/ other does not understand HIV and is a barrier to care Cultural barriers to accessing services more prevalent.	Cannot access system w/o interpreter Family is a major barrier to care due to cultural /language issues Cultural crisis intervention needed
Food and Nutrition Please Select	Eats at least 2 meals per day No problem w/ weight No eating problems No problem with access to food No food morbidity disease	Changes in eating habits <3 months Un planned wt. loss <3 months Some barriers to obtain food to eat Overweight and requires diet plan	Moderate eating problems with dental or mouth issues Signs of "wasting syndrome"/physical maladies Trouble w/obtaining consistent food Obese and difficulty w/following diet	Severe eating related issues Significant with loss <3 months Needs dietician referral Cannot obtain adequate food supply
Transportation Please Select	Consistent transportation No problem with access to private/public transport system	Very little transportation issues May need assistance on occasions	Resides in area but little to no public transport available No access to private transportation No knowledge of public/private transportation options w/I area	No public transport options available causes for medical treatment adherence
Finance and Income Please Select	Income stability Savings and other options for resources available Pays own monthly bills	Income source in jeopardy Short term benefits available Needs information on benefits and assistance available Occasionally needs assistance	Has no income source Financial benefits denied Needs assistance with applying for benefits Financial planning referral needed	Emergency financial assistance required Referral to financial benefits representative for immediate assistance options available.
Emergency Financial Assistance Please Select	No emergency financial assistance needed Able to pay own bills/utilities	Needed 1-2 times/yearly Needs information how to access/request financial assistance Needs assistance w/utilities	Needs assistance >3 to 6 times year Difficult to maintain basic needs due to low income Needs budget/financial planning referral	Needs assistance >6times/ year In financial crisis needs immediate intervention assistance

Revised 04/01/2025

2025 Georgia RW Part B Case Management Acuity Scale

Simply chose the best acuity level representing client's current situation and enter the Level number in the Life AREA	Level 1 (1point)	Level 2 (2 points)	Level 3 (3 points)	Level 4 (4 points)
Housing Please Select	Has affordable stable housing Meets clients' needs Safe secure non-subsidized housing program	Resides n supportive housing Housing unstable in jeopardy Needs assistance with rent and utilities too remain housed	Temporarily housed with family or friends Eviction imminent Lives in transitional shelter	Needs assisted living facility Current residence uninhabitable due to health safety hazards assistance unavailable Recently evicted from housing program Pregnant
HIV Risk Reduction Please Select	Practices safe sex 100% of time, has a strong understanding of preventing the spread of HIV	Has safe sex practices >75% of the time and has a fair understanding of need for safer sex practices	Has safer practices 50-75% of the time with little understanding as to importance of safer sex practices	Has safer sex practices <50% of the time with no understanding of need for safe sex practices
Health Insurance Options and understanding Please Select	Has own medical coverage Able to access medical care as needed w/o barriers	Seeking information and educational assistance to enroll in medical coverage Referral to insurance assister	Assistance needed from enrollment specialist to obtain medical health coverage to other payor sources	Current health crisis requires access to medical coverage for premium assistance Not currently eligible ADAP/HICP only option

Client Name:Click or tap here to enter text. **Client ID#:**Click or tap here to enter text. **Completion Date**:Click or tap here to enter text.

Date of Reassessment (maximum 12 months from completion date):Click or tap here to enter text.

Current client acuity level: Please Select **Is client pregnant?** Please Select **Suggested MCM?** Please Select

Case Manager Signature:Click or tap here to enter text.

Level 1 (16-17 points) Level 2 (18-22 points) Level 3 (23-37 points) Level 4 (38-64 points)

Appendix F: Activity by Acuity Level

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 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

Appendix G: Individual Service Plan

Georgia RW Part B (ISP)

Case Management Individual Service Plan

Areas of assessment will include the following factors necessary to design the best treatment plan for the client.

1. **Medical History/Physical Health:**
    a. List of identified needs: Click or tap here to enter text.
    b. List of desired Goals & Outcomes: Click or tap here to enter text.
    c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
    d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
2. **Medical Treatment Adherence:**
    a. List of identified needs: Click or tap here to enter text.
    b. List of desired Goals & Outcomes: Click or tap here to enter text.
    c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
    d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
3. **Mental Health Assessment:**
    a. List of identified needs: Click or tap here to enter text.
    b. List of desired Goals & Outcomes: Click or tap here to enter text.
    c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
    d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
4. **Dental Care and Treatment Plan**
    a. List of identified needs: Click or tap here to enter text.
    b. List of desired Goals & Outcomes: Click or tap here to enter text.
    c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
    d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
5. **Substance Abuse and/or Addiction**
    a. List of identified needs: Click or tap here to enter text.

b. List of desired Goals & Outcomes: Click or tap here to enter text.

c. List of steps for implementing the desires/goals above: Click or tap here to enter text.

d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

6. **Health Insurance Planning Process**
   a. List of identified needs: Click or tap here to enter text.
   b. List of desired Goals & Outcomes: Click or tap here to enter text.
   c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
   d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
7. **Domestic/Trauma Environment**
   a. List of identified needs: Click or tap here to enter text.
   b. List of desired Goals & Outcomes: Click or tap here to enter text.
   c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
   d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
8. **Personal, Social and Community Support**
   a. List of identified needs: Click or tap here to enter text.
   b. List of desired Goals & Outcomes: Click or tap here to enter text.
   c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
   d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
9. **Current Housing Status**
   a. List of identified needs: Click or tap here to enter text.
   b. List of desired Goals & Outcomes: Click or tap here to enter text.
   c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
   d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.
10. **Transportation Planning for Medical Care and Treatment Adherence**
    a. List of identified needs: Click or tap here to enter text.
    b. List of desired Goals & Outcomes: Click or tap here to enter text.
    c. List of steps for implementing the desires/goals above: Click or tap here to enter text.

d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

11. Client Legal Situation

a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

12. Client Income Level

a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

13. Emergency Financial Status

a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

14. Nutritional and Food Status

a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

15. Identification of Cultural Beliefs

a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

16. Reducing any HIV Risk Exposure

a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

17. Disclosure of Diagnosis Status

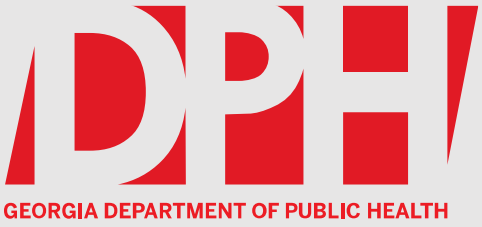
a. List of identified needs: Click or tap here to enter text.
b. List of desired Goals & Outcomes: Click or tap here to enter text.
c. List of steps for implementing the desires/goals above: Click or tap here to enter text.
d. Date to review goals, objectives, and reevaluation: Click or tap here to enter text.

Case Management Signature: Click or tap here to enter text. **Date:** Click or tap to enter a date.
Client Name/ID #: Click or tap here to enter text.
This ISP is a client centered plan activity and therefore receives a copy of the plan.
Date Received: Click or tap to enter a date.

Appendix H: Income/Expense Spreadsheet

Is the client's income enough to cover monthly expenses? yes No

Income		**Expenses**	
Source	Amount	Itemization of Payment Responsibilities	Amount Paid
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**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