CASE MANAGEMENT
STANDARDS OF CARE

FOR

HIV CARE SERVICES IN ORANGE COUNTY

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SECTION 1: INTRODUCTION

The goal of case management is to enhance independence and increase quality of life for individuals living with HIV through adherence to medical care. Case management shall prioritize individuals who need support in accessing and maintaining regular medical care. Case management addresses the needs of clients with HIV and assists them in overcoming the obstacles they face in obtaining critical services. Case management shall 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 shall 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 their needs and developing service plans in collaboration with them. This also means empowering the client to take control of their care. It is recommended to incorporate a strengths-based approach, by helping clients identify barriers to accessing care and subsequently identifying personal strengths to overcome these barriers. This is especially important when working with newly diagnosed clients or clients who are returning to care and linking them into medical care. A client-centered process is beneficial to relationship and trust building between the client and their case manager.

Case managers shall also seize opportunities to educate clients about HIV prevention and care. When appropriate, case managers shall educate their clients on life skills such as: practical living skills, functional communication, community integration, treatment adherence, nutritional counseling, and skill building exercises.

Goals of the Standards. These standards of care are provided to ensure that Orange County's case management services:

- Are accessible to all people living with HIV (PLWH) 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 people living with HIV
- Provide support services to enable clients to stay in medical care
- Increase client self-sufficiency and quality of life

SECTION 2: DEFINITIONS OF CASE MANAGEMENT

The Health Resources and Services Administration (HRSA) defines case management in Policy Clarification Notice (PCN) #16-02 as a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Case management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) timely and coordinated access to medically appropriate levels of health and support services and continuity of care; (4) continuous client monitoring to assess the efficacy of the care plan; (5) re-evaluation of the care plan with adaptations as necessary; (6) ongoing assessment of the client's and other key family members' needs and personal support systems; (7) treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and (8) client-specific advocacy and/or review of utilization of services.

In Orange County, services under case management are provided under various categories of case management: Medical Case Management and Non-Medical Case Management.

Under Medical Case Management there are two (2) levels:

1) Linkage to Care
2) Medical Retention Services

Under Non-Medical Case Management there is one (1) level:

1) Client Support Services

Definitions for each service are stated below:
Linkage to Care (LTC): Includes a range of client-centered services using the Anti-Retroviral Treatment and Access to Services (ARTAS) strengths-based model that link clients to medically appropriate levels of health and supportive services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact,

and any other form of communication. These services ensure timely and coordinated access to medically appropriate levels of health and support services. LTC shall also ensure continuity of care through ongoing assessment of the client's needs and personal support systems. The ARTAS Linkage to Care program shall be limited to six (6) months. Individuals that require additional assistance beyond six (6) months shall be transitioned to ongoing Medical Case Management services to ensure linkage and retention in care. Key activities for LTC include 1) initial assessment of service needs; 2) development of an individualized strength-based service plan; 3) coordination of services required to implement the plan; 4) monitoring of client to assess the efficacy of the plan; 5) periodic re-evaluation and adaptation of the plan, as necessary; and 6) clear documentation of assessment, plan, and referrals.

LTC services are intended for individuals who are:

- Newly HIV-diagnosed
- New to Orange County and have not linked to a HIV medical provider
- Returning or re-engaging to HIV care
- Recently released from incarceration
- Transitioning to another payer source and have not linked to a HIV medical provider

Medical Retention Services: Includes a range of client-centered services that link clients to medically appropriate levels of health and supportive services. These services ensure timely and coordinated access to medically appropriate levels of health and support services. Medical Retention Services shall also ensure continuity of care through ongoing assessment of the client's needs and personal support systems. Medical Case Management services shall focus on ensuring medical adherence and retention in care. Successful engagement in care may be defined by sustained viral load suppression or acuity scores consistent with Client Support Services or Client Advocacy; however, case managers should utilize best judgement in choosing to change the client's level of case management. The rationale must be documented. Individuals who are successfully engaged in care should have a plan for transitioning out of Medical Retention Services. Key activities for Medical Retention Services include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring of client to assess the efficacy of the plan; 5) periodic re-evaluation at least every three (3) months and adaptation of the plan, as necessary; and 6) clear documentation of assessment, plan, and referrals.

Medical Retention Services are intended for individuals who are:

- Not HIV medication adherent
- Medically compromised or have a viral load greater than 100,000 copies/mL
- Dealing with medical and/or behavioral health co-morbidities that impede medical care adherence

Client Support Services: The provision of needs assessment and timely follow up to ensure clients are appropriately accessing needed supportive services. Key activities include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring of client to assess the

efficacy of the plan; 5) periodic re-evaluation at least every six (6) months and adaptation of the plan, as necessary; and 6) clear documentation of assessment, plan, and referrals. Service Coordination may be used as a "step-down" model for transitioning clients to increasing levels of self-sufficiency.

Coordination of Medical Care

Beyond simply educating the client about medical care, all case managers shall make the following efforts to support and coordinate the continuity of medical care:

- **Assess Medical Care Access.** 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 medical care in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.).

- **Monitor Medication Adherence.** 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. Lab reports under Medical Case Management is an integral part of understanding a client's adherence to medications and medical care. 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.
  - 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.).

Standard	Measure
Case managers shall regularly assess client's access to medical care and any barriers to care	Documentation on ARTAS Tools, Psychosocial/Acuity Tool, Psychosocial Follow-up Tool, or progress note will ensure
Case managers shall monitor client medication adherence	Documentation on ARTAS Tools, Psychosocial/Acuity Tool, Psychosocial Follow-up Tool, or progress note will ensure

SECTION 3: STAFFING REQUIREMENTS AND QUALIFICATIONS

Quality case management starts with well-prepared and qualified staff. To ensure this, Ryan White providers must meet all of the following requirements and qualifications:

- **HIV Knowledge.** Staff shall have training and experience with HIV related issues and concerns. At a minimum, case managers will have completed one educational session on any of the topics listed below on an annual basis. Certificate of completion shall be included in employee files as proof of attendance. Education can include round table discussion, training, one-on-one educational session, in-service, or literature review. Topics may include:
  - HIV disease process and current medical treatments
  - Adherence to medication regimens
  - Mental health or psychosocial issues related to HIV
  - Cultural issues related to communities affected by HIV
  - HIV legal and ethical issues
  - Human sexuality, gender, and sexual orientation issues
  - HIV prevention issues and strategies specific to HIV-positive individuals ("prevention with positives")
  - Partner Services
  - Strengths-Based approach to case management training
  - Anti-Retroviral Treatment and Access Services (ARTAS) strengths-based model

- **Licensure and Training Requirements.** Staff shall have the necessary State of California licenses, and/or trainings for the functions they perform.
  - Linkage to Care:
    - Staff performing Linkage to Care services shall be ARTAS trained and are not required to have healthcare licensure.
  - Medical Retention Services:
    - Staff performing Medical Retention Services shall have appropriate healthcare licensure (i.e., Registered Nurse, Licensed Vocational Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, Licensed Professional Clinical Counselor).
    - Staff that do not meet the licensure requirement may be exempted and allowed to provide Medical Retention Services with approval using the established Exemption Policy.
    - Marriage and Family Therapist (AMFT) and Master of Social Work (ASW) interns may provide Medical Case Management services as long as they are earning hours toward licensure, are appropriately registered, and clinically supervised.
      - Staff shall have a current California Board of Behavioral Sciences (BBS) registration in order to provide services.
  - Non-Medical Case Management
    - Staff performing Non-Medical Case Management shall have a minimum of Bachelor's degree in a social service field or comparable case management experience, licensure is not required.

Caseloads. Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently. The following outlines recommended caseloads by case management level:

- Linkage to Care (LTC): 10-15 clients
- Medical Retention Services (MRS): 25-40 clients
- Client Support Services (CSS): 30-45 clients

Caseloads may vary based on agency capacity, staffing, and total client levels.

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 orientation, 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 at minimum monthly or when important client-specific issues arise that require a team or interdisciplinary approach or solution.

Standard	Measure
Case management staff receive initial trainings within 60 days of hire and annual education regarding HIV related issues/concerns	Training/education documentation on file including: • Date, time, and location of the education • Education type • Name of the agency and case managers receiving education • Education outline, meeting agenda and/or minutes
Case management staff receive initial trainings within 60 days of hire and annual education regarding community resources	Training/education documentation on file including: • Date, time, and location of the education • Education type • Name of the agency and case managers receiving education • Certificate of completion

Provider will ensure that staff have necessary licenses or degrees for the functions they perform	Documentation of licensure or degree on file
Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently (with assistance to include supervision and clinical guidance, formal or informal case conferencing, as well as case manager transition if needed)	Program managers shall conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties. Documentation of periodic assessments on file.
Formal or informal monthly case conference focused on clients-specific issues	Documentation of case conference on file

SECTION 4: CULTURAL AND LINGUISTIC AWARENESS

Providers must participate in a process of training and education that increases cultural and linguistic competence and improves the case managers' abilities to provide culturally and linguistically appropriate services to all PLWH. Although an individual's ethnicity is generally central to their identity, it is not the only factor that makes up a person's culture. Other relevant factors include gender, gender identity, language, religious beliefs, disability, sexual orientation, beliefs, and institutions. When providing culturally and linguistically competent services, it is important to acknowledge one's personal limits and treat one's client as the expert on their culture.

Based on the Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards), culturally and linguistically appropriate services and skills include:

- Effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- The ability to respect, relate, and respond to a client's culture in a non-judgmental, respectful manner.
- Meeting the needs and providing services unique to our clients in line with the culture and language of the clients being served, including providing written materials in a language accessible to all clients.
- Recognizing the significant power differential between provider and client and work toward developing a collaborative relationship.
- Considering each client as an individual, not making assumptions based on perceived memberships in any specific group or class.
- Translation and/or interpretation services to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all services.

- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Being non-judgmental in regards to people's sexual practices.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Standard	Measure
Providers will recruit a diverse staff that reflects the culture (including gender, sexual identity, and disability) of the community served	Providers have a written strategy on file
All staff (including administrative staff) will receive initial trainings within 60 days of hire and annual trainings to build cultural and linguistic awareness	Training/education documentation on file including: • Date, time, location, and provider of education • Education type • Name of staff receiving education • Certificate of training completion or education outline, meeting agenda, and/or minutes
Provider shall have posted and written materials in appropriate languages for the clients served	Site visit will ensure
Agency complies with Americans with Disabilities Act (ADA) criteria	Completed form/certification on file
Services are accessible to community served	Site visit to review hours of operation, location, accessibility with public transportation

SECTION 5: CLIENT REGISTRATION

Registration is a time to gather demographic data 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 shall provide an appropriate level of information that is helpful and responsive to client need, but not overwhelming.

If a client is receiving multiple Ryan White services with the same provider, registration is only required to be conducted one time. If registration information was completed as part of another service; documentation in the client file is sufficient.

If a client has been referred by another Ryan White provider to receive services and the client has opted to share their AIDS Regional Information and Evaluation System (ARIES) data, the provider receiving the referral does not have to collect registration information. The provider

shall review ARIES to ensure all registration data has been collected and is documented in ARIES. If the client is non-share in ARIES, the referring provider may provide registration information or the provider receiving the referral shall gather registration information from the client. Provision of information regarding *Client Rights and Responsibilities* and *Client Grievance Process* may be conducted one-time at the referring provider agency. To document the provision of this information, the referring provider may send the provider receiving the referral a signed document indicating that they have provided this information to the client.

The case manager shall conduct the client registration with respect and compassion. The following describe components of registration:

- **Timeframe.** Registration 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 experiencing any other medical crisis, the registration process shall be expedited and appropriate interventions may take place.

- **Eligibility and Qualification Determination.** The service provider shall obtain the necessary information to establish the client's eligibility via the Eligibility Verification Form (EVF); See Requirements to be Eligible and Qualify for Services: http://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=51477

- **Demographic Information.** The service provider 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 emergency contact information.

- **Registration Information.** The provider shall obtain information to complete registration as required for the Ryan White Services Report (RSR). This includes, but is not limited to, information regarding demographics, and risk factors.

- **Provision of Information.** The case manager shall clearly explain what case management entails, levels of case management, and provide information to the client. 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 also provide the client with information about resources, care, and treatment available in Orange County this may include the county-wide HIV Client Handbook.

- **Required Documentation.** The provider shall complete the following forms in accordance with state and local guidelines. The following forms shall be signed and dated by each client.
    - **ARIES Consent:** Clients shall be informed of ARIES. The ARIES consent must be signed at intake prior to entry into the ARIES database and every three (3) years thereafter. The signed consent form shall indicate (1) whether the client agrees to

the use of ARIES in recording and tracking their demographic, eligibility and service information and (2) whether the client agrees to share select information contained in ARIES with other agencies in the Ryan White system of care.

- **Confidentiality and Release of Information (ROI)/Authorization to Disclose (ATD):** When discussing client 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 shall include inquiry about how the client wants to be contacted (at home, at work, by mail, by phone, etc.). 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. Clients receiving Medical Case Management shall strongly be encouraged to sign a Release of Information authorizing their case manager to speak to their medical provider so that the case manager can better assist the client in coordinating care for the client. An ROI/ATD form describes the situations under which a client's information can be released and includes the name of the agency and/or person with whom information will be shared, the specific information to be shared, duration of the release consent, and the client's signature. This form may be signed at intake prior to the actual need for disclosure. The ROI/ATD may be cancelled or modified by the client at any time. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the ROI/ATD must be a HIPAA-compliant disclosure.
- **Consent for Services:** Signed by the client, agreeing to receive case management services.

The following forms shall be signed and dated by each client receiving case management services. For documents available in the HIV Client Handbook, completed forms may indicate that the client has received the HIV Client Handbook.

- **Notice of Privacy Practices (NPP):** Clients shall be informed of the provider's policy regarding privacy rights based on the provider's confidentiality policy. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.
- **Client Rights and Responsibilities:** Clients shall be informed of their rights and responsibilities (included in the HIV Client Handbook).
- **Client Grievance Process:** Clients shall be informed of the grievance process. The HCA's Grievance Process is included in the HIV Client Handbook.

Standard	Measure
Registration process initiated within five (5) business days of initial contact with client or documentation of delay	Registration documents are completed and in client service record
Registration information is obtained	Client's service record includes data required for Ryan White Services Report

Standard	Measure
ARIES Consent signed and completed prior to entry into ARIES	Signed and dated based on ARIES consent form guidelines by client and in client service record
ROI/ATD is discussed and completed as needed	Signed and dated by client and in client service record as needed
Consent for Services completed	Signed and dated by client and in client service record
Client is informed of Notice of Privacy Practices	For clients receiving case management: Signed and dated by client and in client file
Client is informed of Rights and Responsibilities	For clients receiving case management: Signed and dated by client and in client file
Client is informed of Grievance Procedures	For clients receiving case management: Signed and dated by client and in client file

SECTION 6: COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT

Proper assessment of client need is fundamental to case management. A comprehensive psychosocial assessment is required for all persons receiving case management. Assessments shall be provided by staff with the appropriate level of education and experience. Assessments are conducted to determine:

- The client's need for case management services and other treatment and support services,
- Current capacity to meet those needs,
- Ability of the client's social support network to help meet client need,
- Extent to which other agencies are involved in client's care,
- Areas in which the client requires assistance in securing services.

Case management shall target individuals assessed as needing support in accessing and maintaining regular medical care. Individuals who are assessed as self-sufficient and not needing periodic follow-up may not need case management services and may receive services under Client Advocacy.

- **Initial and Annual Assessment.** The case manager shall conduct an in-depth assessment of the client's current and potential needs. The assessment process shall start within five days of client intake and must be completed within thirty (30) days. A strengths assessment consisting of past accomplishments is recommended to identify clients' skills and abilities to successfully follow through with their medical care visits, support a positive, trusting relationship with case manager or accessing other services, and other goals. In addition, a comprehensive Psychosocial assessment must be completed annually thereafter. Case managers shall use the Psychosocial Assessment/Acuity Tool (see Appendix B for the Acuity Scale) to document general findings of the assessment and periodic reassessments of client need.

- **Reassessment.** 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 shall be conducted utilizing the Psychosocial Follow-up Tool (see Appendix C) .

  The following *minimum* standards for reassessments have been set based upon case management type:
  - Linkage to Care: Not applicable for Linkage to Care
  - Medical Retention Services : Face-to-face reassessment every three months
  - Client Support Services: Face-to-face reassessment every six months

  Reassessments shall 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.

Standard	Measure
Initial psychosocial assessment/acuity tool shall be completed within thirty (30) days of intake and annually thereafter	Completed assessment, signed and dated by case manager and in client file
Reassessment conducted at intervals determined by the level of case management	Psychosocial Follow-up Tool demonstrating reassessment in client file

(Continued on next page)

SECTION 7: SERVICE MANAGMENT

Once client registration and intake has been conducted, the provider may provide the appropriate range of services to the client. Service management is the system by which all levels of case management are delivered. Service management shall be consistent with the following principles:

- **Service Delivery.** Services shall be delivered in a manner that promotes continuity of care. Newly diagnosed clients shall be assessed for barriers that prevent linkage to medical care. To address these barriers, as recommended by the strengths-based case management model, skills and abilities shall be identified to assist clients to successfully access medical care and maintain a positive relationship with the care coordinator.

- Providers shall refer clients to other providers if they cannot provide a level of service that is medically, culturally, linguistically, or otherwise appropriate for the needs of the clients.
- Ideally, clients should see the same case manager over time, as this is a desirable arrangement that helps develop trust. However, the program may consider changing client-case manager assignments if a client expresses their wish to do so.

- **Confidentiality.** Provider agencies shall have a policy regarding informing clients of privacy rights, including use of Notice of Privacy Practices. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.

- **Service Planning.** Where service provision options are substantially equivalent, the least costly alternative shall be used in meeting the needs of clients.
  - Services shall be planned, managed, and monitored to avoid the need for urgent or emergency services, the interruption of services, and need for emergency or unplanned appropriations of funding to continue services during contract periods.

- **Documentation and Data Collection**. Program and administrative staff shall provide adequate data collection in a timely manner and documentation of all services provided for accounting, reporting compliance, and evaluation purposes. Program data shall be entered into ARIES within five (5) business days as specified in the contract or scope of work. Providers shall document and keep accurate records of units of services for use in reporting units of service for reimbursement and community planning. Providers shall gather and document data (e.g. demographic and risk factor information) for the Ryan White Services Report.

- **Compliance with Standards and Laws**. Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality. Services shall be consistent with standards set forth in this document.

Standard	Measure
Provider shall have procedure to address walk-ins, telephone triage, and emergencies and after-hour care	Written procedure in place
Provider shall have procedure for making referrals to offsite services	Written procedure in place
Staff shall be aware of HIPAA and Notice of Privacy Practices regulations via training upon employment and annually thereafter	Documentation of HIPAA and Notice of Privacy Practices education or training on file
Provider shall ensure client information is in a secured location	Site visit will ensure

Provider shall screen clients to ensure the least costly case management service is used as appropriate to client needs; screening shall occur at minimum when client is accessing a new service and periodically as the client's needs change	• Written procedure in place • Documentation of client screening and determination on file • Site visit will ensure
Provider shall regularly review client charts to ensure proper documentation including progress notes	Written procedure in place
Providers shall document and keep accurate records of units of services	Site visit and/or audit will ensure
Required client data and services shall be entered in ARIES	Required data fields will be validated by the Ryan White Services Report
Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality	Site visit and/or audit will ensure
Provider shall have a procedure to ensure continuity of care to address changes in case managers, level of case management, and/or service providers	Written procedure in place

SECTION 8: INDIVIDUAL SERVICE PLAN (ISP)

Once client needs have been assessed, case managers together with clients shall prioritize care, support needs, and identify activities to address them. This process is documented on the Individual Service Plan (see Appendix D). Individuals enrolled in Linkage to Care are not required to have a completed ISP if utilizing the ARTAS Session Plan tool to document service plan goals. 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. The ISP shall be completed within thirty (30) days of intake and revised as necessary, but not less than every six (6) months. 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 should drive the referrals, communication, and services with client. Implementation, monitoring, and follow up involve ongoing contact and interventions with (or on behalf of) the client to achieve the goals detailed on the ISP, evaluate whether services are consistent with the ISP and determine any changes in the client's status that require updates to the ISP. These activities ensure that referrals are completed and services are

obtained in a timely, coordinated fashion. In implementing the ISP, case managers are responsible for the following:

- **Client Education.** Based on the client's assessed needs and goals stated in their ISP, case managers shall provide clients with information and education about basic health care, prevention, available resources, and the application process for available resources.

- **Referrals/Linkages/Coordination of Care.** Case managers shall make appropriate and complete referrals to medical and support services offered within the agency or in the community. Case managers shall build strong relationships with health care providers and have a referral network they are comfortable with referring their clients to. 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.
  - It is important that the client is satisfied with the referral since they will be more likely to attend the appointment. 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 shall 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 shall 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.
  - 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 shall be determined by the case manager's assessment of the client's situation.
  - For newly diagnosed clients, case managers may want to meet more frequently during the initial intake process to link clients into care within ninety (90) days.
  - The following table is provided as a guide for the minimum frequency of assessments and contacts (see Appendix E for Client Flow Chart):

Level of Case Management	Minimum Face-to-Face Reassessment Frequency	Minimum Contact Frequency
Linkage to Care	Not Applicable	1 month
Medical Retention Services	3 months	1 month
Client Support Services	6 months	3 months

  - 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. Case managers shall acknowledge clients' successes and appreciate their commitment as progress is made throughout the individual service plan. With positive feedback, clients will be confident and empowered in committing to their service plans.
  - To foster self-sufficiency, clients shall be encouraged to initiate contact with the case manager when changes occur in their health condition, living situation or support systems.

Standard	Measure
ISPs or ARTAS Session Plan (for LTC clients) must be finalized within thirty (30) days of the completion of client intake	Completed ISP/ARTAS Session Plan, signed and dated by case manager, and in client file
Review and revise ISP as necessary, but not less than once every six (6) months	Documentation of updated ISP in client file

SECTION 9: CASE MANAGEMENT SERVICE CLOSURE

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. Client Records will be closed when there is no longer a need for the service. 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.

A client may be discharged from case management services due to the following conditions:

- The client has become ineligible for services (e.g., due to relocation outside Orange County or other eligibility requirements).
- The client no longer demonstrates need for case management due to their own ability to effectively advocate for their needs.
- The client chooses to terminate services.
- The client's needs would be better served by another agency.
- The client is being discharged from the correctional facility at which they are receiving jail case management services.
- The client repeatedly shows behavior that violates the agency's policies on client rights and responsibilities.
- The client cannot be located after documented multiple and extensive attempts for a period no less than three (3) months.
- The client has died.

The following describe components of discharge planning:

- **Efforts to Find Client.** The provider 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 (3) attempts to contact the client are made over a period of three (3) months. Efforts shall be made to locate and contact a client who has not shown up for appointments or responded to provider's phone calls. These efforts shall include contacting last known medical provider and other providers for which releases have previously been obtained. Clients who cannot be located after extensive attempts may be referred to available outreach services so that they may be linked back into the care

system. Emergency contacts may be used to reach a client and may be done based on agency policy.

- **Closure Due to Unacceptable Behavior.** If closure is due to behavior that violates client rights and responsibilities including excessive missed appointments, the provider shall notify the client that his/her services are being terminated and the reason for termination. Within the limits of client's authorization to receive mail, notification of closure shall be mailed to the client. A copy of the notification shall be placed in the client's chart. If the client has no known address or the provider is not authorized to send mail to the client, the provider shall document other types of notification of closure (e.g. phone calls, visit) or attempts to notify the client of closure. If the client does not agree with the reason for closure, he/she shall be informed of the provider's grievance procedure.

- **Case Management Service Closure Summary.** A discharge summary shall be documented in the client's record. The case management service closure summary shall include the following:
  - Circumstances and reasons for closure
  - Summary of service provided
  - Goals completed during case management
  - Diagnosis at closure
  - Referrals and linkages provided at closure

- **Data Collection Closeout.** The provider shall close out the client in the data collection system (ARIES) as soon as possible, but no later than thirty (30) days of service closure unless the client is receiving other services at the agency. A progress note should clearly indicate why the client was not closed out of ARIES.

- **Transfer.** A client may be closed if his/her needs would be better served by another agency. If the client is transferring to another case management provider, case management service closure shall be preceded by a transition plan. To ensure a smooth transition, relevant documents shall be forwarded to the new service provider with authorization from client. Case Management providers from the two agencies shall work together to provide a smooth transition for the client and ensure that all critical services are maintained. Clients may be anxious to attend the first appointment with the new provider. Introducing the new case manager or staff with whom they will be working with may assist in the transfer process.

Standard	Measure
Follow up will be provided to clients who have dropped out of case management without notice	Signed and dated note to document attempt to contact in client service record
Notify client regarding closure if due to repeatedly showing behavior that violates the agency's policies on client rights and responsibilities.	Copy of notification in client service record If client has no known address or is unable to receive mail, documentation of other types of notification or attempt at notification in client service record
A case management service closure summary shall be completed for each client who has terminated case management	Client service record will include signed and dated case management service closure summary to include: • Circumstances and reasons for closure • Summary of service provided • Goals completed during case management • Referrals and linkages provided at closure
Closeout of data collection shall be completed for each client who has been closed from all Ryan White services at that provider agency	Data collection system (ARIES) will indicate client's closure no later than thirty (30) days of service closure
A client may be closed due to transfer if the client's needs would be better served by another agency	Client service record will include signed and dated case management progress note or other documentation that the client was closed due to a transfer and shall include: • authorization from client • transition plan • documentation that relevant documents have been forwarded to the new service provider

SECTION 10: QUALITY MANAGEMENT

Providers shall have at least one member on the Health Care Agency's Quality Management (QM) Committee. The QM Committee will oversee quality management activities for all providers under Ryan White Part A. Providers may continue to have their own QM committee if they desire and/or are required to do so under other funding streams. The intent of a

centralized QM committee with representation from all providers is to ensure information between agencies is consistent, quality initiatives are undertaken by the entire Ryan White system, and service delivery issues can be addressed system wide.

As providers participate in the centralized QM committee, the intent is for all providers to actively participate in and provide feedback on the following items:

- Providers shall participate in community-wide Quality Improvement initiatives as developed by the QM committee.
- Providers will implement strategies that may lead to improvements in health outcomes as outlined in annual Performance Outcome Goals.
- Providers will implement quality assurance strategies that improve the delivery of services.

Each case management provider is responsible for Quality Assurance (QA) activities. QA activities shall include, at minimum, the following:

- Supervisors shall conduct record reviews of all staff utilizing the Ryan White Site Visit Tool at minimum quarterly. The number of records shall be three (3) to five (5), but can be more than five (5) based on findings.
- Providers shall conduct peer reviews utilizing the Ryan White Site Visit Tool at minimum quarterly. Each peer shall review two (2) to three (3) records. Providers that have five (5) or more case managers in a case management tier shall review two (2) records per peer. Providers who have less than five (5) case managers per tier shall review three (3) files per peer.
- All providers shall conduct case conferencing. Case conferencing may include clinical supervision activities, supervisory meetings, team lead meetings, or coordination meetings. Providers shall document their process for case conferencing.

Standard	Measure
Providers shall participate in annual quality initiatives	Documentation of efforts to participate in quality initiatives
Providers shall participate as a member of the Quality Management Committee	Quality Management Committee membership
Supervisor and peer chart reviews shall be conducted at minimum quarterly	Completed site visit tools for client records reviewed
Providers shall conduct case conferencing	Documented policy and procedure for case conferencing and notes, highlights, and/or sign-in sheets of case conferences

The terms defined in the appendix are general terms used throughout all of the standards of care and may not appear in the each individual standard.

Americans with Disabilities Act of 1990 (ADA): The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as the general public.

ARIES: The AIDS Research Information and Evaluation System (ARIES) is a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by Ryan White-funded service providers to automate, plan, manage, and report on client data.

Authorization to Disclose (ATD): Signed consent by client that wants to grant another individual or organization access to their protected health information (PHI).

Benefits Counseling (BC): The provision of specific assistance applying for benefits (i.e., Social Security, State Disability, Medicare, etc.).

Client: Individual receiving services.

Client Advocacy (CA): The provision of information and referrals to services for clients who are not receiving Linkage to Care, Medical Retention Services, or Client Support Services. Client Advocacy clients do not require regular follow-up for eligibility screening, psychosocial assessments, or client service plans. They also do not require registration in ARIES unless a referral is being made on the client's behalf.

Client Support Services (CSS): The provision of services to a client who is HIV medically stable but requires assistance to access support services like housing, food services, legal services, etc.

Eligibility for a service: Is based on Health Resources Services Administration (HRSA) and/or Housing Opportunities for Persons with AIDS (HOPWA) requirements. It includes that a person must have proof of HIV status, proof of Orange County residency, and proof of payer of last resort. Eligibility workers are responsible for verifying this information.

Eligibility Screening (ES): The provision of eligibility screening for Ryan White programs which includes proof of diagnosis, proof of Orange County residency, income verification, and verification or referral to healthcare insurance options based on established criteria. This service also provides screening for and assistance with completing the AIDS Drug Assistance Program (ADAP) and the Office of AIDS CARE Health Insurance Premium Program (CARE-HIPP) documents. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**: Is the US federal legislation that provides data privacy and security provisions for safeguarding medical information. Additional information can be found: https://www.hhs.gov/hipaa/index.html

Health Resources and Services Administration (HRSA): HRSA is an agency of the U.S. Department of Health and Human Services, responsible for improving health care to people who are geographically isolated, economically or medically vulnerable including people living with HIV.

Intake: The process of acquiring information to begin services such as need screening, medical history, and other information that is needed to provide the appropriate level of service and is specific to each provider.

Linkage to Care (LTC): The provision of services to link clients to HIV medical care.

Medical Case Management: The overarching service category that includes services to ensure linkage and retention in medical care. Services under Medical Case Management include Linkage to Care (LTC) and Medical Retention Services (MRS).

Medical Retention Services (MRS): The provision of services to help clients address HIV medical issues and stay engaged in HIV medical care.

Notice of Privacy Practice (NPP): A notice to clients that provides a clear, user friendly explanation of client's rights with respect to their personal health information and the privacy practices of health plans and health care providers as required by HIPAA.

Non-Medical Case Management: The overarching service category that includes supportive services to ensure retention in medical care. Services under Non-Medical Case Management include Client Support Services (CSS), Client Advocacy (CA), Benefits Counseling (BC), and Eligibility Screening (ES).

Protected health information (PHI): Under US law, any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity such as a health plans, health care clearinghouses, and health care providers as defined by HIPAA rules that can be linked to a specific individual.

Provider: An institution or entity that receives funding to provide Ryan White services. This includes a group of practitioners, clinic, or other institution that provide Ryan White services and the agency at which services are provided.

Qualifying for a service: Based on HRSA and/or HOPWA eligibility and Planning Council determined requirements (for example, proof of disability for Food Bank, income less than 300% of Federal Poverty Level for Mental Health Services), providers are responsible for ensuring that services provided adhere to qualifying requirements.

Registration: The process of acquiring documentation such as ARIES consent form, Confidentiality and Release of Information, Consent for Services, Notice of Privacy Practices (NPP), Client Grievance Process, and Client Rights and Responsibilities required to provide services.

Release of Information (ROI): Signed consent by client that wants to grant another individual or organization access to their protected health information (PHI).

Ryan White Act: Federal legislation first authorized in 1990 that created Ryan White HIV/AIDS Program which provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured.

Service Management: The provider specific system by which all levels of case management services are delivered. The structure includes how clients are transitioned, service delivery, confidentiality is maintained, service planning, data collection, and how providers should comply with standards and/or appropriate laws.

Staff: An individual who directly provides Ryan White services, oversees the provision of Ryan White services, or perform administrative functions for Ryan White services. This may include paid employees, subcontractors, volunteers, or interns.

Assessment Conducted at (Check one): ☐Office ☐Client's Home ☐Hospital ☐Other: _____ **Date:** ___/___/___

Assessment/Acuity Type (Check one): ☐ Initial Assessment/Acuity ☐ Annual Assessment/Acuity

First Name	Last Name	MI OR No MI	AKA ☐	Mother's MN

Date of Birth: ___/___/___ **Age:** **Gender** (Check one)**:** ☐**M** ☐**F** ☐**TG (M-F)** ☐**TG (F-M)**

Marital Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Other:** _____ **Sexual Orientation:** _____

Risk Factors OR ☐**N/A** (Only required for initial assessment): ☐MSM ☐Sex W/ Female ☐IDU ☐Infected by Mother ☐Received HIV-Infected Blood/Product ☐Unknown ☐Partner of HIV+ ☐Partner of IDU ☐Partner of MSM ☐Other: _____

☐ **Information in "double line" section is documented elsewhere and not completed below. Indicate Location:**

Race: ☐White ☐Black/African Amer. ☐Asian ☐Pacific Islander/Hawaiian ☐Native Amer. ☐Other:

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Decline to State **Sub-ethnicity:** _____

Primary Language: _____ **Requires Translation Services:** ☐Yes ☐No

Address	City or location if homeless	Zip Code	Ok to Mail ☐Yes ☐No

Preferred Number OR ☐ None	Ok to Call ☐Yes ☐No	Ok to Leave Message ☐Yes ☐No	Ok to Text ☐Yes ☐No	Email	Ok to Email ☐Yes ☐No

Monthly Income (Reported or Based on ARIES-Eligibility): _____ **FPL/AMI Percentage:** _____

Income Type (Check all that apply): ☐Employment ☐Unemployment ☐Disability ☐Retirement ☐Gen. Assist/TANF ☐ Other: _____

Disability: ☐None ☐Type (List): _____ Permanent **OR** ☐Temporary **Expiration:** ___/___/___

Emergency Contact
☐ **ROI/ATD on File** **OR** ☐ **Refused:**
☐ **HIV Aware**
☐ **HIV Unaware** **Name:** _____ **Phone:** _____ **Language of Emergency Contact:** _____

Employment Info OR ☐**N/A** **Employment Type:** _____ ☐**Full Time OR** ☐**Part Time** **Benefits:** ☐Yes ☐No

Current Living Situation: ☐Stable/Permanent Housing ☐Homeless/Unstable ☐Other: _____
☐Temporary/Transitional Housing **-** Indicate Date Housing Ends: ___/___/___

Education Completed: ☐Elementary/Primary ☐Jr. High ☐High School/GED ☐Trade/Vocational ☐College ☐Other: _____

Linkage to Care (Client is newly diagnosed/new to the area, Client is returning to Care, or Client is transitioning to another payer source for medical care). If applicable, check one box for each area of assessment below. ☐N/A

Assessment/Acuity	**HIV Medical Provider:** **None at this time** **Phone:** **OR** ☐				
Medical Home ☐N/A ☐Referral Needed ☐Accepted ☐Declined	**Zero**	**One**	**Two**	**Three**	**Total**
	☐Client is engaged in medical care for longer than 12 months.	☐Client is engaged in care for more than 6 months but less than 12 months.	☐Client has been engaged in care for less than 6 months.	☐Client is not engaged in medical care; **OR** ☐Client is in and out of jail resulting in lack of linkage to care; **OR** ☐Client is newly diagnosed.	
Notes:					

Access to Medical Care ☐N/A ☐Referral Needed ☐Accepted ☐Declined	**Insurance Type:** ☐None ☐Medi-Cal ☐Medi-Medi ☐Medicare ☐Private (list):				
	Zero	**One**	**Two**	**Three**	**Total**
	☐Client has adequate insurance; **OR** ☐Client has HIV medical coverage through Ryan White.	☐Client has insurance but insurance does not include all essential health benefits; **OR** ☐Client has insurance but needs referral for assistance with deductibles, co-payments, share-of-cost requirements; **OR** ☐Client has no health insurance and requires referral to Ryan White care.	☐Client is eligible for insurance but needs referral for assistance to complete application (Medi-Cal, Covered CA, OA-HIPP, ADAP); **OR** ☐Client's application is pending and requires follow-up.	☐Client has history of difficulty or non-compliance completing the application for insurance; **OR** ☐Client refuses treatment; **OR** ☐Client has had a change in medical coverage and is at risk for falling out of care in the next 60 calendar days.	
Notes:					

Linkage to Care (Continued)

HIV Knowledge ☐ N/A ☐ Referral Needed ☐ Accepted ☐ Declined	**Zero** ☐ Client is able to verbalize accurate understanding of HIV disease, treatments disease progression, and/or transmission.	**One** ☐ Client has basic knowledge of HIV disease, treatments, progression, and/or transmission but may benefit from a referral to HIV 101.	**Two** ☐ Client has limited understanding of HIV disease, treatments, progression, and/or transmission and requires significant education to engage in HIV care.	**Three** **There is no indicator for this level.**	**Total**
Notes:					
Assessment/Acuity	**Zero**	**One**	**Two**	**Three**	**Total**
HIV Knowledge re: Access to Care ☐ N/A ☐ Referral Needed ☐ Accepted ☐ Declined	☐ Client is able to verbalize accurate understanding of their medical coverage and/or options for care.	☐ Client has basic knowledge of their medical coverage and/or options for care but may benefit from a referral to a benefits counselor.	☐ Client has limited understanding of their medical coverage and/or options for care and requires significant education to access care appropriately.	**There is no indicator for this level.**	
				Total Linkage to Care Score:	
For Women Only OR ☐ N/A:	**Currently Pregnant:** ☐ No ☐ Yes: If Yes, ☐ In prenatal care **OR** ☐ Referred to prenatal care				
Notes:					

(Continued on the next page)

Client ID:_____

Psychosocial Assessment/Acuity Tool

Retention in Medical Care: Check one box for each area of assessment below. ☐N/A if client is in the process of being Linked to Care.

Assessment/Acuity					
	HIV Medical Provider: **Phone:**				
	Date of Last HIV Medical Appointment: / /				
HIV Medical Care Adherence ☐N/A ☐Referral Needed ☐Accepted ☐Declined	**Reasons for Missed Appointments** (check all that apply) **OR** ☐**N/A:**	☐Forgot ☐Didn't feel good ☐Felt good ☐Work/school ☐No transportation ☐Cost ☐Don't like doctor ☐Don't like office staff ☐Didn't like how treated at last appointment ☐Alcohol/substance use ☐Didn't feel like going ☐Other:			
	Zero	**One**	**Two**	**Three**	**Total**
	☐Client has no missed HIV medical appointments in the last 6 months.	☐Client has missed no more than one (1) HIV medical appointment in the last 6 months.	☐Client has missed more than two (2) HIV medical appointments in last 12 months; **OR** ☐Client's immigration status limits access to medical care.	☐Client has missed more than three (3) HIV medical appointments in the past 12 months; **OR** ☐Client is in and out of jail resulting in lack of medical care adherence.	
Notes:					
HIV Medication Adherence: ☐N/A ☐Referral Needed ☐Accepted ☐Declined Current HIV Meds: _____ Medication Rx: _____ Pills Rx Each Day _____ Days in Month _____ Total Pills Taken/Month _____% Adherence Calculation: Total Pills Taken in a month/(Total Pills Rx	**Problems with ART OR** ☐**N/A:**	☐Too many pills ☐Side effects ☐Alcohol/drug use ☐Forgot ☐No Privacy ☐Cost ☐Not feeling good ☐Feeling good ☐Lost/misplaced pills ☐Other:			
	Zero	**One**	**Two**	**Three**	**Total**
	☐Client reports 90% or greater adherence to HIV meds and is virally suppressed; **OR** ☐Client's doctor chooses not to start HIV meds;	☐Client reports 85-90% adherence to HIV meds and is virally suppressed; **OR** ☐Client reports sporadic issues with adherence and may benefit from referral to treatment adherence assistance; **OR** ☐Client chooses not to start HIV meds with	☐Client reports missing doses of HIV meds and is not virally suppressed; **OR** ☐Client has begun HIV meds within the last three (3) months; **OR** ☐Client is unable to provide medication Rx details.	☐Client reports that he/she has stopped taking HIV meds; **OR** ☐Client reports he/she has not started taking prescribed HIV meds; **OR** ☐Client Mental Health or Substance Use needs to be addressed to increase HIV med adherence; **OR** ☐Client reports taking HIV meds for at least six months as	

Each Day x Number of Days in month)		HIV doctor acknowledgement.		prescribed but viral load is greater than 100,000 copies/mL.	
Notes:					

Retention in Medical Care (Continued)

Assessment/Acuity					
HIV Treatment and Medication Knowledge ☐N/A ☐Referral Needed ☐Accepted ☐Declined	**Zero** ☐Client is able to verbalize accurate understanding of their HIV disease treatments and medication (side effects, purpose of meds).	**One** ☐Client has basic knowledge of their HIV disease treatments (e.g., viral load, CD4, and labs) and medication but may need treatment adherence assistance.	**Two** ☐Client needs repeated oral instructions or assistance to understand health information or medications; **OR** ☐Client is cognitively impaired.	**Three** ☐Client does not know or understand health information or medications.	**Total**
Notes:					
HIV Disease Progression ☐N/A ☐Referral Needed ☐Accepted ☐Declined ☐HIV: Stage Unknown ☐HIV: Asymptomatic ☐HIV: Symptomatic ☐CDC-Defined AIDS Date: _____ ☐Other: _____	**Viral Load**[1] (Suppressed is under 200 copies/mL)**:** **Date of Test:** / / ☐**Unknown** **CD4** (Prophylaxis required under 200 cell/mm^3)**:** **Date of Test:** / / ☐**Unknown** **OI Type if Diagnosed in Last 12 Months:** **Date:** / / **OR** ☐**N/A** **Zero** ☐Client has no history of an Opportunistic Infection (OI); **OR** ☐No HIV-related hospitalization in the last 12 months.				
		One ☐Client has had an OI in the past 12 months with appropriate treatment (TX); **OR** ☐Client has a CD4 count less than 200 cell/mm^3 but has started prophylaxis.	**Two** ☐Client has had an OI in the past 12 months on TX; **OR** ☐Client has been hospitalized due to HIV in past 6 months.	**Three** ☐Client viral load is greater than 100,000; **OR** ☐Client currently has an OI and not currently on TX; **OR** ☐Client has been hospitalized due to HIV in past 3 months.	**Total**
Notes:					

[1]HRSA Viral Load suppression definition is used for consistency.

Client ID:_____

Psychosocial Assessment/Acuity Tool

(Continued on the next page)

Retention in Medical Care (Continued)

Assessment/Acuity					
Disease Co-Morbidities ☐ N/A ☐ Referral Needed ☐ Accepted ☐ Declined	**Problems with Meds OR ☐ N/A:** ☐ Too many pills ☐ Side effects ☐ Alcohol/drug use ☐ Forgot ☐ No Privacy ☐ Cost ☐ Not feeling good ☐ Feeling good ☐ Lost/misplaced pills ☐ Other:				
	Zero	**One**	**Two**	**Three**	**Total**
	☐ Client has no reported co-morbidities; **OR** ☐ Client has reported managed co-morbidities.	☐ Client has reported difficulties managing co-morbidities.	☐ Client has reported an unmanaged co-morbidity.	☐ Client has multiple unmanaged co-morbidities impacting health; **OR** ☐ Client has progressive co-morbidities that require monitoring.	

Notes:

Medication List (Check all that apply):

Antibiotics
- ☐ Amoxicillin (generic for Amoxil)
- ☐ Amoxicillin/Potassium Clavulanate ER (generic for Augmentin XR)
- ☐ Azithromycin (generic for Zithromax)
- ☐ Other: _____

Anti-inflammatories
- ☐ Meloxicam (generic for Mobic) Methylprednisolone (generic for Medrol)
- ☐ Prednisone (generic for Deltasone)
- ☐ Other: _____

Anti-hypertensives/Heart Medications
- ☐ Amlodipine (generic for Norvasc)
- ☐ Atenolol (generic for Tenormin)
- ☐ Carvedilol (generic for Coreg)
- ☐ Clopidogrel (generic for Plavix)
- ☐ Hydrochlorothiazide (generic for Microzide)
- ☐ Lisinopril (generic of Prinivil)
- ☐ Lisinopril/HCTZ (generic for Zestoretic)
- ☐ Losartan (generic for Cozaar)

Asthma/Chronic Obstructive Pulmonary Disease
- ☐ Fluticasone (generic for Flonase)
- ☐ Montelukast (generic for Singulair)
- ☐ Ventolin
- ☐ Other: _____

Cholesterol
- ☐ Atorvastatin Calcium(generic of Lipitor)
- ☐ Crestor
- ☐ Fenofibrate (generic for Tricor)
- ☐ Pravastatin (generic for Pravachol)
- ☐ Simvastatin (generic for Zocor)
- ☐ Other: _____

Diabetes
- ☐ Metformin (generic for Glucophage)
- ☐ Other: _____

Depression
- ☐ Bupropion (generic for Wellbutrin)
- ☐ Citalopram (generic for Celexa)
- ☐ Other: _____

Opiate or Pain Medications

Other
- ☐ Allopurinol (generic for Zyloprim)
- ☐ Cialis
- ☐ Cyclobenzaprine (generic for Flexeril)
- ☐ Furosemide (generic for Lasix)
- ☐ Levothyroxine (generic of Synthroid)
- ☐ Omeprazole (generic of Prilosec)
- ☐ Pantoprazole (generic for Protonix)
- ☐ Potassium Chloride (generic for Klor-Con)
- ☐ Tamsulosin (generic for Flomax)
- ☐ Warfarin (generic for Coumadin)
- ☐ Other: _____

Psychotropic
- ☐ Alprazolam (generic for Xanax)
- ☐ Amphetamine/Dextroamphetamine (generic for Adderall)
- ☐ Duloxetine (Cymbalta)
- ☐ Escitalopram (generic for Lexapro)
- ☐ Fluoxetine (generic for Prozac)
- ☐ Sertraline (generic for Zoloft)

☐ Losartan Potassium (generic for Cozaar) ☐ Metoprolol (generic for Lopressor) ☐ Metoprolol ER(generic for Toprol XL) ☐ Other: _____	☐ Gabapentin (generic for Neurontin) ☐ Hydrocodone/Acetaminophen (generic for Lortab) ☐ Tramadol (generic for Ultram) ☐ Other: _____	☐ Trazodone (generic for Oleptro) ☐ Venlafaxine (generic for Effexor) ☐ Zolpidem (generic for Ambien) ☐ Other: _____

Retention in Medical Care (Continued)

	Dentist: **Phone:** **OR ☐ None at this time**				
Oral Health Needs ☐ N/A ☐ Referral Needed ☐ Accepted ☐ Declined ☐ Client refuses Oral Health Care	**Date of Last Dental Appointment:** / / **OR ☐ Doesn't Recall**				
	Current Dental Issue (Indicate): **OR ☐ N/A**				
	Dental Issue Causing Problems with Eating: ☐ Yes ☐ No				
	Zero	**One**	**Two**	**Three**	**Total**
	☐ Client has a dentist and reports seeing dentist at least once in the last 12 months; **OR** ☐ Client reports no dental issues.	☐ Client has a dentist and requests a referral for general care.	☐ Client does not have a dentist and has not been seen in the last 12 months.	☐ Client reports having an acute and urgent dental situation and/or mouth pain.	
Notes:					
Medical Nutrition Needs (assessment of nutritional needs for improved health) ☐ N/A ☐ Referral Needed ☐ Accepted (Check all) ☐ RD ☐ RW Pantry ☐ Other Pantry ☐ Declined	**Assistance is Needed to Get Food** (check one): ☐ Yes ☐ No ☐ Already getting assistance (Indicate type):				
	Zero	**One**	**Two**	**Three**	**Total**
	☐ Client reports no nutrition problems (e.g., nausea, vomiting, diarrhea).	☐ Client has had occasional episodes of nausea, vomiting, or diarrhea and may benefit from a nutritional referral; **OR** ☐ Client reports need for food services assistance to maintain health.	☐ Client reports on-going nutritional problems; **OR** ☐ Client has reported or observed difficulties preparing meals; **OR** ☐ Observed weight loss or gain in last 6 months that requires a nutrition referral.	☐ Client reports severe and on-going nutritional problems; **OR** ☐ Client has been diagnosed with wasting syndrome.	
For Women Only OR ☐ N/A:	**Currently Pregnant:** ☐ No ☐ Yes: If Yes, ☐ In prenatal care **OR** ☐ Referred to prenatal care				
				Total Retention in Medical Care Score:	
Notes:					

(Continued on the next page)

Client ID:_____

Psychosocial Assessment/Acuity Tool

Barriers to Care: Complete for Linkage and Retention in Care. Check one box for each area of assessment below. The assessment below does not constitute diagnoses.

Brief Mental Health Assessment: Complete the following based on appearance:

Appearance : ☐Neat/Clean ☐Unkempt ☐Poor Hygiene ☐Other: _____

Mood: ☐Normal ☐Euphoric ☐Depressed ☐Irritable ☐Anxious ☐Angry ☐Restless ☐Sedate ☐Other: _____

Speech: ☐Clear ☐Loud ☐Mumbled ☐Slurred ☐Rapid ☐Slow ☐Incoherent ☐Other: _____

Attention: ☐Normal ☐Distracted ☐Hyper ☐Inconsistent ☐Other: _____

Brief Mental Health Questionnaire: Inquire about the following in past year (**If Yes to any of the questions below, offer Mental Health referral.)**

1. Have you felt blue, sad, or depressed for at least two weeks in a row? ☐Yes ☐No
2. Have you lost interested in things like hobbies, work, or activities? ☐Yes ☐No
3. Have you felt worried or anxious for a period that lasted longer than a month? ☐Yes ☐No
4. Have you ever had a sudden feeling of anxiousness or fear? ☐Yes ☐No
5. Have you heard voices or seen things others did not hear or see? ☐Yes ☐No
6. Have you thought about hurting yourself or other? ☐Yes ☐No
7. Have you ever had a Mental Health clinical diagnosis? ☐Yes ☐No (If Yes, check below in assessment section)
8. Do you see a doctor or talk to a counselor about your feelings or diagnosis? ☐Yes ☐No

Assessment/Acuity	**Doctor/Counselor:** **Phone:** **OR ☐None at this time**				
Mental Health ☐Referral Needed ☐Accepted ☐Declined	**Date of Last Appointment:** / /				
	Reasons for Missed Appointments (check all that apply) **OR ☐N/A:**	☐Forgot ☐Didn't feel good ☐Felt good ☐Work/school ☐No transportation ☐Cost ☐Don't like staff or treatment ☐Refused to go after being referred ☐Alcohol/drug use ☐Didn't feel like going ☐ Other:			
(Check all reported) ☐Depression/Anxiety ☐Bipolar ☐Suicidal/Homicidal ☐Other: _____ Current Meds: _____	**Zero**	**One**	**Two**	**Three**	**Total**
	☐Client reports no history of mental health issues or treatment (Tx).	☐Client reports history of mental health issues and is currently in Tx or counseling; **OR** ☐Client reports history of mental health issues but states no current need for Tx or counseling.	☐Client reports history of mental health issues and difficultly adhering to treatment; **OR** ☐Observed behavior or client reports mental health assessment need.	☐Client reports or exhibits behavior that indicates danger to self and/or others; **OR** ☐Client's reported mental health issues may be a barrier to medical treatment or HIV meds adherence; **OR** ☐Client reports non-compliance with mental health meds.	
Treatment (Tx) Options (Check one)	☐In Tx ☐Waiting list ☐Refused Tx ☐Completed Tx ☐Pre-Treatment Process ☐Dropped out of Tx ☐ No Active Tx ☐ TX Resumed ☐Unknown ☐Other:				

Notes:	

Barriers to Care (Continued)

Self-Reported Use of Non-Prescribed Substances: Complete for each substance and check off N/A or History and/or Current Use and Frequency

Substance	N/A	History	Current Use	Frequency
Alcohol	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Cocaine/Crack	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Heroin/Opiates	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Amphetamines (Speed, Crystal)	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Inhalants	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Hallucinogens	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Misuse of prescribed drugs (Indicate):	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Marijuana	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Tobacco	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Other (Indicate):	☐	☐	☐	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

Notes:	

Brief Substance Use Questionnaire: Inquire about the following in past year:

1. Do you think you have a problem with alcohol or other drugs? ☐Yes ☐No ☐Refused to answer
2. Has your alcohol and/or drug use ever interfered with your daily activities? ☐Yes ☐No ☐Refused to answer ☐N/A
3. Have you ever injected drugs? ☐Yes ☐No ☐Refused to answer ☐Don't Know ☐N/A
4. Are you currently in treatment? ☐Yes ☐No (If Yes, Indicate type of treatment: _____) ☐N/A
5. Are you currently in recovery? ☐Yes ☐No ☐N/A
6. Are you willing to go to treatment? ☐Yes ☐No ☐N/A

Assessment/Acuity	**Program/Counselor:**	**Phone:**	**OR ☐None at this time**	
Substance Use/Abuse ☐See Notes ☐Referral Needed ☐Accepted ☐Declined	**Zero** ☐Client reports no history of substance abuse (alcohol and/or other drugs).	**One** ☐Client reports history of substance abuse/misuse and is currently in treatment; **OR** ☐Client reports history of substance abuse/misuse and states he/she is in recovery with appropriate support; **OR** ☐ Client reports using alcohol and/or other drugs intermittently but use does not interfere with daily functioning.	**Two** ☐Client reports current substance abuse or relapse problem and is willing to seek assistance	**Three** ☐Client reports substance abuse problem but is not willing to seek treatment; **OR** ☐Client denies current substance abuse/misuse but behavior or evidence of current substance use is observed.	**Total**
Treatment (Tx) Options (Check one)	☐In Tx ☐Waiting list ☐Refused Tx ☐Completed Tx ☐Pre-Treatment Process ☐Dropped out of Tx ☐ No Active Tx ☐ Tx Resumed ☐Unknown ☐Other:				

Client ID:_____

Psychosocial Assessment/Acuity Tool

Notes:	

Barriers to Care (Continued)

Assessment/Acuity	Zero	One	Two	Three	Total
Financial ☐ See Notes ☐ Referral Needed ☐ Accepted ☐ Declined	☐ Client reports having income or source of financial support is able to meet financial obligations.	☐ Client reports having an unstable income but knows how to request/access financial assistance when needed.	☐ Client currently does not have enough income to meet financial obligations/meet basic needs and requires a referral for financial assistance.	☐ Client has no income or source of financial support; **OR** ☐ Client needs frequent follow up to ensure basic needs are met.	
Notes:					

Living Situation
☐ Referral Needed
☐ Accepted
☐ Declined

Lives: ☐ Homeless ☐ Alone ☐ Friend/roommate ☐ Partner ☐ Parents ☐ Relatives ☐ Other:

Client Reports Difficulty With: ☐ Personal hygiene ☐ Preparing meals ☐ Cleaning ☐ Other: ☐ N/A

Zero	One	Two	Three	Total
☐ Client has permanent housing.	☐ Client currently has stable housing and knows how to access rental/utility assistance when needed.	☐ Client is in transitional or unstable housing; **OR** ☐ Client reports potential risk of eviction or utility shut off; **OR** ☐ Client requests assistance with rent/utilities to maintain housing; **OR** ☐ Client chooses to be homeless.	☐ Client is homeless and requires housing assistance; **OR** ☐ Client has an immediate risk of eviction or utility shut off; **OR** ☐ Client's current living situation presents an immediate health hazard that interferes with HIV care or HIV meds adherence; **OR** ☐ Client is unable to live independently without appropriate assistance.	

Notes:	

Support System
☐ Referral Needed
☐ Accepted
☐ Declined

Person(s)/Activities That Provide Most Support: ☐ Partner ☐ Family ☐ Friend ☐ Church group ☐ Support group ☐ Other:

Zero	One	Two	Three	Total
☐ Client reports dependable and available support.	☐ Client has limited support and may benefit from a referral to support groups or activities; **OR** ☐ Client has general support but limited to no HIV-specific support.	☐ Client has no support and requires referral to support groups or activities.	**There is no indicator for this level.**	

Notes:	

Client ID:_____ Psychosocial Assessment/Acuity Tool

Assessment/Acuity	Zero	One	Two	Three	Total
Linguistic ☐ Referral Needed ☐ Accepted ☐ Declined ☐ Client is monolingual: _____ But language is not a barrier at this agency but may be for referrals.	☐ Client reports no language barriers to care.	☐ Client requests occasional assistance in understanding or completing forms or new information.	☐ Client requires translation or sign interpreters to complete forms or understand medical concepts/directives; **OR** ☐ Client is illiterate or has low literacy that interferes with ability to understand medical concepts/directives.	**There is no indicator for this level.**	
Notes:					
Cultural ☐ Referral Needed ☐ Accepted ☐ Declined	☐ Client reports that culture is not a barrier to accessing services.	☐ Client reports that cultural barriers interfere with the ability to access care.	☐ Client reports that he/she is unable to access care due to cultural barriers.	**There is no indicator for this level.**	
Notes:					
Medical Transportation ☐ Referral Needed ☐ Accepted ☐ Declined	**Primary Type of Transportation:** ☐ Own car ☐ Bus ☐ Walk ☐ Bike ☐ Other: **Assistance Needed or Received:** ☐ Bus pass ☐ ACCESS ☐ Van ☐ Other:				
	Zero	**One**	**Two**	**Three**	**Total**
	☐ Client reports self-sufficiency in getting to medical appointments.	☐ Client needs occasional assistance getting to medical assistance and knows how to access assistance; **OR** ☐ Client requires bus passes to attend medical services.	☐ Client has physical/mental disabilities which require van or ACCESS transportation services to ensure medical care access.	☐ Client has persistent issues/problems utilizing transportation services impacting medical care adherence.	
				Total Barriers to Care Score:	
Notes:					

(Continued on the next page)

Other Risks and Issues

Assessment	
Sexual Risk Behaviors ☐Declined to have conversation regarding sexual risk behaviors ☐See Notes ☐Referral Needed ☐Accepted ☐Declined	**Scale of Least to Highest (1-10), Importance of Protecting Oneself from STDs/STIs:**
	Scale of Least to Highest (1-10), Importance of Reducing Risk of Transmitting HIV to Others:
	Things Currently Done to Protect Oneself from STDs: ☐Reduce number of partners ☐Don't have sex with strangers ☐Have sex with steady partner ☐Abstain
	☐Use condoms or other barriers ☐Ask partners about their STDs/HIV status ☐Other:
	Things Currently Done to Protect Partners from Getting HIV: ☐Have types of sex less likely to transmit HIV ☐Tell Partner HIV status ☐Abstain ☐Take HIV medications
	☐Only have sex with other HIV+ individuals ☐Use condoms or other barriers ☐Other:
	Number of Sex Partners in Last Three (3) Months:
	Sex Partners: ☐Men ☐Women ☐TG (M-F) ☐TG (F-M) ☐Sex workers ☐Other: ☐N/A
	In Past Three (3) Months, Has Had Sex For: ☐Money ☐Alcohol/drugs ☐Basic needs ☐Housing ☐Other: ☐N/A
	Condom Use: ☐Always ☐Often ☐Sometimes ☐Never ☐Only when not with primary partner
	How Often do you Know HIV Status of Partners: ☐Always ☐Often ☐Sometimes ☐Never ☐N/A
	Reasons for Unprotected Sex: ☐Alcohol/drug use ☐No condoms available ☐Partner refused ☐Other: ☐N/A
	Reports Knowing How to Use Condom Correctly: ☐Yes ☐No ☐Not Sure
	Reports Ability to Negotiate Safer Sex Activities with Partner(s): ☐Yes ☐No ☐Not Sure
	STDs Diagnosed or an Outbreak in Last 12 Months: ☐Syphilis ☐Gonorrhea ☐Chlamydia ☐Herpes ☐Other: ☐N/A
Notes:	
Partner Services (PS) ☐Referral Needed ☐Accepted ☐Declined	**Reports Comfort Disclosing HIV-Status to Partners:** ☐Yes ☐No ☐N/A
	Reports Needing Help Disclosing HIV-Status to Partners (Sex and/or Needle Sharing): ☐Yes ☐No ☐N/A
	☐Discussed Partner Services ☐Helped With Disclosure (2nd Party) ☐Referred for Partner Services (2nd or 3rd Party)
Notes:	
Domestic Violence ☐N/A ☐Referral Needed ☐Accepted ☐Declined	**Client Reports Partner/Parent/Friend/Roommate Makes Them Feel Afraid/Unsafe:** ☐Always ☐Often ☐Sometimes ☐Never ☐N/A
	Client Needs/Requests: ☐Help with getting restraining order ☐Help with filing charges ☐Help with a moving out of current home ☐N/A

Notes:	

Other Risks and Issues (Continued)

Legal Issues ☐ N/A ☐ Referral Needed ☐ Accepted ☐ Declined	**Current Legal Issues** (Check all that apply)**:** ☐ On probation ☐ On parole ☐ Recently released ☐ N/A	
	Pending Legal Issue ☐ Yes ☐ No (Indicate Issue if Yes)**:**	
	Client Needs/Requests the Following OR ☐ N/A:	☐ Health Care Directive ☐ Will ☐ Arrangement for guardianship ☐ Power of attorney ☐ Bankruptcy
		☐ Help with discrimination case/issue ☐ Other:
Notes:		

Immigration Status ☐ N/A ☐ Referral Needed ☐ Accepted ☐ Declined	**Immigration Status:**	☐ US Citizen ☐ Lawful US Resident (Indicate Type):
		☐ Undocumented ☐ Other (i.e., asylum, protected status, etc.):
	Immigration Issue/Concern: ☐ Yes ☐ No (Indicate Issue if Yes)**:**	
Notes:		

Case Summary Notes:

(Continued on the next page)

Medical Case Management (Linkage to Care or Medical Retention Services)

Linkage to Care (LTC) services are intended for individuals who are:

- Newly diagnosed;
- New to Orange County and have not linked to a HIV medical provider;
- Returning to HIV care; and/or
- Transitioning to another payer source and have not linked to a HIV medical provider.

Medical Retention Services (MRS) are intended for individuals who are:

- Not HIV medication adherent;
- Medically compromised or have a viral load greater than 100,000 copies/mL; and/or
- Dealing with medical co-morbidities, mental health, or substance use that impede medical care adherence.

MRS must be provided by medically credentialed or other healthcare staff who are part of a clinical team.

	Score	Conditions
Linkage to Care		
Minimum contact once a month unless documentation indicates less contact needed.		Linkage to Care clients will receive up to six (6) months LTC services, regardless of acuity score. Case Manager can refer to a different level of case management at any time.
Medical Retention Services (MRS)		
Minimum psychosocial every three (3) months. Minimum contact once a month. Individual Service Plan (ISP) every six (6) months.		A score of 10 and above in Retention in Care section (first five assessment sections HIV Med Adherence to Disease Co-Morbidities only) requires MRS. Case Manager can refer to a different level of case management based on client needs/progress at any time.
Barriers to Care		
Client should be referred to service(s) that can potentially address barrier(s). Follow up should be conducted at minimum two (2) weeks from referral to confirm linkage to service (s). A face-to-face assessment should be conducted three (3) months from the date of referral to assess status. During assessments, if the services needed do not directly impact medical care, a referral to Non-Medical Case Management (Client Support) may be appropriate.		

OR

Non-Medical Case Management (Client Support or Client Advocacy)

Client Support Services are intended for individuals who are medically stable but require psychosocial support to ensure medical care adherence (e.g., housing, substance use, and food instability). Client Advocacy is available to answer basic questions and provide referrals to services for individuals who do not need on-going case management. Non-Medical Case Management may be provided by non-medically credentialed and unlicensed trained professionals.

Service	Score	Conditions
Client Support		
Minimum psychosocial every six (6) months. Minimum contact every three (3) months. ISP every six (6) months.		A score of 14 and above in Barriers to Care requires Client Support. Scores below 14 should be referred to Client Advocacy.
Client Advocacy		
No minimum psychosocial assessment. No minimum contact.		Service is provided on an as needed basis.

Override Rationale:	

Client ID: _____

Psychosocial Assessment/Acuity Tool

Referrals (Check all referrals made)
☐Benefits Counseling ☐Dental ☐EFA for Medications ☐Eligibility ☐Food Services ☐Health Insurance Premium Assistance ☐HIV Ed.
☐Housing ☐Legal ☐Mental Health ☐Partner Service ☐Prevention Services ☐Psychiatry ☐Registered Dietitian
☐Substance Use/Abuse Services ☐Support Group ☐Transportation ☐TX Adherence ☐Other:

CM Name and Licensure (Print)	Signature	Date
CM Name and Licensure (Print)	**Signature**	**Date**
Clinical Supervisor Signature, If required	**Date**	

Next Psychosocial/Acuity: / / **Next ISP:** / / **Next Eligibility:** / / ☐**Full OR** ☐**Self-Attestation**

Assessment Conducted at (Check one): ☐Office ☐Client's Home ☐Hospital ☐Other: _____ **Date:** ___/___/___

First Name	Last Name	MI OR No MI	AKA	Mother's MN
		☐		

Date of Birth: ___/___/___ **Age:** **Gender** (Check one)**:** ☐**M** ☐**F** ☐**TG (M-F)** ☐**TG (F-M)**

Marital Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Other:** _____ **Sexual Orientation:** _____

☐ **Information in "double line" section is documented elsewhere and not completed below. Indicate Location:**

Race: ☐White ☐Black/African Amer. ☐Asian ☐Pacific Islander/Hawaiian ☐Native Amer. ☐Other: _____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Decline to State

Primary Language: _____ **Requires Translation Services:** ☐Yes ☐No

Address	City or location if homeless	Zip Code	Ok to Mail
			☐Yes ☐No

Preferred Number OR ☐ None	Ok to Call	Ok to Leave Message	Ok to Text	Email	Ok to Email
	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No

Monthly Income (Reported or Based on ARIES-Eligibility): _____ **Federal Poverty Level Percentage:** _____

Income Type (Check all that apply): ☐Employment ☐Unemployment ☐Disability ☐Retirement ☐Gen. Assist/TANF ☐ Other: _____

Disability: ☐None ☐Type (List): _____ Permanent **OR** ☐Temporary **Expiration:** ___/___/___

Emergency Contact

☐ **ROI on File OR** ☐ **Refused:**
☐ **HIV Aware**
☐ **HIV Unaware**

_____ **Phone:** _____ **Language of Emergency Contact:** _____

Employment Info OR ☐**N/A** **Employment Type:** _____ ☐**Full Time OR** ☐**Part Time** **Benefits:** ☐Yes ☐No

Current Living Situation:
☐Stable/Permanent Housing ☐Homeless/Unstable ☐Other: _____
☐Temporary/Transitional Housing **-** Indicate Date Housing Ends: ___/___/___

Education Completed: ☐Elementary/Primary ☐Jr. High ☐High School/GED ☐Trade/Vocational ☐College ☐Other: _____

Core Medical Issues

Access to HIV Medical Care: Describe any pertinent information regarding access to HIV Medical Care, including change in employment, health insurance, or provider

☐ Referral Needed
☐ Accepted
☐ Declined

Access to Other Medical Care: Describe any pertinent information regarding access to other Medical Care, for example, Mental Health, Oral Health, etc.

☐ Referral Needed
☐ Accepted
☐ Declined

Medical Condition: Describe any pertinent information regarding medical condition, including viral load/CD4, co-morbidities, medication adherence, etc.

Viral Load[1] (Suppressed is under 200 copies/mL)**:** **Date of Test:** / / ☐ **Unknown**

CD4 (Prophylaxis required under 200 cell/mm^3)**:** **Date of Test:** / / ☐ **Unknown**

☐ Referral Needed
☐ Accepted
☐ Declined

Mental Health Status: Describe any pertinent information regarding mental health status

☐ Referral Needed
☐ Accepted
☐ Declined

Substance Use Activities: Describe any pertinent information regarding substance use activities

☐ Referral Needed
☐ Accepted
☐ Declined

Risk Behaviors: Describe any pertinent information regarding risk behaviors

☐ Referral Needed
☐ Accepted
☐ Declined

[1]HRSA Viral Load suppression definition is used for consistency.

Psychosocial Issues

Financial: Describe any pertinent information regarding financial situation that may impact health
☐ Referral Needed ☐ Accepted ☐ Declined
Housing: Describe any pertinent information regarding housing/living situation
☐ Referral Needed ☐ Accepted ☐ Declined
Support System: Describe any pertinent information regarding support system
☐ Referral Needed ☐ Accepted ☐ Declined
Transportation: Describe any pertinent information regarding transportation needed to access medical services
☐ Referral Needed ☐ Accepted ☐ Declined
Legal: Describe any pertinent information regarding legal situation or need, including immigration status
☐ Referral Needed ☐ Accepted ☐ Declined
HIV Knowledge: Describe any pertinent information regarding HIV knowledge, disease treatment, or medication effects
☐ Referral Needed ☐ Accepted ☐ Declined
Recommended Level of Case Management: ☐ LTC ☐ Medical Retention Services ☐ Client Support ☐ Client Advocacy
Additional Notes or Goals:

CM Name and Licensure (Print) **Signature** **Date**

Clinical Supervisor Signature, If required **Date**

Next Psychosocial/Acuity: ____/____/____ **Next ISP:** ____/____/____ **Next Eligibility:** ____/____/____ ☐ **Full OR** ☐ **Self-Attestation**

Individual Service Plan

Date: _____ / _____ / _____ **Level of Case Management:** ☐ **Linkage to Care** ☐ **Medical Retention Services** ☐ **Client Support Services**

First Name	**Last Name**	**MI**	**OR** ☐ **No MI**	**AKA**	**Date of Birth**

The Individual Service Plan (ISP) is intended to be a living document to develop goals in collaboration with the client that will lead toward improvements along the HIV Care Continuum (Linkage to Care, Retention in HIV Care, Taking ART, and Viral Load Suppression) and ultimately client self-sufficiency. Case Managers should consider the following in working with the client. A copy of page two may be printed for the client.

- Goals should be **SMART**: **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**imely.
- ISP goals should lead toward the overall long-term goals for the client.
- Clients should have enough time to develop long-term goals, it is not expected that a long-term goal will be completed within a set timeframe.

The following are suggested questions that can help guide goal development:

- Who are the individuals in your life that can help you meet your goals?
- Who are the individuals in your life that can cause a barrier to you meeting your goals?
- How would your life look if you could meet your goals?
- How would your life look if you could not meet your goals?
- What problems or difficulties do you have right now and how do they affect your life?

Long-Term Goal 1: Indicate client's goal: _____ **OR** ☐ Long-term goal was not developed during this session
Indicate barriers to achieving goal:
Notes:

Long-Term Goal 2: Indicate client's goal _____ **OR** ☐ Long-term goal was not developed during this session
Indicate barriers to achieving goal:
Notes:

Please indicate **Goal Area(s)** from the list below:							
☐	Medical Care	☐	Mental Health	☐	Support System	☐	Legal Issues
☐	Medication Adherence	☐	Substance Use	☐	Transportation	☐	Immigration Status
☐	Oral Health	☐	Financial	☐	Sexual Risk/Partner Services	☐	Education/Job Training
☐	Nutrition	☐	Living Situation	☐	Safety Issues	☐	Other:

Step 1 Area: Indicate client's goal for this area:

Indicate at least three actions to reach this goal:

Action	Person(s) Responsible for Helping to Achieve Goal	Target Date	Date Achieved or Modified
1.		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /

Notes:

Referral s Made **OR** ☐ N/A:

Step 2 Area: Indicate client's goal for this area:

Indicate at least three actions to reach this goal:

Action	Person(s) Responsible for Helping to Achieve Goal	Target Date	Date Achieved or Modified
1.		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /

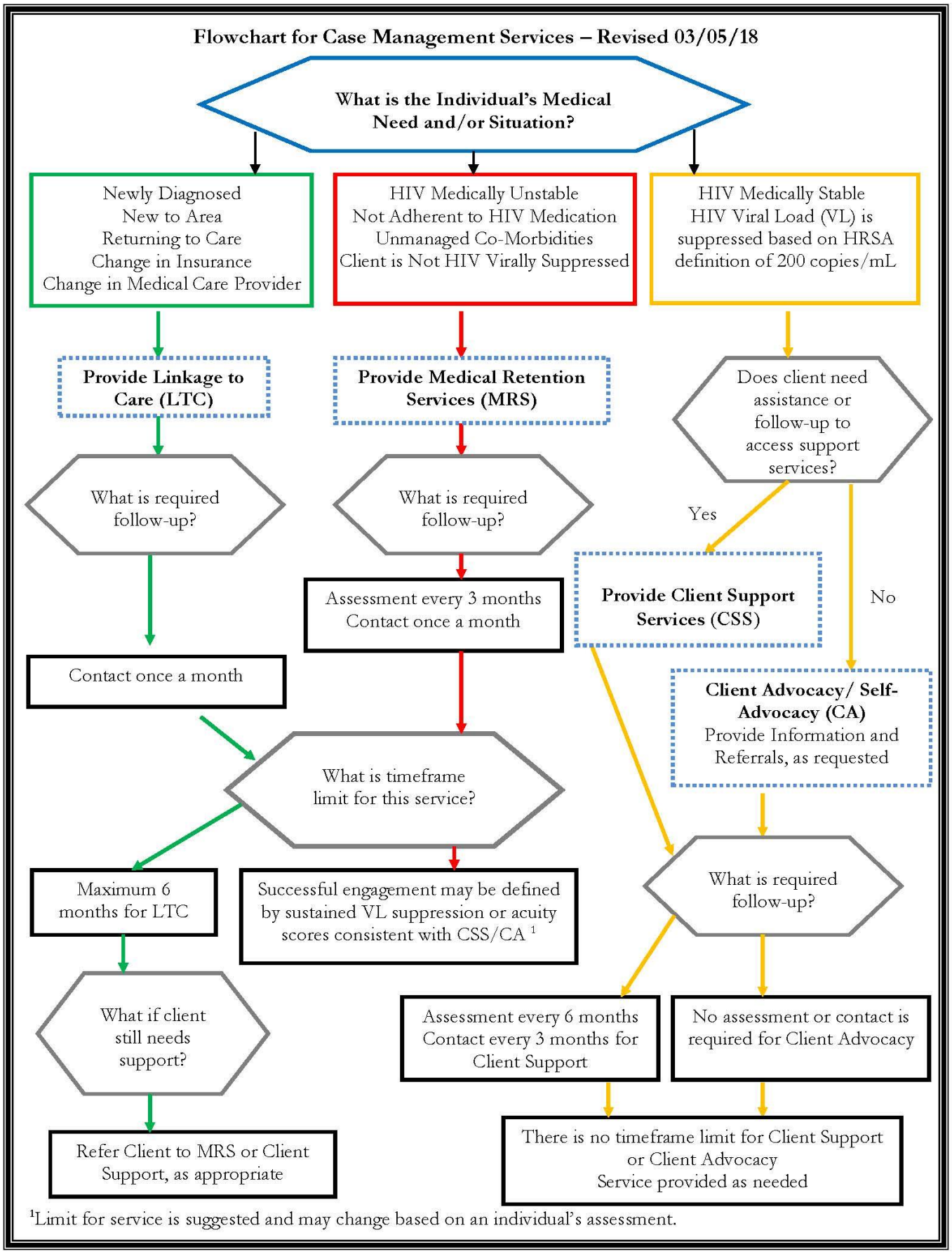
Notes:

Referral s Made **OR** ☐ N/A:

Client Name (Print) - Optional **Client Name (Signature) - Optional** **Date**

CM Name and Licensure (Print) **Date** **Clinical Supervisor Signature, If appropriate**

☐ **N/A** **Next ISP:** / / **Next Psychosocial/ Acuity:** / / **Next Eligibility:** / / ☐ **Full OR** ☐ **Self-Attestation**


Flowchart for Case Management Services – Revised 03/05/18
What is the Individual's Medical Need and/or Situation?
Newly Diagnosed
New to Area
Returning to Care
Change in Insurance
Change in Medical Care Provider
HIV Medically Unstable
Not Adherent to HIV Medication
Unmanaged Co-Morbidities
Client is Not HIV Virally Suppressed
HIV Medically Stable
HIV Viral Load (VL) is suppressed based on HRSA definition of 200 copies/mL
Provide Linkage to Care (LTC)
Provide Medical Retention Services (MRS)
Does client need assistance or follow-up to access support services?
What is required follow-up?
What is required follow-up?
Yes
No
Assessment every 3 months
Contact once a month
Provide Client Support Services (CSS)
Contact once a month
Client Advocacy/ Self-Advocacy (CA)
Provide Information and Referrals, as requested
What is timeframe limit for this service?
What is required follow-up?
Maximum 6 months for LTC
Successful engagement may be defined by sustained VL suppression or acuity scores consistent with CSS/CA [1]
What if client still needs support?
Assessment every 6 months
Contact every 3 months for Client Support
No assessment or contact is required for Client Advocacy
Refer Client to MRS or Client Support, as appropriate
There is no timeframe limit for Client Support or Client Advocacy
Service provided as needed
[1]Limit for service is suggested and may change based on an individual's assessment.