Georgia HIV/AIDS Medical and Non-Medical Case Management Standards 2016

Georgia Department of Public Health
Division of Health Protection
HIV Office

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Introduction

HIV/AIDS case management provides a dynamic system of case management 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). All the Case Managers in the state are Medical Case Managers that also provide referrals to support services to include (transportation, housing, food etc.) Other agencies such as community based organizations may also provide case management services to persons living with HIV/AIDS.

The Georgia HIV/AIDS Case Management Standards may be adapted to other HIV/AIDS programs, but it is intended to assist case managers, case manager supervisors, and other agency staff who are serving HIV/AIDS clients funded through the Ryan White Part B Program. These Standards are not meant to replace or override existing, more detailed standards that provider agencies may already 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 standard. It is intended to assist the agency and case managers in fulfilling the generally agreed upon objectives or 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 reduce the cost of care through coordinated services which keep persons living with HIV and AIDS out of urgent care centers, emergency rooms and hospitals
- To provide client advocacy and crisis intervention services

Background:

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. 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. MCM is the piece of this system that assesses the primary and immediate needs of people with HIV, coordinates referrals, and follows-up with critical core medical and support services to ensure people with HIV remain in medical care. The services that are provided are in alignment with the National HIV/AIDS Strategy and focus on getting people into care, retention in care and viral load suppression.

Case Management Defined

Case management is a directed program of care and social service coordination. Typically clients are enrolled into case management to ensure a more comprehensive continuum of care**,** if needed. They are also enrolled if they exhibit a need for additional assistance required to navigate coordination and follow up medical treatment as well as services that provide advice and assistance to obtaining social, community, legal, financial and other needed services. There are many definitions that vary among agencies; however, the definition of case management used will be that from HRSA for Ryan White Programs.

Medical Case Management: A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan**,** as necessary**,** over the life of the client

Non-Medical Case Management is also a range of client-centered supportive services that link clients with health care, psychosocial, and other services, however the focus is not on adherence or following up specifically on medical treatments. Key activities may also include coordination of services, development of an abbreviated Individualized Service Plan, provision of self-management education and support services, and monitoring and evaluation of the client's needs. It also includes all types of case management contacts, including face-to-face meetings, phone contact, and any other forms of communication.

The Case Manager

Roles of a Case Manager

The roles of the case manager are varied and require that the 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
- Planner
- Prudent Purchaser

Skills of a Case Manager

In addition to requiring that staff be knowledgeable in all areas listed above, effective case managers must possess a wide range of skills in order to carry out their functions. The case manager must have considerable skills in locating, developing, and coordinating the provision of supportive services in the community, as well as skills in coordination and follow-up of medical treatments and adherence counseling. Case

managers can benefit from training in the following areas regardless of their educational background:

- Case management process (Intake, Assessment, Care Plan Development and Implementation, Coordination of Services, Monitoring/Reassessment, and Documentation)
- Interviewing
- Oral, written, and communication skills
- Establishing rapport and maintaining relationships
- Knowledge of eligibility requirements for applicable local, state and federal programs
- Community organizations
- 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 processes.

All staff should be provided opportunities for training to become familiar with the particular aspects of HIV/AIDS to better understand the needs of the clients served. Case managers should particularly be provided 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.

Case Load Size

Caseload size is one of the most important factors affecting job performance. Generally, a caseload of 1:75 is considered an optimum caseload for the reasons stated above, but few case management agencies have caseloads at this level. Limiting caseload below 75 is encouraged, but caseloads are generally 75 or above. When caseloads increase above 75, the nature of the case manager's role may change in the following ways:

- Interactions with clients can become increasingly 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
- Less time will be spent on documentation requirements and 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 a number of ways including caseload number, specialization of cases, level of acuity, and client's geographic location. Funding source is another criteria used to assign cases. Case management programs should establish a fair method of assigning caseloads based on the unique make-up of the HIV/AIDS population in their service area.

Client Advocacy

Client advocacy is a necessary function which requires working closely within the system to make more services available. Advocacy is the act of assisting clients in obtaining needed goods, services or benefits, (such as medical, social, community, legal, financial, and other needed services), especially when the individual has had difficulty obtaining them on his/her own. Case managers discuss strategies to remove obstacles or barriers to a client receiving needed services. Documentation should reflect that client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision. Dates of referral, contact person, reason for client being referred and advocacy activities should also be documented.

Standard Policies and Procedures

The objective of the policies and procedures standard is to ensure that agencies have policies and procedures in place that:

- Establish client eligibility
- Guarantee client confidentiality
- Define client rights and responsibilities
- Outline a process to address client grievances
- Uphold Health Insurance Portability and Accountability Act (HIPPA) policy

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 clients' records including proof of HIV status, residency, income and health insurance coverage status.

Confidentiality Policy

A confidentiality policy protects clients' personal and medical information such as HIV status, behavioral risk factors, and use of services. The confidentiality policy must include consent for release of information and storage of client's records.

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 can facilitate this by ensuring that clients are aware of and understand their rights and responsibilities.

Grievance Policy
An agency's grievance policy must outline a client's options if he or she feels that the case manager or agency is treating him or her unfairly or not providing quality services. The grievance procedure must be posted and visible to clients.

Health Insurance Portability and Accountability Act (HIPPA)
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 1. Case Management Personnel	
Standard	**Measure**
1.1 Newly hired HIV case managers will have the following minimum qualification: ○ 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 managers 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 signed by the case manager/case manager supervisors.
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 date of supervision, type of supervision (one on one **or** group), and content of supervision.
1.6 The optimum caseload per case manager is 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.

Table 2. Agency Policy and Procedures	
Standard	**Measure**
2.1 Each agency must have a**n** 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 client confidentiality policy, and 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) **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 31-22-9-1 (a) (2) for definition of ACI and Georgia Code Section 24-9-47 for medical release of ACI.)	Release of information forms signed by client in case management record.
2.5 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.

Enrollment and Intake Overview

The purpose of the intake process is to ensure the client understands what medical case management is and that the client is currently not receiving this service elsewhere. Explain the goals, objectives, and key activities of MCM outlined in the HRSA definition above. It is extremely important to provide mandated information and obtain required consents, releases, and disclosure. Intake is also a time to gather and provide basic information from the client with care and compassion. It is also a pivotal moment to establish trust, confidence, and rapport with the client. If there is an indication that the client may be facing imminent loss of medication or other forms of medical crisis, the intake process should be expedited and appropriate intervention should take place prior to formal enrollment. Service providers will understand that persons living with HIV/AIDS who are not accessing or utilizing HIV primary medical care can still receive other supportive services if desired.

Five steps that 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/Progress Note. Throughout this document the above mentioned forms will be discussed in further detail.

Intake

The first step is to complete the Client Intake form. Upon completing this form, the Case manager will review all documents to ensure that the requested information has been provided, signed by both client and case manager, and that all supporting documents are attached. The first step of the process has now been completed. The Client Intake must be completed within 15-30 days of beginning the initial intake assessment. Additional information regarding the Client Intake can be found on pages 11-13 and the Case Management Intake is located in Appendix 1.

Income/Expense Spreadsheet

The final 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. The spreadsheet is located in Appendix 2**.**

Acuity Scale

The second step is to complete the Acuity Scale assessment. It **i**s 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 with the initial intake to develop an ISP. The intent is to provide a framework for documenting important assessment elements and standardizing key questions. The Acuity Scale also translates the assessment into a level of support designed to provide assistance appropriate to the client's assessed level of functioning. This document must be completed within 15-30 days of beginning the initial intake. Additional information regarding the Acuity Scale can be found on pages 19-20 and the Case Management Acuity Scale is located in Appendix 3**.**

Individualized Service Plan (ISP)

The third step is to develop the initial 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 clients 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 the 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. ISP's should be developed using SMART objectives; **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime Specific. A completed ISP should be signed by both the client and case manager within 15-30 days of beginning the initial intake process. Additional information regarding the ISP can be found on pages 21-23 and in Appendix 6.

Progress note or case note documentation

The fourth step is to complete a progress note that will contain specific details to explain information mentioned during the intake, acuity scale, and ISP as well as other relevant information. Progress 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 manager chart any 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 that you did in response to your observations and the client's response to your actions. To provide a more complete picture of the clients situation, the case manager may document the client, family member or significant other's actual response (verbal or non-verbal) to any aspect of care provided. A verbal responses may be documented using quotation (e.g. "response" marks. Non-verbal responses should be described in as much detail as possible. This progress note documentation must be completed within 15-30 days of beginning the initial intake. Additional information regarding Progress notes can be found on pages 27-29**.**

Initial Intake

The case manager should become familiar with the eligibility requirements of numerous assistance programs to better meet the needs of the client. The Ryan White HIV/AIDS Program requires that funds are utilized as the pay**e**r of last resort. Depending on the program, the following documents may be requested: photo ID, proof of income, confirmation of HIV status, proof of residency, and/or insurance verification.

Intake is the formal process of collecting information to determine the client's eligibility for services and his/her immediate service needs. During the intake, the client should be informed that the case management services are intended to assist the client in maintaining his/her wellbeing and independence. The information collected during the intake process provides the basis for obtaining an informed consent for case management services and for conducting the comprehensive needs assessment.

The following are the goals and objectives of an intake: establish rapport and trust between the client and case manager, determine the immediate needs of the client and connect the client to appropriate resources, inform the client of the scope of services offered by the Ryan White program, including benefits and limitations, inform the client of his/her rights and responsibilities as a participant in the program, and obtain the client's informed consent to participate in the program. Case managers should allow the interactions with the client to evolve in such a way that the client feels free to express his/her needs openly and for those needs to be acknowledged by the case manager.

Upon a client being referred for case management services an intake must be completed. Information for the intake will likely be derived from a variety of sources. The client should serve as a primary source of information, and the case manager should actively engage the client in the assessment process. Clients may be asked to identify their own strengths and weaknesses and to assist in the determination of the 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 needed health 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. Five 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 needs regarding treatment, the client's right to refuse care or insist upon a different approach, treatment adherence and barriers to adherence, and access to primary care.

2. Psychological – This includes discussion of the client's level of coping and functioning and past coping strategies that were tried; a review of available resources for client support; an assessment of the client's strengths and weaknesses and financial resources available for psychological assistance if

needed; and support groups presented as options. Barriers to care such as financial issues 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, if 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, 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 sources of life, health, and disability coverage should be explored as well as employment options. The client and family should be educated about insurance issues 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 best not to rely on children to interpret for family members. Language assistance may be necessary to interpret and/or translate key documents, including, but not limited to, the consent for services; consent for release of medical and psychosocial information; bill of rights; service provider grievance policy; and any other similar documents that a provider might typically use in the provision of services to clients.

Typically the initial interaction with the client regarding case management services will occur via face-to-face or telephone. However, the intake can be conducted in other locations such as, but not limited to: office, hospital, clinic, home, or shelters. The intake is necessary to determine whether the client is in a crisis situation and/or requires an immediate direct service referral. 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 successful 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 should precede 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 case management agency's grievance policies and procedures, and client's 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 31-22-9-1 (a) (2) for definition of ACI and Georgia Code Section 24-9-47 for medical release of ACI.)

Table 3. Intake	
Standard	**Measure**
1.1 Determine eligibility for HIV case management services if client chooses to enroll in case management services.	Picture ID, physician's note or laboratory test in client's record confirming HIV diagnosis, proof of residency, proof of income, and proof of insurance.
1.2 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.
1.3 Complete the Initial Intake, Income/Expense Spreadsheet, Acuity Scale, initial ISP, and case/progress note within 15-30 days of beginning the initial intake assessment.	Completed intake, income/expense spread sheet, acuity scale, initial ISP, and case/progress note in client's record.

Acuity Scale

The Acuity Scale should be completed within 15-30 days after initiating the Intake. 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. “Level” is defined as a numerical point scale used to identify the severity of each life area. “Life Areas” are defined as activities potentially disabling to a client and therefore have greater priority when developing an ISP and assigning program support activities.

Not all Life Areas have the same point values assigned to them.

1. Clients should be interviewed in accordance with the Case Management Standards.

2. Review all pertinent client documents, secondary assessments done by other professionals (where appropriate) and any relevant information available about the client’s needs.

3. The following steps describe how to complete the Acuity Scale:
    a. The Life Area column should have a completed date**.**
    b. Check each box (per column) that applies to the client regardless of the Acuity Level at the top of each column. This step must be repeated for each Life Area.
    c. After all the applicable boxes has been checked**, t**he acuity level for that column should be determined based on the highest level with checked box(s) for that row. This step must be repeated for each Life Area.
    d. Upon determining scores for each Life Area, all the scores should be added to get an overall Total Score. This score should be written in the space provided on page 5 of the acuity scale document.
    e. Once the Total Score has been documented the level of acuity can be determined based of the corresponding scale found on page 5 of the acuity scale document.
    f. Write the Acuity Level and Date in the space provided.
    g. The final step to completing this document is to complete the bottom of page 5 by adding the Clients Name and Client ID# as well as the Case Managers Name, Initials, and Date.

4. **Using professional judgment, the Assigned Acuity Level can be increased.** If there are indicators which are so compelling that they are potentially disabling to a client, a higher level may be assigned so that a higher level of programmatic support may be provided to stabilize the client.

5. Appropriate case management activities are then assigned according with the Activities by Acuity Levels document.

6. All clients should have an ISP completed upon initial intake regardless of Acuity Level

7. Upon completion of the initial Acuity Scale and ISP, re-assessment is directed by the Activities by Acuity Level document.

8. The Supportive/Self-Management Assessment form **should not** be used as the initial ISP.

Acuity Levels

Levels 1 and 2 clients are at lower acuity level which require less intensive case management 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. 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 14-20 points

The client has demonstrated capability of managing self and disease. The client is independent, medically stable, virally suppressed and has no problem getting access to HIV care. This client might need occasional assistance from the case manager to update eligibility form**s**. A client is appropriate for self-management if they are adherent to their medical care, treatment adherence, independent, and able to advocate for themselves. Additionally, their housing and income source(s) should be stable. If diagnosed with a mental health condition, they should be in the care of a mental health provider and adherent to their treatment plan. If a client has 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. The majority of case management services provided will be non-medical vs. medical. The one page Supportive/Self-Management Assessment form should be reassessed upon request from client or referral.

Level 2 Supportive 21-28 points

This client is adherent to medical appointments, medications, able to reschedule appointments and communicate by phone when needed. The client is in treatment, medically stable with minimal assistance and does not show signs of needing assistance with getting access to care. Supportive case management is appropriate for clients with needs that can be addressed in the short term. The client should be adherent to their medical care, treatment adherence, independent, and able to advocate for themselves. Additionally, their housing and income source(s) should be stable. This client may require service provision assistance no more that 2-3 times a year. If diagnosed with a mental health condition, they should be in the care of a mental health provider and adherent to their treatment plan. If a client has 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. The majority of case management services provided will be non-medical vs. medical. It does not include the comprehensive ISP, as medical case management does. The one page Supportive/Self-Management Assessment form should be reassessed annually.

Level 3 Intermediate 29-42 points

The client requires assistance to access and/or remain in care. The client is at risk of non-compliance to medications and appointments. The client may have opportunistic infections and other co-morbidities that are not being treated or addressed and has no support system in place to address related issues. Intermediate case management is appropriate for clients who are considered medically case managed. Coordination and follow-up of medical treatments are a component of medical case management. 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: Completing initial intake within 30 days of beginning intake, Developments of an individualized service plan (ISP) within 30days of beginning intake, ISP revision at least every 6 months, and reassessment of client needs every 3-4 months. The majority of case management services provided will be medical vs. non-medical. Documentation should be reflective of goals, activities and outcomes in the progress notes. Consultation with multi-disciplinary team, case management supervisor and others as needed should be documented.

Level 4 Intensive 43-56 points

The client requires assistance to access and/or remain in care. The client is at risk of becoming lost to care and is considered medically unstable without MCM assistance to ensure access and participation in the continuum of care. Support services are not adequate to meet the clients immediate needs without intervention. Intensive case management is appropriate for clients who are considered medically case managed. 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: Completing initial intake within 15 days of beginning intake. Developments of an individualized service plan (ISP) within 30days of beginning intake, ISP revision at least every 3 months, and reassessment of client needs every 30 days. The majority of case management services provided will be medical vs. non-medical. Documentation should be reflective of goals, activities and outcomes in the progress notes. Consult with multi-disciplinary team, case management supervisor and others as needed should be documented.

Upon completing and scoring the Acuity Scale, the Activities by Acuity Level document in Appendix 4 provides timelines and activities that must be followed depending on the

acuity level score. Information obtained while completing the Acuity Scale can be utilized to develop the ISP.

When to revise the Acuity Scale, ISP and Supportive/Self-Management documents after the initial intake has been completed

After the initial documents have been completed for a new or re-enrolling client, the next step is to determine when the Acuity Scale will need to be revised. For level 4 clients, at least every 3 months. Level 3 clients, at least every 6 months. However the ISP and Acuity scale can be updated more frequent if needed. For level 3 and 4 clients the Acuity Scale and ISP must be revised at the same time.

For Level 1 and 2 clients, the Supportive/Self-Management Assessment should be completed. If there is a significant change on the Supportive/Self-Management Assessment to reflect that a client is no longer stable, a new Acuity Scale must be completed to reassess if the client is in need of additional services. An example of this would be if there has been changes in the following life areas: health status, domestic issues, housing, Income, ongoing mental health/substance abuse issues. If the new assessment reflects an Acuity Level of 3 or above an ISP must also be completed as well as a detailed progress note. Revision of the acuity scale could occur with any significant or urgent life event or occurrence, etc. hospitalization, eviction and homelessness, or incarceration.

Documentation must ensure that the following activities are being completed for all new and established case management clients:

<u>New</u>

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

<u>Established clients</u>

- Acuity Scale updated and leveled in accordance with the Activities by Acuity Level document
- The ISP updated in accordance with the Activities by Acuity Level document
- The Supportive/Self-Management Assessment updated in accordance with the Activities by Acuity Level document
- Minimum contact document in clients chart, in accordance with the Activities by Acuity Level document

Table 4. Acuity Scale	
Standard	**Measure**
2.1 All new or re-enrolling case management client charts will have a completed Acuity Scale within 15-30 days of initial assessment.	Each Life Area of the Acuity Scale must be assessed and a score assigned.
2.2 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.
2.3 All Acuity Scale assessments will be updated in accordance with the Activities by Acuity Level document. (see Appendix 4)	At a minimum the Acuity Scale should be revised as follows: Level 4 – Every 3 months. Level 3 – Every 6 months. Level 1& 2 – If there is a significant change on the Supportive/Self-Management Assessment to reflect that a client is no longer stable; a new Acuity Scale must be completed.

Individualized Service Plan (ISP) and Supportive/Self-Management Assessment

The development of the ISP consists of the translation of information acquired during intake and/or acuity scale into short-term and long term objectives for the maintenance of the health 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, specification of the procedure that will be followed to assure the client has successfully procured needed services, and a plan for how the various services the client receives will be coordinated, specifically defining the role of the case manager. Client participation in the development of the service plan is encouraged to the fullest extent possible. In particular, client feedback should be obtained on each element of the service plan before it is implemented.

Every new or re-enrolling client must have an ISP completed and signed by both the case manager and client. 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 on the basis of the information obtained from the client assessment and pinpoints the individualized needs of the client and links the appropriate services with the needs. 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 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 provided, 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 clients access and maintain 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 situation. These are goals that the client can realize in the near future, such as in a day, within the week or even a few months. Long term goals are

achieved over a longer period of time. 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 electronic signatures for case managers. Additionally, the client must be offered a copy of his/her ISP and have documentation in clients 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 needed assistance. Implementation of the ISP includes careful documentation in the progress notes of each encounter with the client. Dates of contact, information on who initiated contact and any action that resulted from the contact should be included in the documentation.

When to revise the ISP or Supportive/Self-Management Assessment documents
The ISP should be completed for Level 3 and 4 clients only. Level 4 clients should have an ISP revised at least every 3 months and Level 3 revised at least every 6 months as well as updating the Acuity Scale. 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. Upon revising the ISP a progress note must be completed. The majority of services provided are medical vs. non-medical case management services.

The Supportive/Self-Management Assessment should be completed for every Level 1 and 2 client. Level 2 clients should have a Supportive/Self-Management Assessment completed based on client needs or annually. Level 1 client**s** should have a Supportive/Self-Management Assessment completed upon request from the client or by client referral. If there has been a significant change in the client's stability regardless whether the client is Level 1 or 2, a new Acuity Scale must be completed to assess the clients' needs.

ISP's must ensure that the following activities are being completed for all new and established case management clients:

- All clients should have ISP goals established after initial assessment.
- Develop a comprehensive ISP within 30 days of beginning the intake.
- All clients should have documented evidence of coordination of services required to implement the ISP during service provision, referrals, and follow-up.

- Ensure that every client has ongoing monitoring to assess the efficacy of the ISP.
- All clients must have periodic re-evaluation and adaptation of the ISP at least every 3-6 months.

Table 5. Assessment	
Standard	**Measure**
Conduct client eligibility reassessment 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.
All newly enrolled or reactivated case managed clients must have a comprehensive ISP completed within 15 days for a Level 4 and 30 days for a Level 3 of beginning the initial intake assessment.	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 ○ 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 ○ Additional Service Needs Documentation (in form of progress notes, updated notes on initial assessment, or new assessment form) in client's record.

COORDINATION AND FOLLOW-UP

The Individual Service Plan (ISP) should reflect the client's needs identified in the acuity scale. The priority is always to get clients into or maintain primary medical care. It is critical that the ISP be developed in collaboration with the client, taking into account his/her priorities and perception of needs. The approach should also be strength based. This means building on the clients' strength and accomplishments rather than focusing on short comings or relapses. And finally, the ISP should be updated as needs or new goals are identified. Case managers have found this tool useful for tracking the client's progress.

Table 6. Coordination of Services

Standard	Measure
Implement client's ISP.	Documentation in client's record of progress toward resolution of each item in client's ISP.
Identify and communicate with other case managers with whom the client may be working with and cooperatively determine, in collaboration with 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.
With consent of the client, identify and communicate with other service providers with whom the client may be working. This can be weekly team meetings to coordinate continuity of care.	Documentation of communication in client's record. Agenda and meeting notes.
Coordination and follow-up of HIV primary medical care and treatments. Clients should have one visit with their HIV 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 HIV primary care provider, refer to primary care and follow-up within 30 days to determine whether the client kept the primary care appointment.	Attendance at HIV medical visits. Documentation of referrals to primary care and follow-up within 30 days.

Conduct Re-Assessments – the case manager needs to assess clients' medical, both HIV and non-HIV related, needs in accordance with the Activities by Acuity document for Levels 1-4**.** This includes a reassessment of the clients' understanding of health issues related to HIV, resources available to clients, and continuity/ regularity and access to medical and dental care as well as compliance with treatment. Service

providers will ensure that persons living with HIV/AIDS and not accessing or utilizing HIV primary medical care could still receive other supportive services if desired. Access to other HIV supportive services is not conditional upon access to or utilization of HIV primary medical care.

Table 7. Reassessment

Standard	Measure
ISP's for medical case management clients should document that all areas of assessment has been addressed.	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 ○ 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 ○ Additional Service Needs Documentation (in form of progress notes, updated notes on initial assessment, or new assessment form) in client's record.
All level 3 and 4 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: Identified Needs, Goals, Interventions/Timelines, and Outcomes. Documentation (in form of progress notes, updated notes on initial assessment, or new assessment form) in client's record.
All level 1 and 2 case management clients must have a Supportive/Self-Management Assessment revised in	The following information must be provided for each area assessed: Needs, Goals/Interventions, and Follow-up/Re-evaluation.

accordance to the Activities by Acuity Level document.	Documentation (in form of progress notes, updated notes on initial assessment, or new assessment form) in client's record.

Termination of Case Management Services/Discharge Planning is an important component of medical case management. There are legitimate reasons for terminating medical case management services with a client, but keep in mind that termination should never be assumed. A good faith effort must be attempted and clearly documented in the clients chart prior to discharge from case management. For example, clients may be very difficult to locate because they are recently incarcerated, extended hospitalization, homeless or in transition.

Table 8. Transition and Discharge

Standard	Measure
Discharge a client from case management services if any of the following conditions apply: ○ Client is deceased ○ Client requests discharge ○ Client's needs change and they would be better served through primary case management at another provider agency ○ If a client's actions put the agency, case manager, or other client's 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 twelve (12) months. ○ If the client no longer meets Ryan White eligibility requirements.	Documentation exists in client's record of reason for discharge.

Documentation

Documentation is a key means of communication among interdisciplinary team members. It contributes to a better understanding of a client and his**/**her 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 in client care.

Documentation is an important process that facilitates: continuity of care, accountability, and service improvement. It also explains what services were provided and what actions were taken. Good 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 concise, accurate, up-to-date, meaningful, an internally 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 reviews, and any additional information (e.g. case conferences, email exchanges, consultation with others, and any additional exchanges regarding 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 were 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 received and whether the goals specified in the care plan have been achieved should be documented
- Whether the client has declined services at any time while being an active client in case management
- Timelines for providing services and reassessments
- Clearly document the need and coordination with case managers of other programs
- Entries should be documented in chronological order. Do not skip lines or leave spaces.
- Avoid generalizations with documentation. Be specific, use time frames, and quotations if indicated.

- Avoid labeling or judging a client, family, or visitor in your documentation.
- Use the 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**.**
- Record the client's name and identifiers (e.g., date of birth or clinic ID number) on every page.
- Record date on all entries.
- Document the duration (i.e., 15min, 30min, 1hr 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.
- If an error is made, then make one strike through**, initial and date the error, do not use white our 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.)

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
Each agency must have a documentation policy.	Written policy on file at provider agency.
Case managers must participate in documentation training.	Training records in personnel file.
Case manager must ensure that appropriate signatures are on all applicable documents.	Documents maintained in the clients chart.
Case Managers must document all interactions or collaborations which occurred on clients' behalf.	Documents maintained in the clients chart.

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, progress notes, and other pertinent documents.

Appendix 1

CLIENT INTAKE

☐ New Client ☐ Updated ☐ Reactivated Client

Date: _____ SOC. SEC. # _____ Client # _____

PERSONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL/ MAIDEN NAME
STREET ADDRESS	CITY/STATE	ZIP
ALTERNATE ADDRESS	CITY/STATE	ZIP

O.K. to Mail to Mailing address ☐ YES ☐ NO Anonymous return address requested ☐ YES ☐ NO

COUNTY _____ AGE/DOB _____/_____ GENDER _____

(_____)_____ 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 ☐ OTHER
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN OR ALASKAN NATIVE

PRIMARY LANGUAGE _____ NEED INTERPRETER ☐ YES ☐ NO

KEY CONTACTS

EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER (_____)_____

AWARE OF STATUS? ☐ YES ☐ NO

HIV/AIDS PROVIDER _____ (___) _____

PRIMARY CARE PROVIDER (ADDRESS & PHONE #) _____ (___) _____

DENTAL _____ (___) _____

MENTAL HEALTH _____ (___) _____

OTHER AGENCIES WORKING WITH CLIENT _____ (___) _____

Place Client Label Here

Case Managers Initials:_____

Date:_____

HEALTH INSURANCE (Check all that apply)

☐ Medicaid/OHP # _____
☐ Date of Medicaid Eligibility _____
☐ Medicare A & B #_____
☐ Veterans Benefits#_____
☐ ADAP_____
☐ Private Ins. _____
☐ ID # _____
☐ Medicare D Provider _____
☐ Dental Insurance _____
☐ Not Insured _____

EMPLOYMENT ☐ YES ☐ NO

Aware of HIV/AIDS status? ☐ YES ☐ NO

_____
EMPLOYER

_____ _____
ADDRESS CITY/STATE/ZIP CODE

EDUCATION

Highest grade you completed in school? _____

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

HIV STATUS

☐ HIV-positive not AIDS ☐ HIV-positive, AIDS status unknown ☐ CDC-defined AIDS
Date tested positive _____ Date of AIDS diagnosis _____

Transmission Category (Check One)

☐ MSM ☐ MSM/IDU ☐ Heterosexual ☐ Unknown ☐ Occupational Exposure
☐ IDU ☐ Maternal/Child ☐ Undisclosed ☐ Blood Products ☐ Other

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

MEDICATION	PURPOSE	DOSE	FREQUENCY	BEGAN/REFILLED

Do you need help obtaining medications? ☐ YES ☐ NO

_____
_____
_____
_____
_____

Place Client Label Here

Case Managers Initials:_____

ADHERENCE **New to care** ☐ YES ☐ NO

On the average, how many appointments have you missed within the past 6 months?

☐ None ☐ 1-3 ☐ 3-5 ☐ 5-7 ☐ 7 or more

What keeps you from attending your appointments and how can we help you to keep your appointments? _____

Are you presently taking or have you ever taken medications for HIV (antiretrovirals)? ☐ YES ☐ NO

What do you do when you have side effects? _____

On average how many days per week would you say that you missed at least one dose of your HIV medications? ☐ Every day ☐ 4-6 days/week ☐ 2-3 days/week ☐ Once a week ☐ Less than once a week ☐ Never

What keeps you from taking your medications? _____

What is the hardest thing about taking your medications? _____

Would you like more information about medications for HIV? ☐ YES ☐ NO _____

LIVING SITUATION

☐ Apartment ☐ Own House ☐ Rental House ☐ HUD/Section 8 ☐ Adult Foster Care
☐ With Friends ☐ With Family ☐ Transitional Housing ☐ Hospice
☐ Emergency/Shelter ☐ Homeless ☐ Skilled Nursing Facility
☐ Personal Care Home ☐ 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

Do you have any issues related to child custody? ☐ YES ☐ NO

If yes please explain: _____

_____

Place Client Label Here

Case Managers Initials:_____

Date:_____

TRANSPORTATION
Is transportation available to you? ☐ YES ☐ NO
Own car? ☐ YES ☐ NO Public Transportation ☐ YES ☐ NO _____
What problems have you encountered with transportation? _____

Does the client need help obtaining any of the following? ☐ YES ☐ NO
☐ Clothing ☐ Food ☐ Food Stamps ☐ Housing ☐ Income
Access to Food Programs? ☐ YES ☐ NO
If yes, which ones? _____
Other Household/Personal Items (Toiletries, cleaning supplies, etc.)_____
_____

LEGAL ISSUES ☐ YES ☐ NO
Do you have the following (Check all that apply)
☐ Trust ☐ Will ☐ Advance Directives of Health Care
☐ Financial Power of Attorney
Guardian/Conservator for: ☐ Self and/or ☐ Dependents
If you have a Power of Attorney, who is Power of Attorney?
Do they know your HIV status? ☐ YES ☐ NO

_____ (_____)_____
Name Phone Number

_____ _____
Address City/State/Zip

Have you ever been arrested? ☐ YES ☐ NO _____

Have you ever been convicted of a felony? ☐ YES ☐ NO _____
_____
_____

Do you have/ever had any restraining orders against you? ☐ YES ☐ NO
Have you ever been incarcerated? ☐ YES ☐NO
Are you currently on probation/parole? ☐ YES ☐ NO
If yes, name of probation or parole officer/phone: _____
_____
_____
_____
_____
_____
_____
_____

Place Client Label Here

Case Managers Initials:_____

Date:_____

PREVENTION SCREENING TOOL

1) Are you in a relationship now? ☐ YES ☐ NO
Are you sexually active at this time? ☐ 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? _____

Place Client Label Here

Case Managers Initials:_____

Date:_____

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? _____

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: (Check List)
- ☐ Bank statements showing deposits
- ☐ Copy of Social Security Check
- ☐ Year end 1099 form
- ☐ W-2 tax form from employer
- ☐ Income/Expense form

Federal Poverty Level: _____% of poverty
- ☐ Social Security award letter
- ☐ Pay Stubs
- ☐ Accounting Paperwork
- ☐ Federal income tax return

CM Signature: _____

Case Managers Initials: _____

Date: _____

Place Client Label Here

Appendix 2

Income Expense Spreadsheet

INCOME/EXPENSES – Is your income is adequate to meet you needs? 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)	
VA 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	
		Child Support	
		Alimony	
		Medical Insurance	
		Medical Expense/Co-Pay	
		Medical Equipment	
		Prescription Meds/ Co-Pays	
		Over The Counter Meds	
		Life insurance	
		Personal Hygiene	
		Toiletries	
		Household Supplies	
		Laundry Supplies	
		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

Clients Name _____ **Acuity Level**_____ **Date** _____

Client ID# _____

CM Name _____ _____

Place Client Label Here

New Intake_____
Reactivation____
Update_____

Appendix 3

Acuity Scale Instructions

Goals

The acuity 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 functioning.

Instruction

The Acuity Scale has variable point scoring built in providing more points for "Life Areas." The Life Areas assess activities potentially disabling to a client and therefore have greater priority when developing a personalized care plan and assigning program support activities. Not all Life Areas have the same point values assigned to them.

1. Clients should be interviewed in accordance with the Case Management Standards.

2. Review all pertinent client documents, secondary assessments done by other professionals (where appropriate) and any relevant information available about the client's needs.

3. The following steps describes how to complete the Acuity Scale:

    a. The Life Area column should have a completed date
    b. Check each box (per column) that applies to the client regardless of the Acuity Level at the top of each column. This step must be repeated for each Life Area.
    c. After all the applicable boxes has been checked. The acuity level for that column should be determined based on the **highest level** with checked box(s) for that row. This step must be repeated for each Life Area.
    d. Upon determining scores for each Life Area, all the scores should be added to get an overall Total Score. This score should be written in the space provided on page 5 of the acuity scale document.
    e. Once the Total Score has been documented the level of acuity can be determined based of the corresponding scale found on page 5 of the acuity scale document.
    f. Write the Acuity Level and Date in the space provided.
    g. The final step to completing this document is to complete the bottom of page 5 by adding the Clients Name and Client ID# as well as the Case Managers Name, Initials, and Date.

4. **Using professional judgment the Assigned Acuity Level can be increased**. If there are indicators which are so compelling that they are potentially disabling to a client, a higher level may be assigned so that a higher levels of programmatic support may be provided to stabilize the client.

5. Appropriate case management activities are then assigned according with the Activities by Acuity Levels document.

6. All clients should have an ISP completed upon initial intake regardless of Acuity Level

7. Upon completion of the initial Acuity Scale and ISP, re-assessment is directed by the Activities by Acuity Level document.

8. The Supportive/Self-Management Assessment form **should not** be used as the initial ISP.

Acuity Levels

Levels 1 and 2 clients are at lower acuity level which require less intensive case management 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. 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 and point values.

Level 1	Self-Management	14-20 points
Level 2	Supportive	21-28 points
Level 3	Intermediate	29-42 points
Level 4	Intensive	43-56 points

Appendix 4

Activities by Acuity Levels

Level 4 (Intensive) 43-56 points	Level 3 (Intermediate) 29-42 points
Intake	Intake
• Case Management Intake and assessment should be completed within 15 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 progress notes. • Newly diagnosed clients should automatically be assigned a Level 3 or 4.	• 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 progress notes. • Newly diagnosed clients should automatically be assigned a Level 3 or 4.
Established Client	Established Client
• Revise the Acuity Scale and ISP at least every 3 months from the last date both documents were completed. • Additional goals, activities, and outcomes should be documented in the progress notes. • A progress note should be completed for every encounter with the client or consult regarding the client. • Assist with referrals and follow-up as appropriate. • Consult with multi-disciplinary team, case management supervisor and others as needed. • The majority of case management services provided are medical vs. non-medical. • Minimum contact (phone, face-to-face, or consult) every 30 days.	• Revise the Acuity Scale and ISP at least every 6 months from the last date both documents were completed. • Additional goals, activities, and outcomes should be documented in the progress notes. • A progress note should be completed for every encounter with the client or consult regarding the client. • Assist with referrals and follow-up as appropriate. • Consult with multi-disciplinary team, case management supervisor and others as needed. • The majority of case management services provided are medical vs. non-medical. • Minimum contact (phone, face-to-face, or consult) every 2-3 months.

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Activities by Acuity Level cont.

Level 2 (Supportive) 21-28 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 progress notes.
- Newly diagnosed clients should automatically be assigned a Level 3 or 4.

Established Client

- The one page Supportive/Self-Management Assessment form should be completed based on client need or annually (from the last date completed).
- If a Supportive/Self-Management form reflects a significant change in the client's stability, a new Acuity Scale must be completed. Upon completing and determining the new Acuity Level, refer to the Activities by Acuity Level document to determine what activities must occur for that Acuity Level.
- A progress 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.
- Minimum contact (phone or face-to-face) annually or as needed.

Level 1 (Self-Management) 14-20 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 progress notes.
- Newly diagnosed clients should automatically be assigned a Level 3 or 4.

Established Client

- The one page Supportive/Self-Management Assessment form should be completed based upon request from client or referral.
- If a Supportive/Self-Management form reflects a significant change in the client's stability, a new Acuity Scale must be completed. Upon completing and determining the new Acuity Level, refer to the Activities by Acuity Level document to determine what activities must occur for that Acuity Level.
- A progress 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.
- Contact (phone or face-to-face) as needed.

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Appendix 5

Case Management Acuity Scale

☐ New Client ☐ Updated ☐ Reactivated Client

Life Areas	Level 1	Level 2	Level 3	Level 4
Medical/ Physical Health Date _____ Score _____ Date _____ 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.
Treatment Adherence Date _____ Score _____ Date _____ 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.	☐ 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 schedule medical appointments. ☐ Takes long/extended "drug holidays" against medical advice. ☐ Takes non-HIV systemic therapies without MD knowledge.	☐ 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.
Health Insurance Date _____ Score _____ Date _____ 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.

Client Name _____ **Client ID #** _____ **Date** _____ **CM Initials** _____ **1 of 5**

Georgia (Revised Version) 2/15/16 **Date** _____ **CM Initials** _____

Life Areas	Level 1	Level 2	Level 3	Level 4
Domestic/Trauma Date _____ Score _____ Date _____ 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 Date _____ Score _____ Date _____ 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.
Income Date _____ Score _____ Date _____ 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.

Life Areas	Level 1	Level 2	Level 3	Level 4
Nutrition/Food Date _____ Score _____ Date _____ 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.
Mental Health Date _____ Score _____ Date _____ 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 Date _____ Score _____ Date _____ 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

Life Areas	Level 1	Level 2	Level 3	Level 4
Personal and Community Support Date _____ Score _____ Date _____ 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.
Risk Reduction Date _____ Score _____ Date _____ 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 Date _____ Score _____ Date _____ 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 Date _____ Score _____ Date _____ 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.

Client Name _____ **Client ID #** _____ **Date** _____ **CM Initials** _____ **4 of 5**

Date _____ **CM Initials** _____

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Life Areas	Level 1	Level 2	Level 3	Level 4
Cultural Beliefs Date _____ Score _____ Date _____ 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.

Total Score _____ Assigned Acuity Level _____ Date _____

Total Score _____ Assigned Acuity Level _____ Date _____

Level 1	Self-Management	14-20 points
Level 2	Supportive	21-28 points
Level 3	Intermediate	29-42 points
Level 4	Intensive	42-56 points

Client Name _____ Client ID # _____

Case Managers Name _____ CM Initials _____ Date _____

Case Managers Name _____ CM Initials _____ Date _____

Appendix 6

Case Management Individualized Service Plan

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

Area of Assessment	Identified Needs List individual needs an/or current situation.	Goal(s) Outcomes/Desired. List individual 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 _____				

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

Area of Assessment	Identified Needs List individual need an/or current situation.	Goal(s) Outcomes/Desired. List individual 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 _____				

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

Area of Assessment	Identified Needs List individual need an/or current situation.	Goal(s) Outcomes/Desired. List individual 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 and Community Support Client Initial _____				
Risk Reduction Client Initial _____				
Disclosure Client Initial _____				

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

Area of Assessment	Identified Needs List individual need an/or current situation.	Goal(s) Outcomes/Desired. List individual 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 _____				

Client ID # _____ Acuity Level _____

Client Name _____ Client Initials_____ Date _____

Case Managers Name _____ CM Initials _____ Date _____

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Appendix 7

Supportive/Self-Management Assessment

Life Areas	Stable		Need(s)
	Yes	No	
Medical History / Physical Health			
Medical Treatment and Adherence			
Health Insurance			
Domestic/Trauma			
Housing			
Income			
Nutrition/Food			
Mental Health			
Substance Abuse / Addiction			
Personal and Community Support			
Risk Reduction			
Disclosure			
Legal			
Transportation			
Cultural Beliefs			

Goal/Intervention

Follow-up/Re-evaluation

Date:	Client ID#:	Acuity Level
Client Name:	CM Name:	
Client Signature:	CM Signature:	

Note: If there is a significant change in a client's stability, a new Acuity Scale must be completed.

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Appendix 8

Georgia Case Management Definitions

Medical Case Management

Medical Adherence Assessment
- -- new to treatment or experienced
- -- change in regimen
- -- 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 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 in treatment setting

TB Directly Observed Therapy (DOT)
- -- direct observation as client ingests correct dose of anti-TB meds
- -- by public health RN or trained health care professional

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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
- -- 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,* April 2010

Appendix 9

Case Management Performance Measures			
Criteria	**Indicators**	**Data Elements**	**Data Sources & Methods**
All newly enrolled or reactivated case management clients will have an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment.	Percent of newly enrolled or reactivated case managed client charts with an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment based on level of acuity in accordance with the Activities by Acuity Document.	N: # of newly enrolled or reactivated case managed client charts with an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment during the measurement year D: # of newly enrolled or reactivated case managed client during the measurement year.	Client Chart Review
All case managed client charts containing a completed Acuity Scale in accordance with the Activities by Acuity Document.	Percent of case managed client charts containing a completed Acuity Scale in accordance with the Activities by Acuity Document.	N: # of case managed client charts containing a completed Acuity Scale in accordance with the Activities by Acuity Document during the measurement year. D: # of case managed client containing a completed Acuity Scale during the measurement year.	Client Chart Review
Ensure that the Acuity Scale, ISP, and/or Supportive/Self-Management Assessment documents are updated in accordance with the Activities by Acuity Level Document.	Percent of chart that have updated Acuity Scale, ISP, and Supportive/Self-Management Assessment documents in accordance with the Activities by Acuity Level Document during the measurement period.	N: # of charts that had an updated Acuity Scale, ISP, and Supportive/Self-Management Assessment documents in accordance with the Activities by Acuity Level Document during the measurement year. D: # of case management charts that had an updated Acuity Scale, ISP, and Supportive/Self-Management Assessment during the measurement year.	Client Chart Review

Criteria	Indicators	Data Elements	Data Sources & Methods
Medical Case managed clients (acuity level 3-4) should have documented evidence of coordination of services required to implement the ISP during service provision.	Percent of chart documentation (acuity level 3-4) that reflect evidence of coordination of services required to implement the ISP during service provision, referrals and follow-up.	N: # of client charts (acuity level 3-4) with documented evidence reflecting coordination of services required to implement the ISP during service provision, referrals and follow-up during the measurement year. D: # of case managed clients in a measurement year.	Client chart review
Ensure that clients receiving medical case management (acuity level 3-4) services have continuous monitoring to assess the efficacy of the ISP.	Percent of client charts (acuity level 3-4) with documented evidence of ongoing monitoring to assess the efficacy of the ISP.	N: # of client charts (acuity level 3-4) with documented evidence of ongoing monitoring to assess the efficacy of the ISP during the measurement year. D: # of medically case managed clients in a measurement year.	Client chart review
Clients receiving medical case management (acuity level 3-4) services should have periodic re-evaluation and adaptation of the ISP at least every 3-6 months in accordance with the Activities by Acuity Document.	Percent of client charts (acuity level 3-4) with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 3-6 months.	N: # of client charts (acuity level 3-4) with documented evidence of periodic re-evaluation and adaptation of the ISP at least every **3-**6 months at least 3 months apart during the measurement year. D: # of case managed clients in a measurement year.	Client chart review
Ensure that clients receiving medical case management services have (acuity level 3-4) documentation which includes coordination and follow up of medical treatment.	Percent of client chart (acuity level 3-4) documentation which includes coordination and follow-up of medical treatment.	N: # of MCM client charts (acuity level 3-4) with documentation including coordination and follow-up of medical treatment. D: # of MCM clients in a measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All Case managed client chart documentation must reflect assistance with linkages to programs (health care, psychosocial and other services, as well as assist to access other public and private programs) for which clients are eligible.	Percent of client chart documentation must reflect assistance with linkage to other programs for which clients are eligible.	N: # of client charts with documentation reflecting assistance with linkage to other programs for which clients are eligible during the measurement year. D: # of case managed clients in a measurement year.	Client chart review
All case managed clients (all levels of acuity) must have documented evidence of ongoing assessment of client and other key family members' needs and personal support system as needed.	Percent of clients charts (all levels of acuity) who had documented evidence of ongoing assessment of client and other key family members' needs and personal support system, as needed.	N: # of clients charts (all levels of acuity) with documented evidence of ongoing assessment of client and other key family members' needs and personal support system, as needed. D: # of case managed clients in the measurement year.	Client chart review
Clients receiving medical case management services (acuity level 3-4) will have treatment adherence assessed at least every 4 months.	Percent of medical case management clients (acuity level 3-4) who's charts had a documented treatment adherence visit 2 or more times at least 4 months apart.	N: # of MCM clients (acuity level 3-4) who had a documented treatment adherence visit 2 or more times at least 4 months apart in a measurement year. D: # of MCM clients in the measurement year.	Client chart review
All medical case management clients (acuity level 3-4) who did not have a medical visit in the last 6 months as documented by case manager. (Gap in HIV medical visit)	Percent of medically case managed client (acuity level 3-4) charts who did not have a medical visit in the last 6 months.	N: # of medically case managed client (acuity level 3-4) charts who did not have a medical visit in the last 6 months during the measurement year. D: # of case managed clients in a measurement year	Client chart reviews

Criteria	Indicators	Data Elements	Data Sources & Methods
All medically case managed client charts (acuity level 3-4) who had at least one medical visit in the 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit as documented by the case manager. (MCM Medical: Visit Frequency)	Percent of medically case managed client charts (acuity level 3-4) that had at least one medical visit in the 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit.	N: # of medically case managed client charts (acuity level 3-4) that had at least one medical visit in the 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit. during the measurement year. D: # of medically case managed clients in a measurement year.	Client chart reviews
Documentation should reflect that client specific advocacy has occurred during service provision (all levels of acuity)	Percent of client charts who had documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision.	N: # of client charts who had documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision in a measurement year. D: # of medical case management clients in the measurement year.	Client chart reviews
Ensure that benefits/entitlement counseling and referral services were provided to access other public and private programs, as needed to eligible clients for all levels of acuity.	Percent of clients charts who had documented that benefits/entitlement counseling and referral services were provided.	N: # of client charts who had documented evidence that benefits/entitlement counseling and referral services were provided in the measurement year. D: # of medical case management clients in the measurement year.	Client chart reviews

Criteria	Indicators	Data Elements	Data Sources & Methods
Case management client documentation (all levels of acuity) must ensure that housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received for which clients are eligible.	Percent of case managed client charts who had documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received.	N: # of case managed client charts who had documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received in the measurement year. D: # of case managed clients in the measurement year.	Client chart reviews
Case managed client documentation (all levels of acuity) must reflect that clients received assistance in obtaining stable long-term housing as needed.	Percent of case managed client charts who had documentation reflecting that clients received assistance in obtaining stable long-term housing.	N: # of case management clients chart who had documentation reflecting that clients received assistance in obtaining stable long-term housing in the measurement year. D: # of case managed clients in the measurement year	Client chart reviews
All Case management chart documentation of services and encounters must include: ○ Client Identifier on all pages ○ Date of each encounter ○ Types of services provided ○ Types of encounters/ (face-to-face, telephone contact, etc.) communication ○ Duration and frequency of encounters ○ Key activities	Percent of client charts who had documented services and encounters.	N: # client charts who had documented services and encounters. D: # of case management clients in the measurement year	Client chart reviews

Criteria	Indicators	Data Elements	Data Sources & Methods
All entries in the client record by the case manager should contain the case manager's professional title and signature.	Case management documentation should contain the case manager's professional title and signature.	N: # of client charts with documentation reflecting the case manager's professional title and signature. D: # of clients charts in the measurement year.	Client chart reviews
Obtain assurances and documentation showing that case management staff is operating as part of the clinical care team.	Percent of case managed client charts that had documentation showing that case management staff is operating as part of the clinical care team.	N: # of case managed client charts that had documentation showing that case management staff is operating as part of the clinical care team in the measurement year. D: # of case managed clients in the measurement year.	Client chart reviews
Provide written assurances and maintain documentation showing that case management services are provided by trained professionals who are either medically credentialed or trained health care staff who are part of the clinical care team.	Review credentials and/or evidence of training of health care staff providing case management services.	N: # of staff with credentials and/or evidence of training of health care staff providing case management services in the measurement year. D: # of staff providing case management services in your Ryan White Part B program within your district in the measurement year.	Client chart reviews