AUSTIN TGA

Ryan White Part A

HIV Case Management

Standards

Approved 2-14-2012

Table of Contents

Intent		**3**
Case Management Service Definitions		**4**
Austin TGA HIV Case Management		**6**
Policy and Procedure Requirements for all Case Management Programs		**9**
Case Manager Qualifications and Training		**10**
HIV Case Management Standards		**15**
Screening and Intake		**15**
Eligibility		**18**
Initial Comprehensive Assessment		**19**
Case Management Category, Acuity Score, Acuity Level, and Level of Service		**22**
Comprehensive Reassessment		**27**
Referral and Follow-Up		**30**
Case Closure/Graduation		**32**
Other Documents related to HIV Case Management Standards in Texas	**Appendix A**	**35**
Acronyms in HIV Prevention and Care	**Appendix B**	**37**
Substance Abuse and Mental Illness Symptoms Screener (SAMISS)	**Appendix C**	**41**
Acuity Measurement Tool	**Appendix D**	**44**
Crisis Intervention	**Appendix E**	**63**

Approved 2-14-2012

Intent

This document establishes universal core standards for HIV case management services funded by Ryan White Part A in the Austin TGA. The standards set a minimum service level for programs providing HIV case management regardless of setting, size, or target population.

Universal core case management standards were developed to:

- Promote quality of case management services
- Clearly define case management and describe levels of case management service
- Clarify service expectations and required documentation across HIV programs providing case management
- Simplify and streamline the case management process
- Encourage more efficient use of resources

The overall intent of the *Austin TGA HIV Case Management Standards of Care* is to assist providers of case management services in understanding their case management responsibilities and to promote cooperation and coordination of case management efforts.

As the numbers of Central Texans living with HIV increase and as efforts to engage individuals who are not enrolled in care into medical care escalate, the past systems of case management, many of which were operating above ideal capacity, are no longer sustainable. This current revision of case management standards was intended to develop new systems of case management in which clients are enrolled based on defined need for the service. Additionally, a new system is envisioned which acknowledges that not all HIV infected individuals will require case management and that sustainability relies on promoting self-management for those clients who are able.

Although these standards set minimum requirements for Austin TGA Ryan White Part A funded case management programs, individual agencies may establish additional requirements, modifying the standards to fit particular settings, objectives, and target populations.

Approved 2-14-2012

Case Management Service Definitions

Case management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for a person living with HIV. Medical and non-medical case management are not the provision of one-time services. The role of these services is to assist clients in identifying needs and barriers.

Case managers, through the mechanisms of advocacy, assistance and education, support the client in accessing community resources to meet those needs and reduce barriers. Clients who do not need ongoing assistance with managing their medical care do not need to be case managed if they require insurance co-payments or other vouchers only; rather, their ongoing independence should be praised and encouraged. As the client gains self-efficacy, the involvement of their case manager should decrease.

The doorway of case management should not be the only entry point to services. Since clients can be engaged in the system in an array of ways, they must be able to access medical care or other services through many different avenues. Regional or agency-based policies and practices should be constructed to help a client continue to receive ongoing support that does not require case management.

Case management systems must have clearly defined outcomes which can be monitored to ensure accountability for the delivery of the service if possible. By viewing case management as a service driven by client need, standard outcomes based on elements of those needs should be developed. The expectations for both providers and clients must be clearly stated and followed. This will strengthen the delivery of service across the TGA as well as increase the quality and consistency of service delivery by creating accountability measures for the system, the client, the case manager and the case management supervisor.

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

Approved 2-14-2012

The intended outcomes of HIV case management for PLWHA (Persons Living With HIV/ AIDS) include:

- Early access to and maintenance of comprehensive health care and social services
- Improved integration of services provided across a variety of settings
- Enhanced continuity of care
- Prevention of disease transmission and delay of HIV progression
- Increased knowledge of HIV disease
- Greater participation in and optimal use of the health and social service system
- Reinforcement of positive health behaviors
- Personal empowerment
- An improved quality of life

Key activities of HIV case management include:

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

Approved 2-14-2012

Austin TGA HIV Case Management

Recognizing changes occurring in the HIV epidemic and in the needs of persons living with HIV, the Austin TGA HIV Program currently employs four levels of case management service: Medical Case Management-RN, Medical Case Management, Non-Medical Case Management, and Patient/Client Navigation.

The following are examples of services that might be offered at each level of case management. These services are subject to funding availability.

Medical Case Manager-RN (MCM-RN)

- Pill Fill/Med Box
- Physical Assessments (vitals)
- Medication counseling (side effects, adherence, etc.)
- Lab Results
- Deliver Medical News
- Take Medical history
- Acute assessment/triage
- Referral to clinical trials
- Specialist referral/coordination
- Liaison to doctor and pharmacy
- Health Literacy

Medical Case Manager (MCM)

- HIV education
- Medical adherence (assess and treat behavioral barriers)
- Mental Health Assessment/Diagnose
- Substance Abuse assessment
- Patient Advocacy (medical settings)
- Health Literacy

Medical Case Management (MCM) is a proactive case management model intended to serve persons living with HIV/ with multiple complex health-related and basic psychosocial needs that focuses on maintaining HIV infected persons in systems of primary medical care to improve HIV-related health outcomes. The model is designed to serve individuals who may require a longer time investment and who agree to an intensive level of case management service provision.

Approved 2-14-2012

Medical Case Managers act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan. The Medical Case Manager could be one of many access points to medical care and should not serve as a gatekeeper.

The goals of this service are:

1) The development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the Medical Case Manager.

2) to address needs for concrete services such as health care, entitlements, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system.

Non-Medical Case Management (NMCM)

- Information and Referral
- Basic medical adherence (assess logistical barriers, reinforce MCM adherence plan)
- Basic health literacy
- Comprehensive Psychosocial Assessment & Service Plan (Housing, Education/Employment, Social Support, ADL, Self-Sufficiency, etc.)
- Medical visits for the purpose of client advocacy
- Forms & Applications (initial ADAP, SSI/SSDI, etc.)
- Utilize Stages of Change model to prepare clients for Participation in Medical Care or Medical Case Management

The Non-Medical Case Management (N-MCM) model is responsive to the immediate needs of a person living with HIV and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-Medical Case Management is an appropriate service for clients who have completed Medical Case Management but still require a maintenance level of periodic support from a case manager or case management team. N-MCM may involve limited coordination and follow-up of medical treatments.

Central to the N-MCM model is follow-up by the case manager or team to ensure that arranged services have been received and to determine

Approved 2-14-2012

whether more services are needed. Clients in non-Medical Case Management experiencing a repeat cycle of the same medical crisis or problem should be encouraged to enroll in MCM services, either onsite or offsite, and assisted in attaining these services.

The goal of N-MCM is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability, and to establish a supportive relationship that can lead to enrollment in MCM services, if needed.

Patient/Client Navigation (PN)

- Information and Referral
- Forms & Applications (ADAP renewal, SNAP, CHIP, HACA, etc.)
- Access to Resources (Bus Passes, Gas Vouchers, etc.)
- Transportation to medical visits
- Food pantry delivery
- Appointment reminders
- Reinforce adherence messages

The role of the patient/client navigator is to assist the patient/client in achieving designated service plan goals. The Patient Navigator will provide supportive services as listed above within their scope of competencies. Patient navigators will help patients/clients to access and move through various community/medical systems and overcome any barriers to quality care.

Approved 2-14-2012

POLICIES AND PROCEDURES (P&P) REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS

Each agency providing case management services must establish written policies and procedures specific to each of the services they provide. In addition general agency operation policies must be established and documented. The Policies and Procedures manual should be reviewed on an annual basis and updated as indicated. For additional guidance for policy development in specific service areas, please refer to the Department of State Health Services Texas HIV Case Management Standards.

Approved 2-14-2012

Case Manager Qualifications and Training

Qualifications:

Case management providers must staff their agency with qualified individuals at the case manager, supervisor, support staff and administrative levels. Each agency staff person who provides direct services to clients shall be properly trained in case management. An HIV case manager must be able to work with clients and develop a supportive relationship in order to enable clients to make the best choices for their well- being and facilitate access to and use of available services.

In order to accomplish these goals, the following have been identified by stakeholders as basic skills, traits and/or attitudes that HIV case managers should possess:

- Communication and interpersonal skills
- Creativity, flexibility and accountability
- Time management skills
- The ability to develop rapport
- An emphasis and understanding of professionalism, ethics and values
- Ability to use a strengths-based perspective when working with clients
- Utilization of a holistic approach; and the ability to establish and maintain appropriate boundaries

Training:

All case managers must meet the minimum training requirements established in this document.

The following are minimum requirements for HIV case management staff.

<u>Medical Case Manager-RN</u>
RN

<u>Medical Case Manager</u>
LMSW, LPC, LPCi, LCSW or other Master's level licensure in a related field

Approved 2-14-2012

Non-medical Case Manager

Bachelors' degree. Prefer degree in health, human or education services and 1 yr of case management experience with HIV, homeless, mental illness, substance use. Exceptions will utilize waiver process.

Patient Navigator

- High school or GED
- Prefer six months to 1 year work with target populations

Case Manager Supervisor

Case Manager Supervisors must demonstrate guidance, direction and support in providing case management services to persons living with HIV and should be skilled in directing and evaluating the scope and quality of HIV case management services.

Minimum qualifications for case manager supervisors should be a degreed or licensed individual in the fields of health, social services, mental health or a related area; preferably Masters' level. Additionally, case manager supervisors must have 3 years experience providing case management services; preferably with 1 year of supervisory or clinical experience.

The non-RN medical case managers must receive clinical supervision appropriate to their respective licensure when providing mental health diagnoses.

Waiver of Required Qualifications

Contractors may apply to the Administrative Agent for a waiver of qualifications for staff or supervisors in cases in which staff or supervisor possess nontraditional qualifications or experience that equip them to perform the job adequately.

Approved 2-14-2012

TRAINING REQUIREMENTS

Each agency is responsible for providing new case management staff members and supervisors with agency-related training that commences within 15 working days of hire and is completed no later than 90 days following hire. Mandatory training, meeting the administrative needs of any agency, should include provision of agency

policies and procedures manual and employee handbook to familiarize new staff with the internal workings and processes of their new work environment.

A record of the all trainings and performance evaluations must be included in each case manager's personnel file. The record should highlight specific training topics pertinent to the development of individual case managers (employee's initials next to each training topic), as well as training completion dates and certificates of completion (if provided) addition, all agencies receiving case management funding through Austin HHSD must comply with the following training requirements:

All case managers at agencies receiving City of Austin HHSD case management funds (both medical and non-medical) must complete the following within 6 months of hire (it is recommended that staff complete training within 3 months of hire) pending availability of training:

Initial Courses REQUIRED for all Case Managers:

1. Unified Health Communication 101: Addressing Health Literacy, Cultural Competency and Limited English Proficiency (on-line)*
2. Texas HIV Medication Program (on-line)*
3. HIV Case Management 101: A Foundation (on-line)*
4. HIV Case Management 101: A Foundation Part Two (in-person follow-up)

**These courses may be available through the TRAIN Texas learning management system.*

The above courses address the following core competencies:

- Case Management role and processes
- Funding
- Harm Reduction
- Client-Centered approach
- Medical Literacy/HIV knowledge
- Mental Health
- Patient Education Substance Abuse

Exceptions to this rule *may* be waived by Texas DSHS HIV Program training staff. For current training requirements, contact the HIV Case Management Training Specialist with the Texas DSHS HIV Program.

Approved 2-14-2012

REQUIRED Medical Case Manager Training

Beginning March 1, 2012, staff performing medical case management at agencies receiving Austin HHSD case management funds must fulfill the Texas DSHS HIV Program Medical Case Manager Competency Training Course requirements. New Medical Case Managers must complete all components of the MCM Competency Training Course within 12 months of hire (it's recommended that staff complete training within 9 months of hire). This course addresses the following core competencies:

- Medical Literacy and HIV knowledge
- Harm Reduction
- Mental Health / Substance Use
- Confidentiality/Legal/Consent
- Cultural Competency
- Intake/Assessment/Reassessment
- Patient Education
- Family Violence

**Medical Case Managers including RN receive HIV medication training appropriate to licensure.*

Ongoing Courses REQUIRED for all Case Managers

In addition, all case managers (medical and non-medical) will complete a minimum of 12 hours of continuing education annually. Training should be aimed at the following core competencies:

Core Proficiencies:

- HIV Confidentiality and the Law
- Cultural Competency
- Working with Special Populations (undocumented, LGBT, Women, African-American, Latino, over 50, etc.)
- Family Violence
- Intake/Assessment/Reassessment
- Monitoring/Outcomes Records Management
- Resource Development/Use
- Safety
- Service planning and Implementation

Approved 2-14-2012

- Ethics and HIV
- Hepatitis A, B, C
- Screening Tools (substance use, mental
- health, risk behavior)
- HIV Disclosure
- Harm Reduction
- Mental Health
- Substance Use
- Co-occurring diagnoses
- HIV Medication
- Opportunistic Infections
- STDs

Individual agencies and/or case management supervisors are responsible for monitoring case manager compliance with on-going training requirements and certification maintenance, including authorizing appropriate training opportunities to satisfy the maintenance requirements. Personnel records related to training and certification are subject to review during routine audits.

Approved 2-14-2012

HIV Case Management Standards

The following section includes each of the standards of care established for HIV case management services in the Austin TGA for Part A funded programs. Included in many standards are recommended *Best Practices*. While these are highly recommended, the *Best Practices* discussed are not TGA requirements. These standards are the minimum standards established by the TGA - agencies may require higher standards beyond this for their programs. The standards are outlined below:

- Screening and Intake
- Eligibility
- Initial Comprehensive Assessment
- Case Management Category, Level, and Minimum Client Contact
- Service planning
- Comprehensive Reassessment
- Referral and Follow-Up
- Case Closure/Graduation

Screening and Intake

When requesting services funded through the Ryan White Part A grants, all new clients and returning clients (whose case has been closed for six months) must have a screening and intake to determine eligibility and need for program services. An intake will be performed at the initial meeting in order for the case manager (or case management program staff) to collect and verify any eligibility documentation necessary to initiate services. Appropriate intervention(s) for any identified emergent need(s) will also be provided to the client at this time.

Information collected during the intake will be used to gauge client willingness to participate in case management services, as well as assist in developing future client service plan goals (short or long-term). Intakes may be performed by non-case manager staff; however, such staff should be able to successfully demonstrate a skill set (e.g. assessment, service linkage) comparable to that of a qualified case manager (per determination by their respective supervisor(s) and/or successful completion of training courses required for all case managers).

Approved 2-14-2012

Standard

Key information concerning the client, family, caregivers and informal supports is collected and documented to:

1) Determine need for ongoing case management services and appropriate level of case management services
2) Determine client eligibility
3) Establish relationship with client
4) Educate client about available services, resources and the care system

Time Requirement:

Appointment Scheduled within 10 working days of initial contact with client or designated agent (caretaker, guardian, etc.) Exceptions will be approved by supervisor and documented in client file.

Criteria:

1) When a prospective or returning client requests HIV Case Management services, information necessary to establish preliminary eligibility, presenting problem, and appropriate CM agency will be collected at initial screening (by phone or in person). Screening information includes, at a minimum:

- HIV status
- Disease stage/medical need
- Income/household size
- County of residence
- History of substance use or mental health issues
- Presenting problem

2) Client is then scheduled for an intake or referred to appropriate agency for intake.

3) Immediate needs are addressed promptly.

4) Intake documentation includes, at minimum:

a. Basic Information

Approved 2-14-2012

- Documentation of HIV status
- Contact and identifying information (name, address, phone, birth date, etc.)
- Language(s) spoken
- Literacy level (client self-report)
- Demographics
- Emergency contact
- Household members
- Other current health care and social service providers, including other case management providers
- Pertinent releases of information
- Documentation of insurance status
- Documentation of income (including a "zero income" statement)
- Documentation of state residency
- Photo ID or two other forms of identification
- Review of policies relevant to Client Confidentiality and mandatory reporting requirements (see Texas DSHS HIV Program's "P&P REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS")
- Grievance policy review
- Acknowledgement of client's rights

b. Brief overview of status and needs regarding:

- Food/clothing
- Finances/benefits
- Housing
- Transportation
- Legal services
- Substance use
- Mental health
- Domestic violence
- Support system
- HIV disease, other medical concerns
- Access to and engagement in health care/supportive services
- Prevention of HIV transmission
- Prevention of HIV disease progression

c. Acuity for both Medical and Non-medical Case Management
(See Appendix D)

Approved 2-14-2012

d. Assessment of readiness to engage in Case Management services (Stages of Change)

5) Immediate referrals should be made under the following circumstances:

- Client is in need of but not engaged in medical and/or psychiatric care
- Client demonstrates symptoms of active medical and/or mental illness
- Client is on medication but will run out in less than 10 days
- Client states they are in danger, a danger to themselves, or a danger to others
- Client indicates they are homeless (HUD definition)
- Client indicates they are about to be evicted and/or have their utilities terminated.
- Client states they have no food

Eligibility

A client with an urgent need and who doesn't have the required documentation of HIV status within 30 days and residency within 60 days may be granted conditional eligibility. All service agencies must make reasonable effort to assist clients to obtain the necessary documentation. The following are acceptable forms of documentation:

Proof of Residence

- A valid Texas Driver's License or Texas State Identification Card;
- Mortgage or rental lease agreement in recipient's name;
- Texas utility bill in recipient's name;
- A letter postmarked to a Texas address in the recipient's name in the last 30 days; or
- A letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals.

Proof of HIV status

- A positive Western Blot laboratory result that includes the name of the client;
- A report of detectable HIV viral load that includes that name of the client;
- A positive qualitative Nucleic Acid Amplification Test (NAAT) or other diagnostic assay for HIV infection approved by the Food and Drug Administration that includes the name of the client;
- A signed statement from a physician, physician's assistant, an advanced practice nurse or a registered nurse attesting to the HIV positive status of the person; or,
- A hospital discharge summary documenting HIV positive status.

Approved 2-14-2012

**Information obtained during the Intake should be shared, after client consent, with other providers to coordinate services and avoid duplication of efforts.*

Initial Comprehensive Assessment

The Initial Comprehensive Assessment is required for clients who are enrolled in case management services. It expands upon the information gathered in the intake to provide the broader base of knowledge needed to address complex, longer-standing medical and/or psychosocial needs.

The 30 days completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information. Information obtained from the assessment is used to develop the Service plan and assist in the coordination of a continuum of care that provides:

- Timely access to medically appropriate levels of health and support services,
- An ongoing assessment of the client's and other family members' needs and personal support systems,
- A coordinated effort with in-patient (including hospital and incarceration) case management services to expedite discharge, as appropriate, to access post-discharge care,
- Prevention of unnecessary hospitalization,
- An ongoing assessment of the client's knowledge of relevant disease process/processes) (i.e. HIV, Hepatitis A/B/C, other chronic conditions), medication adherence, and risk behaviors for risk reduction counseling.

Standard

An Initial Comprehensive Assessment describes in detail the client's medical, physical and psychosocial condition and needs. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated.

The assessment also evaluates the client's resources and strengths, including family and other close supports, which can be utilized during service planning.

Approved 2-14-2012

Time Requirement:

Due within 30 calendar days of Intake with client or designated agent (caretaker, guardian, etc.) and includes all required documentation.

Criteria

1. Initial Comprehensive Assessment includes at a minimum:

a) Client health history, health status and health-related needs, including but not limited to:

Core Services

- HIV disease progression
- Tuberculosis
- Hepatitis
- Sexually Transmitted Infections and/or history of screening
- Other medical conditions
- OB/GYN, including current pregnancy status
- Medications and adherence
- Allergies to medications
- Complementary therapy
- Current health care providers; engagement in and barriers to care
- Oral health care
- Vision care
- Home health care and community-based health services
- Alcohol/Drug use (see Forms section for SAMISS tool. SAMISS, or other validated substance use screening tool must be used)
- Mental Health (The SAMISS or other validated mental health screening tool must be used)
- Medical nutritional therapy
- Clinical trials

b) Client's status and needs related to:

Support Services

- Nutrition/Food bank
- Financial resources and entitlements
- Housing
- Transportation

Approved 2-14-2012

- Support systems (including disclosure of status to family and friends)
- Identification of vulnerable populations in the home (i.e. children, elderly, and/or disabled) and assessment of need (i.e. food, shelter, education, medical, safety (CPS/APS referral, as indicated)
- Parenting/care giver needs
- Knowledge of partner elicitation/notification services needs (e.g. case manager (partner elicitation), local Disease Intervention Specialist (DIS)
- Domestic Violence
- Legal needs (e.g. health care proxy, living will, guardianship arrangements, and landlord/tenant disputes)
- Linguistic services, including interpretation and translation needs
- Activities of daily living
- Knowledge, attitudes and beliefs about HIV disease
- Behavior risk assessment and risk reduction counseling
- Employment/Education

c) Additional Information

- Client strengths and resources
- Other agencies service client and collaterals
- Brief narrative summary as needed
- Name of person completing assessment and date of completion
- Dated signature of licensed staff or supervisor

2. The staff completing the Initial Comprehensive Assessment meets face-to-face with the client at least once during the assessment process.

3. If all relevant information is not received from the client by the end of the 30 days, 2 verbal and 1 written request must be filed by the case manager within 30 days of non-receipt. If no response is received from the client within the additional 30 days, the client must be discharged.

4. Completion of the Initial Comprehensive Assessment is documented in the Universal Reporting System (URS) and the client's record.

Best Practices

A comprehensive assessment performed over time rather than in one sitting is often more complete and less intrusive for a client. Information is gathered from client self

Approved 2-14-2012

report and (with appropriate releases) a variety of sources, including providers serving the client and the clients' collaterals.

Case Management Category, Acuity Score, Acuity Level, and Level of Service*

The Austin TGA HIV services program is a needs-based program which strives to provide the appropriate type and level of case management support to clients with the greatest level of need to help them access and maintain quality medical care and manage their disease effectively. Case managers will utilize two designated acuity scales, one for Medical Case Management and one for Non-medical case management, in combination with the initial comprehensive assessment in assessing the need for case management services.

*Definitions:

Acuity Score	The point total of the standard tool used to measure intensity of client need. (See Acuity Measurement Tool - Appendix D)
Acuity level	**0, 1, 2,** or **3 -** based upon the acuity score and other relevant factors
Level of service	Minimum frequency of contact and case management activities (See Chart 1 below)

Standard

Clients are enrolled in a case management category (Medical, Non-Medical, or both) and level appropriate to the nature and intensity of their needs. Acuity should also be used to help show the impact that the client will have on the system of care and ensure that case management case loads are distributed evenly at the agency level. Each acuity level will determine the expected level of service.

*** Clients at acuity level 0 will not receive (nor be enrolled in) Case Management services unless the client later presents with a higher level of need. ***

Approved 2-14-2012

CHART 1: ACUITY LEVELS AND LEVELS OF SERVICE

Acuity Level	Minimum Contact with Case Manager	Comprehensive Re-assessment	Acuity Re-Evaluation	Service Plan Update
0 *	None (contact initiated by client only)	N/A	N/A	N/A
1	quarterly	Annual, in person	every 6 months	every 6 months
2	monthly	Annual, in person	every 6 months	every 6 months, or as necessary
3	2x/month	every 6 months, in person	quarterly	every 3 months

Approved 2-14-2012

Time Requirement

Case management acuity level should be completed within 30 calendar days of the Intake and annually thereafter or as life circumstances change.

Criteria

1) Acuity scales are *tools* for case managers to use; acuity scales complement professional case management assessment interviews -- they don't replace them.

2) The case manager and the client use the Intake and/or the Initial Comprehensive Assessment to collaboratively develop a Service plan for the client based on need and client readiness. The acuity score should be based on the results of the intake/assessment.

3) The level of service of the case management intervention delivered should be assigned based on the client's current acuity score and the case manager's professional judgment. Case managers should document the rationale in the client's record when the level of service does not match the assigned acuity level or when the assigned acuity level does not match the acuity score **.

System–wide implementation issues: The determination of when a client receives both medical and non-medical case management within the Austin TGA will be decided based on client need, funding levels, community level of need for case management, and guidance from the Administrative Agent. This will not occur on a case-by-case basis but will be the result of a TGA-wide policy.

4) Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in a client's acuity should be documented appropriately.

5) There should be a clear correlation among acuity score, acuity level and case management level of service.
Client acuity must, at a minimum, be measured in the following areas:

- medical/clinical transportation
- basic necessities/life skills
- HIV-related legal
- mental health
- cultural/linguistic
- substance use
- self-efficacy in daily functioning
- housing/living situation
- HIV education and risk reduction
- support system
- employment/income
- insurance benefits
- medication adherence
- domestic violence
- Service Planning

Approved 2-14-2012

Service planning is a critical component of case management activities and guides the client and the case manager with a proactive, concrete, step-by-step approach to addressing client needs. Together, the client and the case manager identify problems and issues to address, and identify barriers to care and strategies for overcoming those barriers. The Service plan can serve additional functions, including: focusing a client and case manager on priorities and broader goals, especially after crisis periods; teaching clients how to negotiate the service delivery system and break objectives into attainable steps; and serving as a tool at reassessment to evaluate accomplishments, barriers, and re-direct future work.

Standard

Client needs identified in the Assessment/Reassessment are prioritized and translated into a service plan which defines specific goals, objectives and activities to meet those needs. The client and the case manager will actively work together to develop and implement the service plan.

Time Requirement

Following completion of the Comprehensive Assessment/Reassessment, Service plans should be updated as needed with significant changes in a client's needs. A temporary service plan may be executed following completion of the Intake based upon immediate needs or concerns.

Criteria

1. Service plan includes at a minimum:
   - Problem statement (Need)
   - Goal(s)
   - Intervention
   - Task(s) - measurable
   - Referral(s)
   - Service Deliveries
   - Individuals responsible for the activity (e.g., case manager, client, team member, family)
   - Anticipated time frame for each task
   - Client signature and date, signifying agreement
   - Minimum frequency of contact with case manager

Approved 2-14-2012

2. The Service plan should be updated for each significant new need.

3. The case manager has primary responsibility for development of the Service plan

4. Issues noted in the Service plan should have ongoing case notes that match the stated need and the progress towards meeting the goal identified.

5. A record of the completion of the Service plan Assessment is documented in the Universal Reporting System (URS) and the client's record.

Best Practices
Service plans negotiated face-to-face with clients encourage their active participation and empowerment. Service plans are living documents for planning and tracking client goals, tasks, and outcomes for specific needs and a copy should be offered to the client to emphasize the partnership.

The Service plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals. Tasks, referrals and services should be updated as they are identified or completed, not at set intervals.

In general, service plans should follow these guidelines:

- *Client centered - how does this benefit the client?*
- *Client driven - has the client expressed this as a need or have you assessed this as a need and the client agrees?*
- *Delineates responsible person(s) - who will make this appointment/decide what is to be done?*
- *Outcome based - what need will this satisfy or the client?*
- *Action oriented - what does the case manager and/or client needs to do in order to get this accomplished?*
- Time specific - what period of time has been set to get this accomplished?

Approved 2-14-2012

Comprehensive Reassessment

The Comprehensive Reassessment is required for all clients enrolled in case management services. Comprehensive Reassessment provides an opportunity to review a client's progress, consider successes and barriers and evaluate the previous period of case management activities. In conjunction with updating the Service plan, Reassessment is a useful time to determine whether the current level of case management services is appropriate, or if the client should be offered alternatives.

Standard

A comprehensive reassessment reevaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or on-going needs

Time Requirement:

Comprehensive Reassessment is required, at a minimum, annually after completion of the Initial Comprehensive Assessment, or sooner if client circumstances change significantly.

Criteria

1. If the client is receiving only one Case Management service (i.e. Medical OR Non-medical), the case manager working with the client will conduct the full assessment. If the client is receiving *both* Medical and Non-medical Case Management services, the Medical Case Manager will assess areas under Core Services, and the Non-medical Case Manager will assess areas under Support Services.

2. Each comprehensive reassessment includes at a minimum:

a. Updated personal information

- Current contact and identifying information
- Emergency contact
- Confidentiality concerns
- Household members
- Insurance status
- Other health and social service providers, including other
- Case Management providers
- Current proof of income and residency

Approved 2-14-2012

b. Client health history, health status and health-related needs, including but not limited to:

Core Services

- HIV disease progression
- Tuberculosis
- Hepatitis
- Sexually Transmitted Infections and screening history
- Other medical conditions
- OB/GYN, including current pregnancy status for females
- Medications and adherence
- Allergies to medications
- Complementary therapy
- Current health care providers; engagement in and barriers to care
- Oral health care
- Vision care
- Home health care and community-based health services
- Alcohol/Drug use
- Mental Health
- Medical nutritional therapy
- Clinical trials

c) Client's status and needs related to:

Support Service

- Support Service
- Nutrition/Food bank
- Financial resources and entitlements
- Housing
- Transportation
- Support Systems
- Identification of vulnerable populations in the home (i.e. children, elderly, and/or disables)
- Assessment of need (i.e. food, shelter, education, medical,. safety (CPS/APS referral, as indicated
- Parenting/Care Giver needs

Approved 2-14-2012

- Knowledge of partner elicitation/notification services needed (e.g. Case Manager (partner elicitation), local Disease Intervention Specialist (DIS)
- Domestic Violence
- Legal needs (e.g. health care proxy, living will, guardianship arrangements or landlord/tenant disputes)
- Linguistic Services including interpretation and translation needs
- Activities of Daily Living (ADL)
- Knowledge, attitudes, and beliefs about HIV disease
- Behavior risk assessment and risk reduction counseling
- Employment/Education

d) Additional Information

- Client strengths and resources
- Other agencies service client and collaterals
- Brief narrative summary
- Name of person completing assessment and date of completion
- Signature of licensed staff or supervisor and date

3. The case manager has the primary responsibility for the Comprehensive Reassessment and meets face-to-face with the client at least once during the assessment process.

4. If all relevant information is not received from the client within 30 days of the reassessment appointment date, two verbal and one written requests must be filed by the case manager within 30 days of non-receipt. If no response is received from the client within the additional 30 days, the client must be discharged.

5. Completion of the Comprehensive Reassessment is documents in the Universal Reporting System (URS) and the client's record.

Best Practices

A case conference with key parties before or during the reassessment process can augment and verify reassessment information and bring all parties into the service planning process. See also Best Practices under comprehensive Assessment.

Approved 2-14-2012

Referral and Follow-Up

Case management is effective when it utilizes all the resources of the community on behalf of the client. Referrals to outside agencies (including agencies outside the Ryan White system) for specified services are often needed in order to meet planning goals and to ensure that Ryan White funding is used as the Payor of Last Resort (PLR). Establishing formal links among agencies, especially through developing Memorandums of Understanding (MOU), can facilitate the information flow and referral process among providers.

What is a referral?

A referral is a joint decision between the client and case manager in which the client agrees to accept a service referral from the case manager. This referral should be to a service that the client is not currently accessing.

A referral is NOT:

- A casual suggestion to a client during conversation;

- A written comment about a potentially necessary service that appears in a client's file;

- Activities that are considered part of care coordination. For example, if a client is already receiving regular medical care, but the client has not received an annual pap smear, the case manager may suggest to the client that this would be a good idea and may even contact the physician to schedule an appointment for the client. This is not a referral to medical care since the client is already in medical care, this would be considered care coordination.

Standard

Case managers will facilitate client access to services critical to achieving optimal health and well being. Case managers will assist clients in identifying and overcoming barriers to accessing services. The case manager will advocate for the client by collaborating and working with individual service providers.

Approved 2-14-2012

Time Requirement:

Referrals should be initiated immediately upon identification of client needs.

Criteria

1) Referrals should be appropriate to client situation, lifestyle and need. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered part of the referral process.

2) The case manager will initiate referrals immediately upon a need being identified.

3) The case manager will work with the client to determine barriers to referrals and facilitate access to referrals

4) The case manager will utilize a referral tracking mechanism to monitor completion of all case management referrals.

5) Follow-up is a systematic process to determine if the client is accessing services. The case manager will ensure that clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their Service plan.

6) The case manager will document follow-up activities and outcomes in the client record and in the URS. This includes documentation of follow-up after missed referral appointments.

7) The following services require documentation beyond client self-report to be considered complete:

Medical
Dental
Mental Health
AODA

Suggested documentation for the above services includes but is not limited to the URS, contact with provider, copy of report from service provider, etc.

Approved 2-14-2012

Best Practices

To be effective, case managers should work with providers to ensure that referrals are well received and services delivered.

Agencies that coordinate with a variety of service providers and hold multiple MOUs can best meet diverse client needs.

When clients are referred for case management services elsewhere, case notes include not only documentation of follow-up but also level of client satisfaction with referral.

Case Closure/Graduation

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. A closure summary usually outlines the progress toward meeting identified goals and services received to date.

Common reasons for case closure include:

- Client completed case management goals
- Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case manager assistance)
- Client is referred to another case management program
- Client relocates outside of service area
- Client chooses to terminate services
- Client is no longer eligible for services
- Client is lost to care or does not engage in service
- Client incarceration greater than 3 months
- Agency-initiated termination due to behavioral violations
- Client death

Standard

Upon termination of active case management services, a client case is closed and a closure summary documenting the case disposition is documented.

Approved 2-14-2012

Criteria

Discharge/graduation

1. Closed cases include documentation stating the reason for closure and a closure summary (e.g., brief narrative in progress notes, formal discharge summary, etc.).

2. In the event that a consumer becomes ineligible for case management services:

a. Case manager notifies supervisor of intent to discharge consumer.

b. Case manager reports to supervisor on the client's circumstances that make them ineligible for continued services (decrease in acuity level, behavior, etc.)

3. Client is considered non compliant with care if 3 attempts to contact client (via phone, e-mail or written correspondence) are unsuccessful. Attempts to contact must be at least twenty-four hours apart. Discharge proceedings may be initiated by agency 10 working days following the 3rd attempt.

4. In accord with written policies and procedures established by each agency, the case manager notifies the client (through face-to-face meeting, telephone conversation or letter) of plans to discharge the client from case management services.

5. The client receives written documentation explaining the reason(s) for discharge and the process to be followed if consumer elects to appeal the discharge from service.

6. Client is provided with contact information and process to reestablish services.

7. Appropriate referrals are offered to the client.

Approved 2-14-2012

Best Practice

Case manager attempts to reconnect clients lost to care services may require contact with a client's known medical and human service providers (with prior written consent).

When services are terminated, an exit interview is conducted if appropriate.

Case managers attempt to secure releases that will enable them to share pertinent information with a new provider.

In situations where case closure may be involuntary or involving non-standard rationale, case managers will staff with their supervisor to secure approval for closure.

Approved 2-14-2012

APPENDIX A

Other Documents related to HIV Case Management Services in Texas

HIV Medical and Support Services Taxonomy

This taxonomy reflects service categories fundable though Ryan White Program Part B, DSHS State Services and HOPWA formula funds awarded to the State only. It may not reflect fully services fundable through other Ryan White Program Parts, direct HOPWA or other funding source.

Find it here: http://www.dshs.state.tx.us/hivstd/taxonomy/default.shtm

Child Abuse Reporting Requirements

Texas requires that all suspected cases of child abuse be reported. More information on this requirement and the process for reporting can be found in the link below.

Find it here: http://www.dshs.state.tx.us/childabusereporting/default.shtm

HIV and STD Program Operating Procedures and Standards manual

Guidelines for delivery of consistent quality services for DSHS HIV/STD contractors

Please note that program and contract policies established by the HIV/STD Program are separate documents and are not included in the HIV/ STD Program Operating Procedures manual except by reference.

Find it here:
http://www.dshs.state.tx.us/hivstd/pops/default.shtm

HIV/STD Program Procedures

Procedures developed by the DSHS HIV/STD Program.

Approved 2-14-2012

Find it here: http://www.dshs.state.tx.us/hivstd/policy/procedures.shtm

HIV/STD Program Security Policies and Procedures

Complete list of HIV/STD Program policies and procedures regarding security.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/security.shtm

HIV/STD Laws and Regulations (Texas and Federal) -

State and Federal laws, rules, and authorization regarding HIV/STD

Find it here:
http://www.dshs.state.tx.us/hivstd/policy/laws.shtm

Documenting Case Management Actions in ARIES

A guide to Ryan White and State Service funded case management agencies on the use of the AIDS Regional Information and Evaluation System (ARIES) including, but not limited to, required fields of data entry.

Find it here:
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=61670 (*PDF*)

Eligibility to receive HIV services

Requirements to receive services funded though Ryan White Part B, States Services and/ or HOPWA grants.

Find it here:
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22501 (*PDF*)

Approved 2-14-2012

APPENDIX B

Common Acronyms in HIV Prevention and Care

AA	Administrative Agency
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immune Deficiency Syndrome
AODA	Alcohol or Other Drug Abuse
ARIES	AIDS Regional Information and Evaluation System
ARV	Antiretroviral
ASH	Austin State Hospital
ASL	American Sign Language
ASO	American Sign Language
BRFSS	Behavioral Risk Factor Surveillance System
BVCOG	Brazos Valley Council of Governments (AA)
CADR	CARE Act Data Report renamed in 2007 - see RDR
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act - renamed in 2006 and 2009. Commonly referred to as the Ryan White Program
CBO	Community Based Organization
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program - Medicaid
CLD	Client Level Data
CLI	Community Level Intervention
CM	Case Manager or Case Management
CMS	Centers for Medicare and Medicaid Services (Federal)
COBRA	Consolidate Omnibus Reconciliation Act
CPG	Community Planning Group
CQI	Continuous Quality Improvement
CRCS	Comprehensive Risk Counseling and Services
D&HH	Deaf and Hard of Hearing Developmental Disabilities
DD	Developmental Disabilities
DEBI	Diffusion of Effective Behavioral Interventions

Approved 2-14-2012

DIS	Disease Intervention Specialists
DNA	Deoxyribonucleic Acid
DSHS	Department of State Health Services (Texas)
EBI	Evidence Based Intervention
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
EPT	Expedited Partner Therapy
FDA	Food and Drug Administration
FTE	Full Time Equivalent
FTM	Female-To-Male (Transgender)
FQHC	Federally Qualified Health Center
GLBT	Gay, Lesbian, Bisexual, Transgender
GLI	Group Level Intervention
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau (Federal)
HARS	HIV/AIDS Reporting System
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People With AIDS
HPV	Human Papillomavirus
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
IDU	Injection Drug Use(r)
MAI	Minority AIDS Initiative
MH/SA	Mental Health/Substance Abuse
MMP	Medical Monitoring Project
MMWR	Morbidity and Mortality Weekly Report
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men who are Injection Drug Users

Approved 2-14-2012

MTF	Male-To-Female (Transgender)
NAAT	Nucleic Acid Amplification Testing (for HIV)
NASTAD	National Alliance of State and Territorial AIDS Directors
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OMB	Office of Management and Budget (Federal)
OSHA	Occupational Safety and Health Administration
PBC	Protocol Based Counseling
PCR	Polymerase Chain Reaction (test or assay)
PEMS	Prevention Evaluation Monitoring System
PI	Protease Inhibitor
PID	Pelvic Inflammatory Disease
PLWH	People Living With HIV
PLWHA	People Living With HIV/AIDS
POL	Popular Opinion Leader
POPS	Program Operating Procedures and Standards
PSE	Public Sex Environment
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RDR	Ryan White Program Data Report (replaces CADR)
RFP	Request For Proposals
RNA	Ribonucleic Acid
SAM	System Acuity Measurement
SAMHSA (Federal)	Substance Abuse and Mental Health Services Administration
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SCSN	Statewide Coordinated Statement of Need
SEP	Syringe Exchange Program
SPAP	State Pharmacy Assistance Program
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

Approved 2-14-2012

TA	Technical Assistance
TB	Tuberculosis
TDCJ	Texas Department of Criminal Justice
TGA	Transitional Grant Area
THMP	Texas HIV Medication Program
TIPP	Texas Infertility Prevention Project
TTY	Text Telephone
VL	Viral Load
WSW	Women who have Sex with Women
YRBS	Youth Risk Behavior Survey Medical Monitoring Project

Approved 2-14-2012

APPENDIX C

Substance Abuse and Mental Illness Symptoms Screener (SAMISS)

The Substance Abuse and Mental Illness Symptoms Screener (SAMISS) - Key

Substance Abuse:

Respondent screens positive if sum of responses to questions 1-3 is equal to or greater than 5, response to question 4 or 5 is equal to or greater than 3, or response to question 6 or 7 is equal to or greater than 1.

1. How often do you have a drink containing alcohol?
Never 0 Monthly or less 1 2-4 times/mo. 2 2-3 times/wk. 3 4 or more times/wk. 4

2. How many drinks do you have on a typical day when you are drinking?
None 0 1 or 2 1 3 or 4 2 5 or 6 3 7-9 4 10 or more 5

3. How often do you have 4 or more drinks on 1 occasion?
Never 0 Less than monthly 1 Monthly 2 Weekly 3 Daily or almost daily 4

4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?
Never 0 Less than monthly 1 Monthly 2 Weekly 3 Daily or almost daily 4

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?
Never 0 Less than monthly 1 Monthly 2 Weekly 3 Daily or almost daily 4

6. In the past year, how often did you drink or use drugs more than you meant to?
Never 0 Less than monthly 1 Monthly 2 Weekly 3 Daily or almost daily 4

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to?
Never 0 Less than monthly 1 Monthly 2 Weekly 3 Daily or almost daily 4

Approved 2-14-2012

Mental Illness:

Respondent screens positive if response to any question is ''Yes.''

8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?

Yes No

9. In the past year, were you ever on medication or antidepressants for depression or nerve problems?

Yes No

10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?

Yes No

11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

Yes No

12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?

Yes No

13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?

Yes No

14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If respondent volunteers, ''Only when having a heart attack or due to physical causes.'' mark ''No.'')

Yes No

15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others?

Yes No

Approved 2-14-2012

If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?

Yes No

16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?

Yes No

This questionnaire is based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry, Medicine, Public Policy, and Community and Family Medicine; and the Health Inequities Program of Duke University.

Approved 2-14-2012

Appendix D

*** Acuity Measurement Tool **
** (to be determined) **

System Acuity Measurement (SAM) Tool (example only)

1 Medical/Clinical

This category concerns access to primary medical care, oral health services, specialty clinical care for HIV disease, physical therapy and access to HIV specific medications.

Scoring Considerations:

- General stability of health (regardless of specific diagnosis),
- Client's ability to maintain an ongoing relationship with providers of medical and clinical services,
- Client's access to and local availability of medical and clinical services, and/or,
- Client's medical condition as it relates to the amount of time you will spend with the client (case management time) and resources necessary to initiate and maintain their access to care and medications

<u>Score Suggestions</u>

1 Stable health status. Client has stable, ongoing access to primary HIV medical care and treatment. Client is fully empowered for self-care and can independently maintain medical care with information and very occasional referral.

2 Client's health stable or may have moderate health problems. Client needs active occasional assistance to access or maintain access to medical, clinical and/or oral health services.

3 Client is medically fragile but still able to maintain the activities of daily living. Client requires regular assistance to access and maintain access to

Approved 2-14-2012

appropriate medical, clinical and/or oral health services. Client may require active coordination of multiple care providers.

4 Client has serious-to-sever medical issues; may be life threatening or one-time medical crisis as a result of multiple adverse health diagnoses or events. Client may require complex coordination between multiple providers or agencies; may have end of life issues.

Notes about scoring this category:

Availability and access of medical services should be considered; limited services may lead to more time needed to assist the client in locating or coordinating among providers. This would increase the impact on the care case management system (i.e., increasing system acuity).

2 Basic Necessities/Life Skills

This category concerns food, clothing, skills related to activities of daily living (ADLs) and access to household items necessary for daily living.

Scoring Considerations:

- General ability of client to function/cope with daily activities (e.g. Get to and from work, medical appointments and/or cook for self or other dependent family members),
- Client's ability to maintain basic personal and household hygiene standards,
- Client's ability to manage activities of daily living (ADL) in light of mental health, substance use, disease progression, effects of medications, living situations, and/or education level, and/or,
- If applicable, the client's attention to a dependent family member's basic needs (i.e. clothing, feeding and caring for children)

Score Suggestions

1 Client's basic needs being adequately met; client has high level of skills, no evidence of inability to manage ADL.

2 Client has the ability to meet basic needs and manage ADL, but may need referral and information to identify available resources

Approved 2-14-2012

3 Client needs assistance to identify, obtain and maintain basic needs and manage ADL. Poor ADL management is noticeable and pronounced.

4 Client is unable to manage ADL without immediate, ongoing assistance; in acute need of caregiver services.

Notes about using this category:

There may be interactions with other categories such as mental health, substance use, and/or self-efficacy.

A person's mental health or substance use could affect their ability to deal with basic needs. However, a person's life skills may not always be affected by mental health or substance use; deficiencies could be related to other factors such as education. This category concerns the client's ability to manage their basic needs regardless of the root of their problems.

A client's ability to maintain ADL may be related to their disease progression and/or effects of medications. Fatigue related to treatment may prevent a client from brushing his/her teeth, bathing and/or cooking.

It is appropriate to consider the client's family or relationship dynamics and the role these may play in a client's ability to maintain their basic needs. Clients who are in abusive relationships might not be able to access resources for daily living because of power dynamics within the relationship (e.g. have access to money to pay for groceries).

3 Mental Health/Psychosocial

This category broadly involves the client's level of impairment with respect to emotional stability, mental health status, history of past or current clinical depression, social adjustment disorders or other potentially significant mental health issues.

Approved 2-14-2012

Scoring Considerations:

- Client's ability to demonstrate appropriate behavior and coping skills in everyday interactions and problems,
- Client's ability to deal with family and other significant relationships,
- Client's history of mental health issues (counseling, treatment, stabilization dependent on medication and/or treatment, and/or,
- Client's current mental health (harm to self or others, emotional instability, current diagnoses).

Score Suggestions

1 No known history or evidence of mental illness, high level of social functioning, appropriate behavior and coping skills.

2 History of mental illness with appropriate treatment, stabilized as a result of past treatment, ongoing compliance with outpatient counseling, emotional stability and coping skills are adequate to manage ADL, minimal difficulty in family or other significant relationships.

3 Moderate emotional stress in significant relationships, ongoing diagnosis/treatment of chronic or major mental illness, limited access to mental health services, inability to maintain adherence to psychiatric medication, inappropriate social behaviors, mild to moderate impairment in ADL.

4 Danger to self or others, highly depressed, suicidal, violent thoughts towards others, frequent or ongoing psychotic, violent or threatening behaviors, in crises, immediate psychiatric intervention needed.

Notes about using this category:

This category is weighted, reflecting the potential impact that mental health issues may have on the level of care case management time and resources needed in multiple categories. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders can be useful for understanding some of the mental health terms and most common mental health conditions such as post-traumatic stress disorder; clinically significant depression; schizophrenia; bi-polar disorder I and II and borderline personality disorder. Also, some HIV medications have potentially dangerous side effects that can trigger or mimic psychotic episodes.

Approved 2-14-2012

Mental health conditions should only be diagnosed by a qualified mental health provider licensed for clinical practice.

4 Substance/Alcohol Use

This category covers addictive, dependent or abusive use of mind/mood altering substances (alcohol, illicit, nonprescription and prescription drugs). Behavioral, legal or family-related problems associated with substance use should be considered.

Scoring Considerations:

- Client's history and current level of substance use,
- The degree to which substance use is affecting the client's ability to function,
- Concurrent mental health issues which may be aggravated by substance use, and client's willingness to acknowledge substance use issues (denial, in or seeking treatment),
- The degree to which another's substance use is affecting the client's life (child, primary relationship, adherence to medical or mental health treatment), and/or,
- Client's ability to access services (motivation, health coverage, access and availability).

Score Suggestions

1 No evidence to suggest that client's use of substances constitutes abuse or dependence; no evidence of behavioral disturbances related to substance use.

2 Client has history of substance use/moderate abuse; no current indication of dependency or abuse; may need education or referral.

3 History of substance and/or alcohol abuse and is currently using; functional difficulties because of own or family member's substance abuse; client

Approved 2-14-2012

identifies need for treatment; services are available and client has ability to access services with referral and support.

4 Ongoing substance abuse crisis, emergency medical detoxification indicated, major impairment of function, refusal of treatment services, family crises, dangerous infection-risk behaviors, etc. may require intensive effort to maintain adherence to substance abuse treatment.

Notes about using this category:

This category is weighted, reflecting the potential impact that substance use/abuse may have on care case management time and resources in multiple categories. It should also be understood that there are frequently mental health issues that are a result of substance or alcohol use and that individuals with undiagnosed mental health issues often self medicate by using legal or illicit substances. Family member or significant other's substance abuse issues may be considered in scoring this category if they have the potential to adversely affect client's recovery. It may also be difficult for persons who have a criminal record or substance use issues to access treatment services or housing, especially difficult if they are primary providers with dependents (children or adults).

5 Housing/Living Situation

This category is specific to physical shelter, living environment, access to critical utilities (heat, water, etc.) and the relationship of the client to others residing within the living environment (partner/family).

Scoring Considerations:

- Client's current physical living situation (own house, rent, homeless),
- Client's ability to pay rent, utilities and other housing requirements,
- Client's living environment, who resides with the client (dependents, partner with shared income, abusive relationship), and/or
- Client's ability to maintain access to housing services (history of incarceration, substance use, availability of housing in the area).

Approved 2-14-2012

Score Suggestions

1 Secure, fully adequate housing, stable living situation, and client is independently capable of financial and physical maintenance and is in no danger of losing housing.

2 Adequate current housing situation; client may infrequently need short-term rent or utilities assistance or may have mild stress in their living situation.

3 In transitional or unstable housing, may have unhealthy, stressful living environment. Client may be in continuous financial strain, eviction risk or risk of utility shutoff. Clients in this range are at risk of losing housing.

4 Client is homeless, in crises, living in shelter, sleeping on streets or in his/her car. Client's living situation presents immediate health hazard or physical danger from abuse. Client may be unable to qualify for housing opportunities due to criminal behavior.

Notes about using this category:

This category is weighted, reflecting the potential that inadequate, dangerous or socially untenable housing situations adversely impact care case management time and resources needed to keep the client engaged in primary HIV care or other supportive services. It is appropriate to consider the nature of the client's living situation with respect to the people they reside with; issues of domestic violence, physical and emotional abuse may adversely affect client stability. History of incarceration, substance use with client or a primary partner or dependent(s) may disqualify clients from some housing programs.

6 Support System

This category refers specifically to the network of formal and informal relationships providing appropriate emotional support to the client. This includes friends, family, faith communities, agencies and support groups.

Approved 2-14-2012

Scoring Considerations:

- Client's current support system,
- Client's level of need for additional support,
- Client's ability to identify additional supportive services, and/or
- Availability of supportive services in the area needed by the client (support groups at a time and place client can access them).

Score Suggestions

1 Client has, and is aware of, extensive, appropriate and supportive relationships providing emotional support.

2 Moderate gaps in availability and adequacy of support network. Client may need additional skills to recognize and access support.

3 Client is chronically unable to access supportive network; support that is available is inadequate and unstable; client may be new to community with no friends, family or community support; client may need routine referral and follow-up.

4 Client is in acute crisis situation and cannot or will not access supportive relationships and may be isolated and/or depressed.

Notes about using this category:

Clients with supportive needs should be referred to emotional support groups, mental health counseling or to faith communities to assist them in fostering and independent support network.

7 Insurance Benefits

This category concerns the client's eligibility for, and access to, private or public insurance coverage adequate to provide a continuum of care for medical, dental or psychosocial services. This category also includes access to HIV medications through the AIDS Drug Assistance Program (ADAP).

Approved 2-14-2012

Scoring Considerations:

- Client's current medical coverage,
- Client's current need for insurance coverage,
- Client's eligibility for private or pubic insurance benefits, and/or
- Client's ability to identify benefits and/or follow up on insurance enrollment requirements (provide needed documents, navigate the paperwork/system).

Score Suggestions

1 Client is insured with coverage adequate to provide access to the full continuum of clinical, dental and medication services available. Client may need occasional information or periodic review for renewal of eligibility.

2 Client needs assistance to complete eligibility reviews and may need directions and assistance compiling and completing documentation and application materials.

3 Client needs assistance meeting deductibles, co-payments and/or spend-down requirements. Client may need significant active advocacy with insurance representatives, providers or DSHS to resolve billing and eligibility disputes.

4 Client is without coverage adequate to provide minimal access to care, or is unable to pay for care through other sources and needs immediate assistance with eligibility reviews, etc.

Notes about using this category:

Current public and private insurance programs available in their service area may impact the SAM score in this category. Knowledge of available insurance programs and eligibility criteria is necessary to adequately evaluate clients in this category.

Approved 2-14-2012

8 Transportation

This category covers the client's ability to travel for medical, psychosocial support, groceries and other essential HIV-related purposes.

Scoring Considerations:

- Client's current transportation methods (car, taxi, bus, walking, etc.),
- Client's ability to access transportation (have money for bus, bus route close to medical care, can physically get to medical care, transportation appropriate for dependents), and/or
- Client's lack of transportation affecting their ability to access medical care or other essential needs (e.g., grocery)

<u>Score Suggestions</u>

1 Client is fully self-sufficient and has access to reliable transportation for all HIV-related needs.

2 Client needs occasional, infrequent assistance in obtaining transportation for HIV-related needs. Client may need assistance in reading and understanding bus schedules; may need referral to volunteer or other transportation services

3 Client has limited access to public transport and is having routine difficulty accessing transportation services because of physical disabilities. Clients in this category may often miss appointments due to lack of transportation.

4 Client has no access to transportation, lives in an area not served by public transport and/or has no resources available for other transportation options. Clients with this score have an immediate need to be transported to HIV-related medical or supportive services.

Approved 2-14-2012

Notes about using this category:

Current public transportation programs available in the service area may impact SAM scores in this category. Knowledge of available transportation programs is critical to adequately evaluate this category.

9 HIV-Related Legal

This category pertains specifically to *HIV-related* legal needs such as guardianship orders, medical durable power of attorney, Social Security Insurance (SSI) benefits advocacy and assignment, Living Wills, Do Not Resuscitate (DNR) orders and other needs directly related to the client's HIV status.

Scoring Considerations:

- Client's ability to identify need for legal services and knowledge of where to obtain them as they relate to their HIV status (power of attorney, guardianship for minor dependents), and/or
- Client's need for legal services directly related to their HIV disease.

Score Suggestions

1 Client has no unmet HIV-related legal needs.

2 Clients may need minimal, one time, assistance in completing documents or referral to appropriate legal services.

3 Client needs assistance identifying HIV-related legal needs and may require ongoing follow-up to insure that appropriate documents are available and appropriate orders are in place.

4 Client is in crisis situation, may not have valid power of attorney needed for immediate clinical decisions, or may be at risk of dying without a will; guardianship issues for minor children not properly resolved.

Approved 2-14-2012

Notes about using this category:

When scoring this category the focus must be on legal issues directly related to the client's HIV status.

10 Cultural/Linguistic

This category relates to the client's ability to function appropriately in spoken and written English and the client's ability to fully understand what is happening to and around them. This category also encompasses issues relating to the cultural sensitivity of providers to client's needs based on gender identity, sexual orientation, religion, age, sight/hearing/physical disability, race and ethnicity.

Scoring Considerations:

- Client's ability to read, write and speak English or other languages essential to receiving services,
- Client's ability to understand their disease with respect to their educational, linguistic or cultural competence,
- Client's ability to access linguistically and/or culturally appropriate services (medical, supportive), and/or
- Client's immigration status as it relates to gaining access to services.

Score Suggestions

1 Client has no difficulty accessing services and is capable of high-level functioning within the linguistic and cultural environment.

2 Client may need infrequent, occasional assistance in understanding complicated forms, may need occasional help from translators or sign interpreters.

3 Client often needs translation or sign interpretation. Client may by functionally illiterate and needs most forms and written materials explained. Client may be experiencing moderate barriers to services due to lack of cultural sensitivity of providers.

Approved 2-14-2012

4 Client is completely unable to understand or function within the service system, is in crisis situation and needs immediate assistance with translation or culturally sensitive system interpreters and advocates.

Notes about using this category:

It is appropriate for case managers to consider the client's full range of issues such as their first language, views on family, emotional development, spirituality, gender identity, beliefs about disease, values on alternative/non-western approaches to health care and ideas about confidentiality and disclosure. The client's immigration status may also be considered as it may cause significant stress and apprehension in seeking services.

11 Self-Efficacy

This category encompasses the client's ability to initiate and maintain positive behavioral changes, be an effective self-advocate and seek out and maintain services independently.

Scoring Considerations:

- Client's ability to make choices and put forth effort to change or access services or change behaviors (follow up on referrals, make phone calls, ask appropriate/needed questions),
- Client's ability to persist when confronted with obstacles to accessing services and/or making positive behavioral changes,
- Client's judgment of their capabilities to perform given tasks, and/or
- Client's ability to access services or make positive changes in behaviors.

Score Suggestions

1 Client is capable of initiating and maintaining access to services independently and is an effective self-advocate.

2 Client is able to initiate and seek out services with minimal assistance, may need information and referral.

Approved 2-14-2012

3 Client needs frequent assistance getting motivated for completing tasks related to their own care and often needs active follow-up to insure continued care.

4 Client is in crisis situation, unable to motivate to access needed care, unable to identify appropriate needs or actions, does not follow through on scheduled appointments. Client needs immediate care case management assistance.

Notes about using this category:

Case managers should consider the client's willingness and ability to be independent in filling out forms, making phone calls to set up their own appointments, their ability to correctly identify their own needs and their follow-through on commitments as appropriate criteria in scoring this category. A client's ability to be more self-efficacious reduces the impact on case management services in this category.

12 HIV Education/Prevention

This category covers the client's knowledge of HIV disease, HIV-transmission modes, his/her ability to identify past and present HIV transmission risk and ability and willingness to *engage* in and sustain behavior change interventions, including notifying past and present partners.

Scoring Considerations:

- Client's current and past risk taking behavior (sharing needles, anonymous sexual partners, unprotected sexual exposure, etc.),
- Client's knowledge of HIV transmission and prevention; awareness of his/her own risk,
- Client's willingness and skills level necessary to initiate and maintain risk reduction behaviors, including disclosure of HIV status with past, current or future needle sharing or sex partners,
- Client's participation in HIV behavior change interventions, and/or
- Client's history of other sexually transmitted diseases.

Approved 2-14-2012

Score Suggestions

1 Client has adequate knowledge of multiple aspects of HIV treatment and prevention; has skills necessary to initiate and maintain protective behaviors and/or engages in positive behavior change, including harm reduction programs and partner services. Client reports no recent history of STDs.

2 Client is knowledgeable about most available HIV behavior change interventions and education services; client may have difficulty initiating or maintaining protective behaviors, may not be appropriately personalizing risk and may need education and referral. Client reports no recent history of STDs.

3 Client reports significant difficulty initiating and maintaining protective behaviors, inappropriately personalizes risk or reports frequent relapse to risk-behaviors. Client may report recent history of STD infection.

4 Client is active engaging in risk behaviors, unable or unwilling to identify and personalize transmission risk. Client in need of immediate, active referral to appropriate HIV behavior change interventions.

Notes about using this category:

Case managers should consider if the client is in an abusive relationship that might limit risk reduction for HIV transmission (e.g., sex industry workers). This may increase their SAM score.

13 Employment/Income

This category refers to the adequacy of the client's income, from all sources, to maintain independent access to care and to meet basic needs.

Scoring Considerations:

- Client's current source of income (employed, depend on other's income),
- Client's current need for income to cover basic needs (head of household with dependents, excessive debt, emergency situations), and/or

Approved 2-14-2012

- Client's need for job placement/training or debt counseling.

Score Suggestions

1 Client's income is sufficient for basic needs; may be employed full-time or has alternate income.

2 Client's income may occasionally be inadequate for basic needs, may be employed part-time and may infrequently need emergency financial assistance or referral to other available services

3 Client has difficulty maintaining sufficient income from all sources to meet basic needs and requires frequent, ongoing case management referrals and benefits advocacy.

4 Client is in financial crisis and in danger of losing housing, access to basic utilities or critical health services because of inability to pay for co-pays or other bills. Client needs immediate, emergency intervention.

Notes about using this category:

Case managers should consider extenuating circumstances and conditions such as client being the head of a household with dependent children, pregnancy, genuine family emergency situations or other factors which make his/her financial situation more difficult.

14 Medication Adherence

This category refers to the client's ability to take all HIV-related medications as prescribed by their physician.

Scoring Considerations:

- Client's need, desire and readiness to take HIV-related medications,

Approved 2-14-2012

- Client's ability to take medications consistently,
- Client's ability to weigh pros and cons of taking antiretroviral medications, and/or
- Client's ability to access HIV-related medications (insurance, ADAP).

Score Suggestions

1 Client is following antiretroviral regimen, adherence greater than or equal to 95% or patient chooses not to take antiretroviral medications; no barriers to adherence; good access to resources. Client fully empowered for self-care in this category.

2 Client is on antiretroviral regimen, 90% to 95% adherent but may have some sporadic barriers to adherence. Client requires occasional case management information and referral to maintain optimal adherence.

3 Client is on antiretroviral regimen, 80% to 0% adherent, and experiencing ongoing barriers to adherence. Client needs continuing case manager follow-up to remain engaged with medication adherence programs or guidelines.

4 Client is in medication crisis, has stopped taking meds against medical advice or is being non-compliant for other reasons such as drug abuse, rapidly developing dementia, decreased ability to perform and maintain ADLs as part of disease progress, or mental health crises. Client needs immediate case management intervention.

Notes about using this category:

Case managers should consider factors such as scheduling medications around meals, side effects and the client's general ability to establish and maintain positive routines. You should also consider if the client is incarcerated, hospitalized, or detained in a mental health facility and how this may affect access to medications.

Scoring and applying System Acuity

Approved 2-14-2012

The scoring schema for interpreting SAM scores incorporates weighting applied selectively to Mental Health, Substance Use/Abuse and Housing categories. Weighted scores can suggest the level of case management services most appropriate for the client at the time of measurement.

Scoring Directions

The following formula should be used to calculate weighted SAM scores:

[Medical] + [Basic Need] + ([Mental] x [Mental]) + ([Substance] x [Substance]) + ([Housing] x [Housing]) + [Support] + [Insurance] + [Transportation] + [Legal] + [Cultural] + [Efficacy] + [Education] + [Income] + [Adherence] = Weighted System Acuity

Where the integer value (1 - 4) for each category of need from the client acuity assessment is inserted in the appropriate bracket in the above formula (Addition is indicated by '+' and multiplication by 'x').

Case Management Levels

Suggested case management levels based on weighted SAM scores:

Weighted Score	Suggested Level of CM Services
14 - 16	**Open file, but ongoing Case Management not indicated**
17 – 28	**Case Management - client monitoring**
29 – 44	**Basic Case Management**
45+	**Intensive Case Management**

Approved 2-14-2012

Sample Charting Tool

Area of Service/Date of Assessment	02/11/08	03/18/08	03/21/08	05/20/08
1 Medical/Clinical	2	1	1	1
2 Basic Necessities/Life skills	1	1	1	1
3 Mental Health	1	2	1	1
4 Substance Use	1	1	1	1
5 Housing	1	1	1	1
6 Support System	2	1	1	1
7 Insurance Benefits	1	2	1	1
8 Transportation	1	1	1	1
9 Legal	1	1	1	1
10 Cultural/Linguistic	1	1	1	1
11 Self- Efficacy	2	1	1	1
12 HIV Education/Prevention	1	1	1	1
13 Employment/Income	1	1	1	1
14 Medication Adherence	1	1	1	1
Raw Score	17	16	14	15
Weighted Score (see instructions)	**17**	**18**	**14**	**17**

Approved 2-14-2012

Appendix E

Crisis Intervention

A clear crisis intervention policy and staff training on crisis intervention help ensure quick resolution of emergencies to minimize any damaging consequences (i.e. acute medical, social, physical or emotional stress).

Standard

Agency has a policy for consumer crisis intervention that ensures all onsite emergencies are addressed immediately and effectively. This policy is reviewed and updated annually or more frequently as necessary.

Criteria

1. All consumers are provided with emergency contact information that includes resources and guidance to secure assistance outside of agency business hours upon intake.

2. Program staff is trained on agency crisis policy and how to respond to crisis situations. This training and the policy is conducted internally at each agency on an annual basis.

Approved 2-14-2012