CASE MANAGEMENT STANDARDS OF CARE

FOR

RYAN WHITE ACT-FUNDED SERVICES IN ORANGE COUNTY

Effective March 10, 2008
INTRODUCTION
The goal of case management is to enhance independence and increase quality of life for individuals living with HIV and AIDS through adherence to medical care. Case management addresses the needs of clients with HIV disease and assists them in overcoming the obstacles they face in obtaining critical services. Case management should be flexible to accommodate the medical and psychosocial needs of clients with different backgrounds and in various stages of health and illness. The services delivered should reflect a philosophy of service delivery that affirms a client’s right to privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Case management is a client-centered process. This means respecting the client’s perception of his/her needs and developing service plans in collaboration with him/her. This also means empowering the client to take control of his/her care. A client-centered approach is conducive to relationship and trust building between the client and his/her case manager.

Case managers should also see themselves as educators and seize opportunities to educate clients about HIV prevention and care. When needed, case managers should educate their clients on life skills.

GOALS OF THE STANDARDS
These standards of care are provided to ensure that Orange County’s Ryan White-funded case management services:
- Are accessible to all persons infected with HIV who meet eligibility requirements
- Promote continuity of care, client monitoring, and follow-up
- Enhance coordination among service providers to eliminate duplication of services
• Foster interagency collaboration
• Provide opportunities and structure to promote client and provider education
• Maintain the highest standards of care for clients
• Protect the rights of persons living with HIV/AIDS
• Provide support services to enable clients to stay in medical care
• Increase client self sufficiency and quality of life

DEFINITION OF CASE MANAGEMENT
There are two categories of case management: 1) medical case management and 2) non-medical case management. Definitions for each service are stated below:

Medical Case Management: Includes a range of client-centered services that link clients with health care, psychosocial, and other services. Medical case management should be provided to clients assessed with moderate and high acuity levels (see discussion of assessment on pages 5-7). The coordination and follow-up of medical treatments is a primary component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services. Case management should also ensure continuity of care through ongoing assessment of the client’s 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.

Non-Medical Case Management: Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management should be provided to clients assessed with low acuity (see discussion of assessment on pages 5-7). Non-medical case management does not involve intensive coordination and follow-up of medical treatments, as medical case management does.

Primary activities for both medical and non-medical case management include:
• Appropriate staffing
• Client intake
• Comprehensive assessment of client needs
• Education
• Development of individual service plans
• Referral/advocacy and coordination of services
• Follow-up, monitoring, and re-evaluating client progress
• Coordination and follow-up of medical treatments (mandated activity for medical case management but is also a recommended component of non-medical case management)
• Discharge planning

Client Advocacy: In addition to case management, case managers may also provide client advocacy services to clients whose assessed acuity does not indicate a need for medical or non-medical case management services (see page discussion of assessment beginning on page 5).
Client advocacy services do not require regular follow-up and coordination of client services as described in this document. Primary activities for client advocacy shall include:

- Client intake
- Comprehensive assessment of client needs
- Education, as necessary
- Referral to services

### STAFFING REQUIREMENTS AND QUALIFICATIONS

Quality case management starts with well-prepared and qualified staff. To ensure this:

- **HIV/AIDS Knowledge.** Staff shall have medically accurate and up-to-date knowledge of HIV/AIDS including prevention and care.

- **Licensure.** Staff shall have the necessary State of California licenses for the functions they perform.
  - Staff performing intensive level case management shall have a Master’s or nursing degree.
  - Staff performing moderate or basic level case management shall have a minimum of Bachelor’s degree in a social service field or comparable case management experience.

- **Training.** Staff shall have access to, and avail themselves of training, including:
  - County-coordinated training programs for case managers to keep them abreast of the latest information regarding HIV prevention, treatment, and resources.
  - Trainings to increase cultural competency. Such trainings should be provided to enhance the case manager’s understanding of various culturally important issues such as different communication styles, different help-seeking behaviors, implications of legal status, different concepts of illness, cultural barriers in disclosure, somatization of mental conditions, different cultural views of medicine (western vs. folk), etc.
  - Trainings on prevention issues and strategies specific to HIV-positive individuals (“prevention with positives”).

- **Caseloads.** Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently. Caseloads should be established based upon intensity of needs of clients and program managers should conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties. The following general standards for active caseloads per a full-time case manager have been set based upon general categorization of client acuity:
  - Low: 81 to 110 clients
  - Moderate: 51 to 80 clients
  - High: 30 to 50 clients

Actual caseload figures vary as a result of multiple factors that may include, but are not limited to, the following:

- Extra time a case manager spends with a client due to language barriers or the need for use of an interpreter.
- The mix of clients with low, moderate, and high acuity scores that a case manager may have in their caseload.
The above caseloads refer to community-based case management. Clinic-based caseloads (including the Health Care Agency’s 17th Street Care Clinic) serve a different programmatic function and typically carry higher caseloads and have different standards of care.

- **Supervision.** Programs shall provide appropriate supervision to case management staff, which includes, but is not limited to, the following:
  - Staff and clients shall have access to supervisory levels of case management.
  - Supervision that is observant and attentive to possible bias in treatment of clients because of their sexual preference, ethnicity, gender, substance use, etc.
  - Individual supervision and clinical guidance that is available to case managers as needed.
  - Multiple methods shall be used to evaluate case manager performance including: direct observation; chart reviews; and client feedback (e.g., through surveys, focus groups, complaint and grievance processes, etc.).

- **Case Conferencing.** Formal or informal case conferencing shall occur when important client-specific issues arise that require a team or interdisciplinary approach or solution.

- **Case Manager Transition.** Changes in client-case manager assignment should be minimized to maintain continuity of care. Literature suggests that a client should be able to see the same case manager over time, as this is a desirable arrangement that helps develop trust. However, the program should also be willing to change client-case manager assignments if a client expresses his/her wish to do so based on negative experience or lack of trust.

**CLIENT INTAKE**

Intake is a time to gather registration information and provide basic information about case management and other HIV services. It is also a pivotal moment for establishment of trust and confidence in the care system. Case managers should be careful to provide an appropriate level of information that is helpful and responsive to client need, but not overwhelming. The case manager shall conduct the client intake with respect and compassion. The following describe components of intake:

- **Intake shall take place as soon as possible, at minimum within five days of referral or initial client contact.** If there is an indication that the client may be facing imminent loss of medication or is facing other forms of medical crisis, the intake process should be expedited and appropriate intervention may take place prior to formal intake.

- **The case manager shall obtain the necessary information to establish the client’s eligibility.** This includes verifying documentation of the client’s HIV status, medical or dental coverage (for medical and oral health services, respectively), income (for services with income requirements for eligibility), and primary residency. (See the Eligibility Requirements and Checklist Spreadsheet under separate cover)

- **The case manager shall obtain the appropriate and necessary demographic information to complete registration;** this includes basic information about the client’s HIV medical history, living situation, employment and financial status, service linkages, and key contact information.
• The case manager shall clearly explain what case management entails. The case manager shall provide adequate information about the availability of various services or resources within the agency and in the community.

• The case manager shall provide mandated information to the client described below:
  - Written information about resources, care, and treatment (this should include the county-wide HIV Client Handbook) available in Orange County.
  - A copy of the client’s Rights and Responsibilities (included in the HIV Client Handbook).
  - Information about filing a grievance if he/she feels his/her rights has been violated.
  - Clients shall also be given the Notice of Privacy Practices (NPP) form. Clients shall be informed of their right to confidentiality. It is important not to assume that the client’s family or partner knows the HIV-positive status of the client. Part of the discussion about client confidentiality should include inquiry about how the client wants to be contacted (at home, at work, by mail, by phone, etc).

• The case manager should also obtain the following required documents:
  - An Informed Consent form, signed by the client, agreeing to participate in the case management program.
  - A signed document indicating receipt of Rights and Responsibilities.
  - If there is a need to disclose information about a client to a third party, including family members, clients shall be asked to sign a Release of Information form, authorizing such disclosure. This form may be signed at intake prior to the actual need for disclosure. Releases of information may be cancelled or modified by the client at any time.
  - For clients who require oral health care, an authorization to use and disclose protected health information to the Orange County Health Care Agency (HCA) Dental Clinic is required along with an oral health referral. The referral and release of information must be completed and sent to the HCA dental clinic for annual dental service need.
  - For clients who require Psychiatric services, an authorization to use and disclose protected health information to the Orange County HCA HIV Clinic is required along with a Psychiatric service referral. The referral and release of information must be completed and sent to the HCA HIV clinic for each mental health service need.

• The case manager shall conduct the intake session with cultural sensitivity and, when possible, in the native language of the client. When language is a barrier, providers shall utilize appropriate interpretation resources. Providers shall not rely on children to interpret for family members.

COMPREHENSIVE ASSESSMENT
Proper assessment of client need is fundamental to case management. Assessments should be provided by staff with the appropriate level of education and experience. The case manager shall conduct an in-depth assessment of the client’s current and potential needs. This process shall, at minimum, assess the following:
### Medical (HIV and non-HIV) Need
- Understanding of health issues related to HIV
- Resources for medical/dental care
- Continuity and regularity of medical/dental care
- Quality of and adequacy of medical/dental care
- Access to, and compliance with, HIV treatment
- Need for assistance with activities of daily living and available support
- Use of herbs, folk medicine, and alternative therapies

### Understanding of, and Response to, HIV Transmission Factors
- Knowledge, attitudes, and behaviors associated with risk reduction techniques
- Need for partner education and notification services
- Need for extended HIV testing and counseling

### Substance Use
- History and extent of current substance use
- Resources for substance use issues, if applicable

### Mental Health Issues
- History of and current mental health issues
- Resources for mental health issues, if applicable

### Financial Needs
- Income
- Employment issues
- Public benefits eligibility
- Health insurance
- AIDS Drug Assistance Program (ADAP)

### Nutritional Needs
- Dietary restrictions
- Access to food
- Need for supplements

### Housing and Living Situation
- Current housing situation
- Ability to maintain stable housing

### Social and Emotional Support
- The extent and availability of family and other support networks
- Disclosure issues
- Current or past history of domestic violence

### Legal Issues
- Ability to access eligible benefits
- Criminal offenses, parole, or probation status
- Citizenship
- Guardianship

### Transportation
- Ability to access services through public or private modes of transportation
The following describes components of assessment:

- The assessment process should start within one week of client intake and completed within two weeks. In addition, a comprehensive assessment must be completed annually.
- Assessments should be sensitive to the needs and interests of clients and should balance comprehensiveness with the “need to know.”
- The case manager shall assess barriers preventing the above needs from being met. Legal residency status, language problems, criminal offenses, and family violence might be examples of such barriers.
- The case manager shall assess the client’s capacity to meet the above needs. The extent to which the client can draw upon his/her personal, family, and community resources shall be assessed.
- The case manager shall assess the capacity of available agency or community resources to address the client’s needs. The availability of various modes of substance abuse treatment programs or mental health services may be an example. Insufficient bilingual and multi-cultural capabilities of providing agencies may limit their ability to serve the clients in certain areas. Incarceration may also present limitations to the availability of certain services.
- Assessment should be viewed as a continuing, evolving process, rather than an activity that can be initiated and completed at a single session. This dynamic view of assessment means that important information shared by the client during each contact would be noted in the client’s file (in progress notes or other documentation as appropriate), as it can help in assessing progress or identifying the emergence of new issues or problems. Reassessments (which may be more focused and less comprehensive) shall be conducted whenever health and situational changes make it helpful and necessary to do so. Notwithstanding situational changes, reassessments should be conducted at intervals determined by the level of client’s acuity and type of case management. The following minimum standards have been set based upon general categorization of client acuity:
  - Low: reassessment every six months
  - Moderate: reassessment every three months
  - High: reassessment every two months
- Reassessments should include a review of all pertinent issues. This may be accomplished by reviewing recent comprehensive assessments with the client and focusing only on areas of need. They can also, if appropriate, invite clients to use a form or checklist to self-assess their needs. It is expected that assessments be face-to-face.
- Case managers shall use the Acuity Scale (see Appendix A for the Acuity Scale) to document general findings of the assessment and periodic reassessments of client need. The Acuity Scale is not an assessment tool in and of itself.

EDUCATION
Case managers often perform the role of educators particularly as it relates to prevention and health care. This is especially true when the case manager, depending on case management model and client preference, is the only person providing coordination of care and psychosocial support to the client. To adequately fulfill this role:
• Case managers must be knowledgeable about basic HIV standards of medical care and treatment.
• Case managers shall assure that clients have access to, and are encouraged to be compliant with, basic medical care. Case managers shall document cases where a client is not compliant, known reasons for noncompliance, and strategies implemented to promote compliance.
• Case managers should incorporate general and client-specific prevention education in case management sessions. They should periodically inquire about the client’s risk behavior such as substance use or unprotected sex.

INDIVIDUAL SERVICE PLAN
• Once client needs have been assessed, case managers and clients shall prioritize care, support needs, and identify activities to address them. This process is documented on the Individual Service Plan (ISP). The plan provides a map for both the client and case manager on how to address needs in a manner that promotes self-sufficiency of the client. Discernment is required on the part of case managers to provide enough support to assist clients in meeting needs, while fostering client ability and responsibility for self-care. Often this requires an approach that is heavier in initial support, which includes a transition over time to increased client responsibility. Good communication regarding roles and expectations is essential from the beginning of the client-case manager relationship because it is necessary to respectfully and successfully navigate the process of establishing and modifying the ISP. The ISP must be developed in collaboration with the client, taking into account his/her priorities and perception of needs. The ISP shall describe the following:
  • The needs and goals of the client
  • Concrete actions that need to be taken to address them
  • Timeframes for such actions
  • The responsible parties for each activity

Case managers shall have a mechanism for checking on ISP progress that coincides with timing of activities on the plan. For example, if the ISP indicates that the client will apply for the AIDS Drug Assistance Program by May 1, then the case manager shall have a mechanism for follow-up on that activity. This may include, as appropriate, having the client take responsibility for initiating communication regarding follow-up. The ISP should also be considered a dynamic tool. It should be updated as needs are addressed or identified. At a minimum, the ISP shall be updated once every six months.

REFERRAL/ADVOCACY AND COORDINATION OF SERVICES
The goal of referral should be to secure the needed care and services, not just the provision of information. Orange County utilizes a network of public or private providers to deliver high quality care and services to people with HIV. Resource limitations, specialization of services, and responsiveness to client need require a collaborative and cooperative approach to service delivery in the county. A primary function of case management is to educate clients about
available resources and facilitate access to those resources. It is expected that case managers shall make appropriate and complete referrals to medical and support services offered within the agency or in the community. After the referral, the case manager shall make contacts with the client and/or the agency to which he or she was referred to make sure linkages were established. This must be done even when the client has been the one to initiate the referral. To ensure that appropriate and complete referrals are made, the following are required:

- Information about resources shall be readily and continually available to all clients.
- As appropriate, case managers shall facilitate referrals by obtaining releases of information to permit provision of information about the client’s needs and other important information to the service provider.
- Case managers are encouraged to help clients access services on their own (advocacy). Advocacy is a form of empowerment and may help the client to take control of his or her own care. However, case managers must first assess the client’s ability to do so, and shall actively facilitate referrals when the likelihood is high that a client will be unable to follow through on his or her own. Examples of these situations include: minimal English language ability; impairment in cognitive functioning, developmental delays, lack of client understanding of, or experience with, the system to be able to negotiate access to care; an unstable living situation; fragile health; drug, alcohol or substance use that interferes with the client’s ability to follow through; emotional burden from a new diagnosis; mental health issues; cultural or other reasons that cause the client to be apprehensive about approaching a service providers. In such cases, case managers must take an active role in making and following up on the referral.
- If the client shows a sense of resignation or lack of motivation, he or she is not likely to seek needed care and services. In such cases, the case manager shall take an active role in making the referral, and an assessment shall be done to determine the basis for the client’s behavior. In particular the need for a medical evaluation and/or mental health assessment may be in order.
- Whenever appropriate, case managers should assure ongoing coordination of services between providers of care for the client. Case managers shall follow up with clients and providers of services to make sure clients are staying in care, making progress toward their individual service plans, and to see if there are changes in the their living situation or if there are any problems that need to be addressed. This may be done on a one-on-one basis or through case conferencing.

**FOLLOW-UP AND MONITORING**

Case management is to be an ongoing “management” process, not simply initial or occasional assessments and referrals. Individuals who are self-sufficient and do not need periodic follow-up may not need case management services. Case management should target individuals needing support in accessing and maintaining regular care. Follow-up contact by case managers shall be appropriate to the needs of the client rather than at predetermined intervals (e.g., once every one, three, or six months). To that end:

- Case managers shall respond in a timely and appropriate manner to client requests for assistance and to client needs identified by other providers. In general, case managers are expected to respond to clients and provider within one working day.
Case Management Standards of Care  
Ryan White HIV/AIDS Treatment Modernization Act

- Even when a case manager has not become aware of any care-related problems or situational issues, he or she shall contact the client periodically in case the client has hesitated contacting the case manager about his or her needs or issues regarding services. Such contacts can serve as opportunities for reassessment of the client’s needs and living situation. Frequency of these contacts should be determined by the case manager’s assessment of the client’s situation. The following table is provided as a guide for the minimum frequency of assessments and contacts:

<table>
<thead>
<tr>
<th>Level of Case Management</th>
<th>General Caseload</th>
<th>Client Acuity Level</th>
<th>Minimum Reassessment Frequency</th>
<th>Minimum Contact Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic (Non-Medical)</td>
<td>81-110</td>
<td>Low</td>
<td>6 months</td>
<td>3 months</td>
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<tr>
<td>Moderate (Medical)</td>
<td>51-80</td>
<td>Moderate</td>
<td>3 months</td>
<td>1 month</td>
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<tr>
<td>Intensive (Medical)</td>
<td>30-50</td>
<td>High</td>
<td>2 months</td>
<td>1 month</td>
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- These follow-up contacts need not all be face-to-face; telephone contacts would be adequate. However, periodic face-to-face contact is highly desirable, as it provides the chance for development of relationship and trust between the client and the case manager.

- The Acuity Scale shall be used to support the general categorization of client acuity; however, this categorization should not be used as the primary determinant of frequency of contact; need should be the determining factor. In addition, the category of client acuity (low, moderate or high) should not be based upon total acuity score. Instead, severity of need in any area(s) of the scale will indicate the low, moderate or high need for acuity. For example, a client may have a low total acuity score, but may have a high acuity score in one area that requires frequent contacts to ensure he or she stays in medical care or adheres to the treatment plan. Temporary loss of housing or transportation, for example, may make it difficult for a patient to comply with the medication regimen or to keep medical appointments. The case manager must adequately note the determining factors that indicate the need to override a client’s acuity.

- To foster self-sufficiency, clients should be encouraged to initiate contact with the case manager when changes occur in their health condition, living situation or support systems.

COORDINATION OF MEDICAL CARE
Beyond simply educating the client about medical care, the case manager shall make the following efforts to support and coordinate the continuity of medical care:

- Case managers shall regularly assess client’s access to medical care and any barriers to care. Case managers shall make an effort to identify barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.).

- Case managers shall monitor client medication adherence. Client self-reports, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc., are used to assist with adherence. The case manager needs to be able to
determine which method may be more helpful for a particular client. As needed, the case manager shall find out who has the primary responsibility for giving medication and shall provide HIV and adherence education to family members or caregivers. Case managers shall refer clients to additional treatment adherence services as needed.

- Case managers shall communicate any adherence barriers to client medical care providers.

**DISCHARGE PLANNING**

Case management is considered a critical component in assuring access to medical care and other critical services. Discharge from case management services may affect the client’s ability to receive and stay compliant with medical care. As such, discharge from case management must be carefully considered and reasonable steps must be taken to assure clients who need assistance in accessing care are maintained in case management programs.

<table>
<thead>
<tr>
<th>A client may be discharged from case management services due to the following conditions:</th>
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<tbody>
<tr>
<td>- The client has died.</td>
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<td>- The client has become ineligible for services (e.g., due to relocation outside Orange County or other eligibility requirements).</td>
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<td>- The client no longer demonstrates need for case management due to his/her own ability to effectively advocate for his/her needs.</td>
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<td>- The client chooses to terminate services.</td>
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<td>- The client’s needs would be better served by another agency.</td>
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<td>- The client is being discharged from the correctional facility at which he/she is receiving jail case management services.</td>
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<td>- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.</td>
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<td>- The client cannot be located after documented multiple and extensive attempts for a period no less than three months.</td>
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</table>

The following describe components of discharge planning:

- Providers and the County shall periodically query data systems to identify clients who appear to be lost to follow-up.

- It is recommended, but not mandatory, that at least three attempts to contact the client are made over a period of three months. However, termination should not be assumed after a predetermined number of unsuccessful attempts at reaching the client at their documented address or phone number. Efforts shall be made to locate and contact a client who has not shown up for appointments or responded to case manager’s phone calls. These efforts shall include contacting last known medical provider and other providers for which releases have previously obtained. *Within the constraints of previously signed releases of information*, speaking to other individuals who have been included on a signed release or staff at other programs, asking program’s outreach workers for help, consulting the County’s public records, making inquiries at shelters and charities may be examples of what can be done to locate the client. Clients who cannot be located after
extensive attempts should be referred to available outreach services so that they may be linked back into the care system.

- The case manager shall contact the client or the caregiver, in person, by phone, or with a formal letter, to explain why he/she is being discharged. If the client does not agree with the reason for discharge, he/she should be informed of the provider’s grievance procedure.

- A discharge summary should be documented in the client’s record. The discharge summary shall include a reason for the discharge and a transition plan to other services or other provider agencies, if applicable.

- The case manager shall close out the client in data collection system as soon as possible within thirty (30) days of case termination.

- A client may be discharged if his/her needs would be better served by another agency and is transferred to that agency. If the client is transferring to another case management program, case closure should be preceded by a transition plan. To ensure a smooth transition, relevant intake documents may be forwarded to the new service provider. Case managers from the two agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained.

- If a jail case management client is being released from a correctional (or other institutional) setting, case closure should be preceded by discharge planning. To ensure a smooth transition, provide a discharge plan to the new service provider as soon as possible, however no greater than thirty (30) days. Intense case management efforts may be needed prior to and immediately following a person’s release/discharge. Since a person may leave custody of a correctional facility with only a few days’ worth of medication, case managers should plan ahead and help the client qualify for AIDS Drug Assistance Program (ADAP) or other programs to ensure continued access to medication. Also, a person leaving a correctional facility may have immediate problems in finding employment, housing, substance abuse treatment, etc. Social support systems may also be absent. Instability in living situation may interfere with the person’s ability to access care and supportive services. Therefore, case managers should plan ahead and try to help the person access public assistance or link him/her with community resources that could bring some stability to that person’s situation.
APPENDIX A
Orange County Ryan White Act-Funded Services Case Management Acuity Scale

This acuity scale is designed to assess one’s need for case management. It is not intended to assess one’s overall needs. Case managers are to use their skills and best judgment in scoring the client’s acuity. Each area is to be assessed and scored in the column that best fits the client’s current level of functioning. Score each item with a number of one through four in the date column after writing in the date that acuity is scored. Total the score at the end of page three to determine acuity level. Client’s chart must have documentation of acuity assessment based on Standards of Care periodicity requirements.

<table>
<thead>
<tr>
<th>Area of Assessment</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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<td>Medical</td>
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<td></td>
<td>Asymptomatic. Linked to medical care and adherent to medical treatment.</td>
<td>Recent diagnosis or symptomatic. Needs linkage to medical treatment.</td>
<td>One or more active medical conditions. Poor adherence to medical treatment.</td>
<td>Debilitating disease and/or approaching terminal stages of illness.</td>
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<td>Substance Abuse</td>
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<td></td>
<td>No current or past issues with substance use. Over 5 years sobriety.</td>
<td>Less than 5 years sobriety. Intermittent abuse of substances that does not interfere with daily functioning. Vulnerable to substance use triggers.</td>
<td>Periodic/current substance abuse that interferes with daily functioning.</td>
<td>Chronic or acute substance abuse/dependence causing major impairments in daily functioning.</td>
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<td>Mental Health</td>
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<td>Support System</td>
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<td></td>
<td>Dependable and available support.</td>
<td>Needs linkage to appropriate support.</td>
<td>Needs support but is not accessing it.</td>
<td>No support system. Unable to cope without intervention.</td>
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<td>Transportation</td>
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<td>Has means of transportation consistently available.</td>
<td>Needs linkage to transportation services.</td>
<td>Unable to access transportation without continued assistance and coordination.</td>
<td>Not applicable</td>
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<td>Education</td>
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Revised 3/5/08
### Appendix A Continued: Case Management Acuity Scale

<table>
<thead>
<tr>
<th>Area of Assessment</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Legal</strong></td>
<td>No current or recent legal problems.</td>
<td>Needs linkage to legal services.</td>
<td>Crisis involving civil matters.</td>
<td>Active in the criminal justice system.</td>
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<tr>
<td><strong>Basic Needs</strong></td>
<td>Food, clothing, and other sustenance items available through own means. Able to perform activities of daily living (ADL).</td>
<td>Sustenance needs met regularly with some periods of relapse. Access assistance programs for food and household items. Able to perform ADL.</td>
<td>Often needs help with accessing assistance programs. Often without food or clothing. Needs some ADL assistance.</td>
<td>Chronic nutritional deficit due to inability to access food programs. ADL assistance required.</td>
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<tr>
<td><strong>Primary Relationships</strong></td>
<td>Supportive family environment. Family provides emotional and financial support when needed.</td>
<td>Limited support within family structure. Occasional verbal conflicts.</td>
<td>Some family members have substance abuse and/or mental health issues. Sporadic verbal and/or physical conflicts among family members on a regular basis.</td>
<td>Frequent verbal, physical, and/or sexual abuse in family members on a regular basis. Active disruptive Family mental health and/or substance abuse issues.</td>
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<tr>
<td><strong>Living Situation</strong></td>
<td>Stable and adequate housing</td>
<td>Needs short term assistance, rent or utilities to remain in adequate housing.</td>
<td>Residing in overcrowded or substandard living conditions. Imminent or recent eviction. Living in a shelter or transitional housing.</td>
<td>Homeless. Chronic housing placement issues.</td>
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<tr>
<td><strong>Financial/ Benefits</strong></td>
<td>Steady source of income not in jeopardy.</td>
<td>Occasional need for financial assistance and/or benefits counseling.</td>
<td>No steady income/financial resources.</td>
<td>No income or financial resources.</td>
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<tr>
<td><strong>Culture</strong></td>
<td>Culture is not a barrier to accessing services.</td>
<td>Occasional need for education for client/family.</td>
<td>Culture barriers interfere with ability to access care.</td>
<td>Unable to access care due to cultural barriers.</td>
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<tr>
<td><strong>Language</strong></td>
<td>Language is not a barrier to accessing services.</td>
<td>Occasional need for interpretation/translation services.</td>
<td>Limited English proficiency is a continual barrier to care.</td>
<td>Not Applicable</td>
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<tr>
<td><strong>Self Determination</strong></td>
<td>Understands service system. Ability to access resources without assistance.</td>
<td>Able to use own initiative to identify and access resources given some assistance and guidance.</td>
<td>Unable to identify and access resources without sustained assistance.</td>
<td>Not Applicable</td>
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### ACUITY GUIDE

<table>
<thead>
<tr>
<th>Level of Case Management</th>
<th>Total Score</th>
<th>Acuity Determination Conditions</th>
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<tbody>
<tr>
<td><strong>INTENSIVE (Medical Case Management)</strong></td>
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<tr>
<td>Minimum face-to-face acuity reassessment every two months</td>
<td>29-56</td>
<td>Score with threes in medical, mental health and/or substance abuse</td>
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<tr>
<td>Minimum contact every month</td>
<td>Any</td>
<td>Score with fours in medical, mental health and/or substance abuse</td>
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<tr>
<td><strong>MODERATE (Medical Case Management)</strong></td>
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<tr>
<td>Minimum face-to-face acuity reassessment every three months</td>
<td>16-28</td>
<td>Score with threes in medical, mental health and/or substance abuse</td>
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<tr>
<td>Minimum contact every month</td>
<td>29-54</td>
<td>Score with three or four in any category except Med, MH or SA</td>
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<tr>
<td><strong>BASIC (Non-Medical Case Management)</strong></td>
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<tr>
<td>Minimum face-to-face acuity reassessment every six months</td>
<td>16-28</td>
<td>Score with three or four in any category except Med, MH or SA</td>
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<tr>
<td>Minimum contact every three months</td>
<td>19-28</td>
<td>No scores of three or four in any category</td>
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<tr>
<td><strong>NO NEED FOR CASE MANAGEMENT - Make appropriate referrals under CLIENT ADVOCACY</strong></td>
<td>14-18</td>
<td>No scores of three or four in any category</td>
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### NOTES:

<table>
<thead>
<tr>
<th>Date</th>
<th>Total Score</th>
<th>Level of CM</th>
<th>Justification of Score Over-ride (if applicable)</th>
<th>Referral Made</th>
<th>CD4/VLoad</th>
<th>Case Manager Name</th>
<th>Signature</th>
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Client Name: ___________________________  Chart Number: ____________

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Revised 3/5/08