

The Greater Hampton Roads HIV Health Services Planning Council

**HIV/AIDS Case
Management
Standards**

Revised 2010

ACKNOWLEDGMENT

The Greater Hampton Roads HIV Health Services Planning Council thanks the contributions of the Care Strategy Committee and the Virginia Department of Health, Division of Disease Prevention on these standards. Their hard work and dedication enabled this document to be completed.

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* HRSA defined core services and definitions can be found at: <http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>

INTRODUCTION

The Virginia Department of Health (VDH), Division of Disease prevention, established a committee in June 2006 to revise the standards for community-based HIV/AIDS case management with a focus on Ryan White Part B (formerly Title II) funded case management services. The Ryan White CARE Act of 1990 was amended in 1996, revised in 2000 and amended in 2004. Ryan White funds are administered through the federal Health Resources and Services Administration (HRSA).

Congress allocated funding with an emphasis on service quality and fiscal accountability. The Virginia Department of Health shared this goal of assuring quality service delivery. Therefore, the Division of Disease Prevention will continue to implement standardized expectations as a guide for HIV/AIDS case management service delivery.

The Ryan White CARE Act was reauthorized in 2006 as the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The reauthorization placed a major emphasis on provision of core medical services to include medical case management. The revised HIV/AIDS Case Management Standards reflect this requirement by emphasizing the link between case management services and medical outcomes. A complete list of service categories and definitions approved by HRSA can be found at:

<http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>.

This document represents the first major revision of the original 1997 document. A committee of case managers, members of the Part B peer review committee and representatives from the Virginia HIV/AIDS Resource and Consultation Center collaborated on this revision. They tried to work within the same framework and guidelines that guided the original committee while, at the same time, revising the practice of case management to better reflect the current state of the disease.

The Greater Hampton Roads HIV Health Services Planning Council reviewed these standards and considered them excellent standards to incorporate for case management in the Norfolk TGA making revisions to the VDH standards where necessary to meet the needs of case management in the TGA. While wanting to continue to reflect the original framework and ethical standards, the review committee also had some additional goals for this revision. These are to:

- Have the practice of case management reflect current best practice nationally and within the Greater Hampton Roads TGA.
- Expand the pool of available case managers.
- Provide clear, easy to follow standards of practice for case managers.

The standards as presented here were revised by the Care Strategies Committee of the Greater Hampton Roads HIV Health Services Planning Council and were approved and adopted by the Council in October, 2009.

As the VDH standards adopted a Definition and Guiding Principles for HIV/AIDS case management standards, and identified one theme as a major thrust of HIV/AIDS case

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management, the Greater Hampton Roads HIV Health Services Planning Council acknowledges the same:

Case management will promote independence among people living with HIV/AIDS who seek services.

In addition to establishing a focus on the client, listening actively and respecting boundaries, the Committee noted the importance of an ethical approach to case management. These basic ethical principles are broad statements regarding the major considerations in the equitable provision of HIV/AIDS case management services.

The ethical guidelines for delivery of HIV case management services must:

1. Enhance the overall availability of HIV case management services in the Norfolk TGA,
2. Allocate services based upon case management standards. Strive to benefit Clients while preventing or limiting harm or burdens,
3. Provide case management clients reasonable access and opportunity for Services, and to render entitled services equally,
4. Maintain the confidentiality of client records and other client disclosed Information,
5. Respect clients and their autonomy by honoring competent choices and Wishes, and,
6. Follow HIPAA compliance.

HIV/AIDS CASE MANAGEMENT STANDARDS: DEFINITION

There are many different definitions of case management. However, the Ryan White HIV/AIDS Treatment Modernization Act of 2006 emphasizes medical case management. Therefore, these standards reflect a medically-based definition of case management services.

DEFINITION

Medical case management is a cost effective program that includes a series of interactions between case manager and client ultimately resulting in the client reaching his or her optimum level of health, and being able to manage his or her own care.

The definition is broadly written to ensure that clients can receive case management services from a wide range of providers, with the key element being an outcome related to the client's health status and health management. It also supports the concept of medical case management described by HRSA.

HRSA issued service definitions of both "medical" and "non-medical" case management as a result of the approval of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, with definitions available at <http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>. These terms are also presented here for reference:

Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. The support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. 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) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Case Management (non-Medical) includes the provision of advice and assistance in obtaining medical, social community, legal financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

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LEVELS OF CASE MANAGEMENT

Three levels of case management service may be provided, corresponding to acuity of client need and relatedness to the medical and health needs of the client.

Comprehensive – An intensive, time limited service that includes advocacy and service coordination for clients dealing with multiple, complex service systems. Services are provided in an efficient, cost effective manner while allowing clients to reach their optimum level of overall health. Comprehensive case management must specifically have outcomes related to health status and medical care of the client, and, therefore, is always categorized as “medical case management”.

A suggested case load size for a case manager with only Comprehensive level clients is 15-25* The number of clients that can be managed by one case manager will vary depending on factors including, but not limited to, the intensity of service needed, whether clients are living in rural or urban settings and the number and type of other support systems available to clients.

The majority of clients admitted to Comprehensive Case Management will be transitioned within 18 months to Supportive Case Management, a non HIV/AIDS Case Management provider or discharged.

Supportive - A moderate to long term task oriented service that meets the immediate health and psychosocial needs of the client, at his/her level of readiness, in order to restore or sustain client stability. Supportive Case Management will also establish a supportive relationship between case manager and client that, if needed, can lead to enrollment in more comprehensive case management services. While the majority of Supportive Case Management interventions will be related medical and health outcomes and therefore be considered “medical case management”, some activities may be more appropriately defined as “non-medical case management”.

A suggested case load size for a case manager with only supportive level clients is 50-100.

If a case manager has a case manager has a case load which contains both Comprehensive and Supportive level clients, the appropriate number of clients of each level that can be effectively managed will decrease proportionately.

Limited - A service that enables access to other Ryan White services by using a case management agency for eligibility and referral. Clients who receive Limited Case Management services will receive a service specific plan according to need, annual eligibility, brief assessment, and referral. Limited Case Management does not required screening, intake or reassessment.

* Rothman, J (1992) Guidelines for case management: Putting research to professional use. Itasca, IL: FE Peacock Publishers, Inc. Muskie School of Public Service, University of Southern Maine, and Children’s Targeted Case Management practice Guidelines, July 1, 2005. Caseload Standards: APA Issues Committee Report. “Perspectives” (summer 1991): 34-36.

* HRSA defined core services and definitions can be found at: <http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>

HIV/AIDS CASE MANAGEMENT STANDARDS: QUALIFICATIONS

Case managers must be able to work effectively with clients. This entails developing a supportive relationship, facilitating access to needed services, and assisting clients to the maximum possible level of independence in decision making. The ability accomplish these objectives requires specific skills that can be acquired through education or previous work experience.

All newly hired case managers must meet the minimum qualifications as listed below.

COMPREHENSIVE/SUPPORTIVE
A Master's/Bachelor's Degree in a Human Service field OR
A Registered Nurse OR
A Master's /Bachelor's degree in Human Services related field and 2 years Case Management experience

Comprehensive case managers who have been employed at least 4 years as a case manager as of January 1, 2008 but do not meet the minimum qualifications will be allowed to continue as Comprehensive case managers. Persons with less than 4 years experience will have until January 1, 2010 to meet the minimum qualifications. If they cannot or choose not to meet the minimum standard by that time, their job duties will be changed to reflect that only Supportive Case Management will be provided.

An agency may choose to use a qualified Comprehensive case manager to provide Comprehensive, Supportive and Limited Case Management for clients. However, if an agency has only supportive case managers, clients who need Comprehensive case management should be referred to another agency. Agencies who employ only supportive case managers should have written agreements with Comprehensive Case Management agencies for referrals.

* HRSA defined core services and definitions can be found at: <http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>

Training

All newly hired case managers, Comprehensive, Supportive, and Limited, must complete a minimum training regimen within one year of their hire date. This includes:

- Case Management Standards
- Cultural Competency (1 hour annually)
- 4 hour introductory training on HIV Medical CM within 90 days of employment
- Training on (12 hours annually):
 - HIV Disease Process
 - Treatment
 - Testing
 - Legal ramifications to include confidentiality
 - Counseling and Referral
 - Prevention

If the newly hired case manager has previously obtained all the required training, he/she does not need to repeat it. Documentation of completion of the required trainings must be kept in the case manager's personnel file.

Administrative Supervision

Each agency that provides Case Management services must provide adequate supervision for staff. The supervisor should meet the same minimum educational qualifications as a Comprehensive case manager. In addition, Case Management supervisors should have at least 2 years experience working in practice that treats clients with HIV/AIDS or 2 years of other supervisory experience. Supervisors without experience in these areas are strongly encouraged to complete the same trainings required of Comprehensive case managers.

HIV/AIDS CASE MANAGEMENT AGREEMENT STANDARDS; AGENCY SCREENING

DEFINITION: Agency Screening is the **first** contact between a client and an agency and is used to gather basic information about a client and to set an appropriate time for a face to face meeting between the prospective client and an agency staff member.

PROCESS: Agency Screening is not a case management function. The service is provided by a receptionist or other administrative staff person. Not all clients will participate in a screening. If a client's first contact at a case management agency is with a case manager, the intake process will begin immediately and this will include the information gathered at an Agency Screening.

1. The client or client representative will contact a case management agency by phone or in person to request services.
2. The agency representative will obtain basic information from the client to include at a minimum:
 - Client name
 - Address
 - Contact information
 - Availability of third party insurance
 - General financial information to determine if client will qualify for services (Virginia's Ryan White Part A financial eligibility scale may be found at: <http://www.vdh.virginia.gov/epidemiologydiseaseprevntion/hcs.htm>)
 - What services are being requested
 - Who referred client to the agency
3. If the client appears to qualify for services, an appointment will be made for the client to come in for an intake. The client will be informed of:
 - The date and time of the appointment
 - What documents should be brought to the appointment
4. This information should be provided orally and in writing whenever possible. If the screening is done by phone, the information should be mailed to the client after the call.
5. If a client tries to contact an agency outside of normal business hours or otherwise leaves a message without actually talking to an agency staff person, the agency shall respond to the client's message within 3 working days of the initial contact.

DOCUMENTATION REQUIREMENTS:

- Documentation of screening contacts will be on approved agency forms.
- All documents containing client identifying information will be kept in a secure location.
- Documentation must include the date of the initial contact.
- Documentation must include the name of the person who completed the form.
- Agency Screening documentation must contain the date and time of any follow-up appointment or that the client declined an appointment.
- If a client is opened to service, the Agency Screening documentation will become a part of the client's record.

HIV/AIDS CASE MANAGEMENT STANDARDS INTAKE

DEFINITION: Intake is the process of collecting information concerning the client and his or her support system. It determines program eligibility and provides the basis for the initiation of case management standards.

PROCESS: Intake may or may not be performed by the case manager. In some agencies, there may be one person assigned to complete all intakes. All required steps must be completed by the person assigned to this function whether or not it is a case manager.

1. The staff person will have a face to face meeting with the client to complete the intake process.
2. At the first meeting, the following information will be collected:
 - Verification of medical diagnosis
 - Medical status
 - Emergency needs
 - Areas of particular concern
 - Name of physician
 - Medications
3. Some clients may need immediate assistance from a case manager. The client will be referred immediately to the case manager for assistance if at any point during the intake process, the client is found to meet one of the following criteria:
 - Currently is not in medical care
 - Taking medication but supply will run out within the next seven days
 - May be in danger to himself/herself or others

In these cases, the case manager will complete the intake process after assisting the client in receiving needed care services. **If a client may be a danger to himself/herself or others and a Comprehensive case manager is not immediately available, the client must be referred to a qualified mental health professional.**

4. Completion of the eligibility process will include:
 - Financial screening including eligibility for third party insurance (Virginia's Ryan White Part A financial eligibility scale may be found at: <http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>)
 - Providing copies of the agency's grievance procedure, and rights and responsibilities form(s)
 - Obtaining signatures on any needed release of information form

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5. If the client is unable to provide all the required financial and other documentation to determine eligibility for services during the first appointment, the case management agency is required to allow up to 45 days for the client to produce the missing documents. During that 45 day period, the agency will notify the client at least 3 times that some documentation is missing. The final notification must be in writing and include information that the client's file will be closed if the documentation is not produced. If the documentation is not in the case management agency's files within 45 days after the initial intake meeting, the client's file will be closed.
6. The initial meeting may also include gathering information on other areas such as availability of support systems, housing status, mental health status, and use of addictive substances. However, these issues, if not emergent needs, can be deferred to later visits when a rapport has been developed.
7. If during the intake process it is determined that the client is not appropriate for HIV/AIDS Case Management services and needs a referral to another provider agency, the intake staff person will initiate the referral process.
8. At the conclusion of the intake, an appointment will be made with a case manager for an assessment.
9. The intake process must occur within 10 days of the initial agency screening.

DOCUMENTATION REQUIREMENTS:

- A copy of the intake form will be kept in the client's record.
- The intake form will be signed and dated by the person completing the intake.
- Copies of all eligibility forms including the financial screening will be kept in the record.
- Documentation will show that the client received copies of the grievance procedure and the rights and responsibilities forms.
- If referrals were made to other agencies, the dates referrals were made and dates of the appointments must be included in the case management record.

HIV/AIDS CASE MANAGEMENT STANDARDS: ASSESSMENT

DEFINITION: Assessment is a collaborative process between the client, or client representative, and the case manager. The process must include at least one face-to-face interview with the client, but may also include information from other sources such as medical records or meetings with other health and human service professionals. The purpose of the assessment process is to identify:

- The extent of the client's unmet needs
- The ability of the client or the client's social network to meet these needs
- The need for improved coordination of services that are currently being used by the client
- Capacity of the medical and human services network to address the needs
- The level of case management service needed by the client (Comprehensive, Supportive, or Limited)

PROCESS:

1. Each client or his/her legal representative will meet with a case manager.
2. The assessment will evaluate the client's strengths and weaknesses in at least the following areas: (a more comprehensive list is included in Appendix A)
 - A. Medical care including adequate access to treatment
 - B. Knowledge of HIV disease process, transmission systems and prevention
 - C. Ability to adhere to medical and medication treatment
 - D. Mental health and substance use issues and services accessed
 - E. Transportation
 - F. Eligibility for public and private programs; e.g. third party insurance, Medicaid, Medicare, SSI, SSDI
 - G. Availability of informal support systems (family, friends and peers)
 - H. Communication skills, e.g. literacy, ability to effectively communicate with providers, sensory deficits
 - I. Employment
 - J. Housing
 - K. Financial resources
 - L. Legal issues
 - M. Practical assistance; e.g. child care, food, assistance with activities of daily living
 - N. Self-sustaining activities; e.g. hobbies, interests, pets, spiritual pursuits
 - O. Dental
3. The case manager should also assess barriers that restrict the client's ability to access or participate in his/her care. (A sample tool can be found in Appendix B.)
4. An Acuity Scale may be helpful as a tool to assess a client's severity of need in the context of a full psychosocial assessment (see Appendix F).

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5. The case manager must also identify any other case managers who are currently working with the client. Though optimal service would need only one case manager, many programs require the use of a program specific case manager, e.g. HOPWA, or Mental Retardation services. Even within HIV/AIDS service programs, it is not uncommon for a client to have a case manager assigned by a medical provider and another in a Community Based Organization, especially when the client lives in a rural area. During the Assessment process, the case manager must identify other case managers, if any, so the plan of care can address collaboration and avoid duplication of service.
6. To qualify for HIV/AIDS Case Management, the client must need assistance in one of the following areas:

COMPREHENSIVE CASE MANAGEMENT	SUPPORTIVE CASE MANAGEMENT	LIMITED Clients must be enrolled in Comprehensive or Supportive Case Management prior to entering Limited Case Management.
<ol style="list-style-type: none"> 1. Lack of adequate knowledge of HIV/AIDS disease process and treatment. 2. Multiple unstable HIV related medical conditions (to include psychiatric diagnoses). 3. Ineffective treatment, including but not limited to, declining laboratory values and/or client self reported non-adherence to drug or medical treatment regimen. 4. Need for frequent support to access HRSA defined core services.* 	<ol style="list-style-type: none"> 1. The need for episodic support to access any of the HRSA defined core medical service.* 2. Transportation services if provision of transportation will ensure the client receives core services. 3. An emergent or periodic need for assistance in non core services other than transportation. Clients needing assistance in these services more than twice in a calendar year must be referred to other agencies for ongoing assistance, within 30 calendar days of the second request for help 	<ol style="list-style-type: none"> 1. Case manager will complete brief assessment relative to need for referral. 2. An emergent or periodic need for assistance in non core medical services other than transportation, not to exceed twice in a calendar year. Clients needing assistance in these services more than a twice in a calendar year must be referred to other agencies for ongoing assistance or moved to Supportive Case Management, within 30 days of the second request for help.

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It is anticipated that many clients will move between Comprehensive and Supportive Case Management services multiple times as their needs and disease status changes.

7. Clients that need Comprehensive Case Management services should be able to receive that service. Agencies that offer only Supportive Case Management services should have agreements with Comprehensive Case Management agencies to provide the higher level of service to clients. However, if it is impossible to arrange Comprehensive Case Management for a client, it is permissible for the client to receive only Supportive Case Management. The reason for the provision of the lower level of service must be documented in the client's record. If the reason for the lower level of service is that the client refuses the higher service, the case manager should work with the client over time with the goal of moving him/her to Comprehensive Case Management at a later time.
8. The assessment must be completed within 30 calendar days of intake. If the assessment is not completed within this time frame, the record must include documentation which explains the delay.

DOCUMENTATION REQUIREMENTS

- Assessment must include name of the assigned case manager, title, signed and dated.
- Assessment must indicate the level of case management to be provided.
- Assessment must include initial score(s) on outcome measure(s) to be utilized.
- If client is not opened to case management, record must include any referrals to outside agencies including date of referral, and date of appointment at outside agency.

Each client will be assessed to determine if he/she currently receives primary medical care and assisted with establishing linkages to primary medical care, if care is not currently received.

Medical Case Management shall coordinate a Primary Medical Care appointment for consenting client within one (1 week) of client consent to be referred to medical care.

MCM Client Record/Progress notes evidence a medical focus, and include assessment of need for cored medical and support services; HVI/AIDS status, updated lists of current medications, treatment adherence assessments/interventions, laboratory monitoring values and other medically relevant documentation, including diagnosis of new OIs and other health issues. For Comprehensive and Support Services only.

If MCM cannot confirm client's maintenance and/or participation in PMC and MCM cannot successfully contact client to establish service activity, a referral to Outreach/Case Finding is appropriate. MCM must demonstrate an attempt to contact client with a minimum of 3 client contacts (2 by telephone and 1 by letter, if possible).

- Documented lack of PMC participation in the client record, along with documented efforts to unsuccessfully reach/re-engage client.
- Confirmed referral to Outreach is documented in the client record.

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- Example means to identify “at risk” or Out of Care:
 - ✓ “No-show for PMC appointments.
 - ✓ Erratic appointment compliance.
 - ✓ Confirmation or suspicion of active substance abuse and/or undertreated mental health issues; homelessness, or other existing issues that complicate one’s opportunity to remain optimally in care.

- Example responses once client is identified ‘at risk’
 - ✓ 24 hour prior to appointment reminder phone calls.
 - ✓ Contact “no-shows” within 48 hours following failure to appear to reschedule missed appointment (caveat: frequently changed phone #s/addresses)
 - ✓ Once client has missed appointment and contact is not verified to confirm why they missed, referral can be made to Targeted Outreach provider for services based on MCM assessment.

HIV/AIDS CASE MANAGEMENT STANDARDS: SERVICE PLAN DEVELOPMENT

DEFINITION: Service planning is the process of detailing client’s goals and needs and developing an action plan to achieve these goals or meet the needs while assisting the client to achieve a positive medical outcome.

PROCESS:

COMPREHENSIVE	SUPPORTIVE
<ol style="list-style-type: none"> 1. The case manager will meet with each client or client representative to jointly develop the individual service plan (ISP). 2. For each need, the ISP must address the following areas: <ol style="list-style-type: none"> A. Goal B. Expected medical outcome for the goal (from Outcome Measurement Scale in Outcome Measures section) C. Actions to be taken to reach the goal D. Person responsible for completing each action E. Target date for completion of each action F. Results from each action (outputs) G. Actual medical outcome showing benefit of result of action <p>The anticipated frequency of contact should be included in the actions section. Information should include estimated frequency for face-to-face and collateral contacts.</p> <p>It is recommended that ISPs also include information on client strengths and on barriers to accomplishment of the goals. While the client continues in case management, the ISP must continue to address the medical need(s) identified at assessment.</p> 	<ol style="list-style-type: none"> 1. Each client or client representative will meet with the case manager to identify issues/areas in which he/she needs assistance and expected medical outcome for each. 2. For each contact, the case manager will document: <ol style="list-style-type: none"> A. The issue being addressed B. Outcome to be used C. Actions taken by the case manager/client. D. Results from actions, when appropriate. 3. Progress toward achievement of medical outcomes will be measured using the Outcome Measurement Scale found in the Outcome Measures section of the Standards and documented in the record at each reassessment. 4. As new issues are identified between assessments, they will be added to the Issues List. 5. The Issues List must be completed within 15 working days of the completion of the assessment.

COMPREHENSIVE	SUPPORTIVE
<p>3. The ISP must be completed within 45 calendar days of assessment. If the ISP is not completed within this time frame, the record must include documentation which explains the delay.</p> <p>4. Each ISP must include a section on preparation for discharge or transition. The target date for completion must be within 18 months of the date the client was admitted to case management services.</p>	

DOCUMENTATION REQUIREMENTS

COMPREHENSIVE	SUPPORTIVE
<ul style="list-style-type: none"> • ISP must be signed by the client and the case manager, including title. • ISP must be dated. • ISP must include name of the assigned case manager. • If client has multiple case managers, the ISP must include information on how they will work collaboratively to meet the needs of the client. • The record will reflect that the client was offered a copy of the ISP and whether or not the client received a copy. • See Appendix D for sample ISP. 	<ul style="list-style-type: none"> • Issues List must be signed and dated by client and case manager, including title. • If a separate Issues List is not maintained in the record, the client must initial and date the first entry for each issue. • The record will reflect that the client was offered a copy of the Issues List and whether the client accepted the copy. • If client has multiple case managers, the record must include information on how they will work collaboratively to meet the needs of the client. • Each entry must be signed and dated by the case manager, including title. • See Appendix D for sample documentation.

HIV/AIDS CASE MANAGEMENT STANDARDS: SERVICE PLAN IMPLEMENTATION

DEFINITION: Service plan implementation provides a structured, accountable approach to show how the case manager is assisting the clients to meet their goals or fulfill their needs and move toward independence.

PROCESS:

COMPREHENSIVE	SUPPORTIVE
<ol style="list-style-type: none"> 1. Case manager will meet with client at least two times monthly. Contact with medical providers or other service providers may also be necessary. For clients within 6 months of transitioning to Supportive Case Management or discharge from service, the frequency of visits may decrease to once per month. 2. If the client has multiple case managers, the HIV/AIDS case manager will contact the client's other case manager(s) at least quarterly to ensure there is no duplication of services or efforts and client's needs are being addressed in the most effective and efficient manner. 3. Case manager will evaluate progress toward outcome measure at each reassessment. 4. The ISP must show progress toward improvement with a goal of transitioning to a lower level of case management or independence within 18 months of initiation of service. Clients with extremely complex needs can continue in Comprehensive Case Management longer than 18 months as long as the record shows the client is continuing to progress. 5. If a client is found to no longer meet the criteria for any Case Management service (Supportive or Comprehensive), he/she will be offered Supportive service for a maximum of 90 days. This transition will allow time to ensure client is stable. If client remains stable, he will be closed to service at the end of the 90 day period. 	<ol style="list-style-type: none"> 1. Case manager will contact the client at least once in each 6 month period for a case management service as identified during the initial visit. (The six month reassessment visit will not meet this requirement.) 2. Case manager will evaluate progress toward outcome measure at each reassessment. 3. If client is found to no longer meet the criteria for any Case Management service (Supportive or Comprehensive), he/she will be allowed to continue in Supportive service for a maximum of 30 days. This transition will allow time to ensure client is stable. If client remains stable, he/she will be closed to service at the end of the 30 day period.

| DOCUMENTATION REQUIREMENTS:

COMPREHENSIVE	SUPPORTIVE
<ul style="list-style-type: none"> • Each visit or contact with client or other provider on behalf of the client will be documented on the ISP or in the progress notes. • Each note will be dated and signed by the case manager, including title. • Clients who are maintained in Comprehensive Case Management for longer than 18 months must have justification for the continuation of service in the record. • If a client has more than one case manager, the record must show documentation of regular (at least quarterly) contact with other case managers. • See Appendix D for sample ISP. 	<ul style="list-style-type: none"> • Each visit or contact with client or other provider on behalf of client must be documented on a case management form or in a progress note. • Each note will be dated and signed by the case manager, including title. • If a client has more than one case manager, the record must show documentation of regular (at least once every six months) contact with any other case managers. • See Appendix D for sample documentation.

HIV/AIDS CASE MANAGEMENT STANDARDS: REASSESSMENT

DEFINITION: Reassessment is a collaborative process between the client, or client representative, and the case manager. The purpose of the reassessment process is to ensure continued progress in meeting consumer needs and identify new needs or problems.

PROCESS:

Reassessments should focus on medical care, medications and client issues that have been identified in previous assessments, in addition to identifying new concerns or problems. While some clients will transition toward increased independence and stability over time, increased or newly identified needs may result in the transition of a client to a more intensive level of case management. Although time frames are presented that correspond to level of case management, reassessments may occur whenever there are changes in a client’s situation or need. It is preferable for reassessments to be completed during a face-to-face meeting between the case manager and the client. If this is not possible, it is permissible to reassess by phone.

COMPREHENSIVE	SUPPORTIVE	LIMITED
<ol style="list-style-type: none"> 1. Client or representative will meet with case manager every 90 days to complete reassessment. 2. Reassessment will focus on previously identified issues and particularly on progress towards items found in the ISP. 3. The Reassessment process will lead to revisions in the ISP. 4. Each goal on the ISP must show a current score from the Outcome scale using Outcomes identified at previous Assessment/Reassessment. (If goals are changed, the new ISP may utilize new Outcome measures.) 5. Client must continue to meet at least one criterion for Comprehensive Case Management. 6. If a client is found to no longer meet the criteria for any Case Management service (Supportive or Comprehensive), he/she will be offered Supportive service for a maximum of 90 days. This transition will allow time to ensure client is stable. If client remains stable, he/she will be closed to service at the end of the 90 day period. 	<ol style="list-style-type: none"> 1. Client or representative will meet with case manager every 180 days to complete reassessment. 2. Reassessment will focus on previously identified needs. 3. Case manager must ask client about other concerns or needs, but does not need to complete a full assessment. 4. Client must continue to meet at least one criterion for Supportive Case Management. 5. If client is found to no longer meet the criteria for any Case Management service (Supportive or Comprehensive), he/she will be allowed to continue in Supportive service for a maximum of 30 days. This transition will allow time to ensure client is stable. If client remains stable, he/she will be closed to service at the end of the 30 day period. 	<p>Client or representative will meet with case manager once per year for eligibility and brief reassessment.</p>

DOCUMENTATION REQUIREMENTS:

- Reassessments will be documented on forms approved for use by the Case Management agency
- Reassessment must be signed by the case manager, including title.
- Reassessment must be dated.
- Reassessment must document the level of case management to be provided and show how client continues to meet criteria for that level of case management.
- If client is closed to case management, record must include any referrals to outside agencies including date of referral, and date of appointment at outside agency.
- Sample tools may be found in Appendix C.

HIV/AIDS CASE MANAGEMENT STANDARDS: OUTCOME MEASURES

DEFINITION: Outcome measurement is a quantitative method of monitoring case management services. Outcomes are measured to ensure that case management services are adequately meeting the needs of the client.

PROCESS:

1. The case manager will choose an outcome measure for each goal in the ISP (Comprehensive) or each service area (Supportive).
2. At the development of the ISP or Issues List, the case manager will assign a score of 3-0 for each goal or service area.
3. The same outcome measure can be used for more than one goal/issue. For example, "Access to care" could be used for clients needing help with transportation and help with finding a dentist. Adherence could be used for clients on new drug regimens and attending substance abuse treatment sessions.
4. If an ISP/Issues list includes services not covered by Ryan White funding, such as pursuing educational goals or returning to work, the outcome measure used for these activities should usually be "Access to Care - core services or support services".
5. The case manager will rescore the client on each goal or service area at the following intervals:
 - Comprehensive- when ISP is reviewed or every 90 days, whichever comes first.
 - Supportive-at least once every 6 months when the reassessment is completed.
6. If a client gets a score of 0 in any area, the client is no longer in need of case management services for that goal or service.
7. It is expected that scores will fluctuate over time, both up and down, as a client's situation changes.

DOCUMENTATION REQUIREMENTS:

- Documentation of the outcome score will be on the initial ISP/Issues List and then at each reassessment.
- ISPs and Issues lists must contain an easily identified space for recording outcome scores.

OUTCOME MEASUREMENT SCALE

Level of Intervention	Intensive	Moderate	Minimal	Independent
Outcome Score	3	2	1	0
Health Status	Health unstable, lab values deteriorating or physical side effects increasing or new health issues are emerging. Case manager needed to intervene with medical staff for client at more than 75% of appointments	Health stable, lab values stable, no new side effects developing and side effects being controlled. No new health issues emerging. Case manager intervenes with medical staff at more than 30% of appointments	Improving. Lab values stable or improving. Other health conditions stable or improving by quantitative measure. Case manager needed to talk with medical staff at less than 30% of appointments	Maintaining health status without help/oversight from case manager
Knowledge of HIV and treatment	Needs education intervention more than 1 time/month	Needs education intervention at least once every other month	Needs education intervention less than once per quarter	Demonstrates knowledge of HIV disease and treatment
Access to third party payment	Has not tried to access third party payer despite possible eligibility	Application in process. No final determination	Has alternate payment source, but needs assistance with co-pays and other costs	Fully utilizes third party payment source without assistance from case manager
Adherence to medications or treatment plan(s)	Needs assistance to maintain adherence more than one time per month	Needs assistance to maintain adherence at least once every other month	Needs support to maintain adherence once per quarter or less	Maintains 95% adherence to medication regimens or treatment plan without assistance
Access to care-core services or support services	Needs assistance to access services at least once per month	Needs assistance to access services at least once every other month	Needs support to access services once per quarter or less	Accesses needed services without assistance
Access to medical care	Not in care	In care less than 6 months or missing more than 50% of appointments	In care, but missing 10-50% of appointments	In care and compliant, missing less than 10% of appointments

HIV/AIDS CASE MANAGEMENT STANDARDS: DISCHARGE

DEFINITION: Discharge is a systematic process that occurs when the consumer no longer requires case management services or when the consumer and case manager are unable to work in partnership. The purpose of discharge is to assure the consumer as smooth a transition as possible from cessation of services to the next step in his or her life.

PROCESS: Discharge from Case Management services will occur when one or more of the following conditions are met:

1. The client no longer meets any of the criteria for Case Management services.
2. Client transfers to another location or service provider.
If a client transfers to another location, agency, or service provider, (including a non HIV/AIDS case manager), a discharge summary will be provided on request. If a client moves to another area, the case manager will make a referral for case management services in the new location.
3. The case manager is unable to locate or contact the client within designated time frames, the client will be closed.

COMPREHENSIVE	SUPPORTIVE	LIMITED
The client is unable to be located by the case manager after three documented contact attempts over a 6 month period.	The client has not contacted the case manager in the previous 6 month period. The case manager will make 2 documented attempts to contact the client over the next 90 days.	The client does not come for the annual eligibility determination and there is no response to one documented attempt to contact the client.

4. The client self reports that services are no longer needed. An exit interview will be conducted.
There may be clients who do not consider services a priority or overriding issues may interfere with the development or continuation of a partnership. In the case of overriding issues, agencies are strongly encouraged to refer these clients to agencies skilled in service provisions of any problem area.
5. Administrative Discharge
Clients who engage in behavior that threatens the safety or confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by the Executive Director of the AIDS Service Organization or, in other settings, the appropriate manager. The results of this review must be documented in the client's record. Clients who are discharged for administrative reasons must be

provided notification of and reason for the discharge in writing, and must be notified of possible alternative resources. An agency may also discharge consumers who purposefully falsify information to secure or duplicate resources and/or services. An administrative review will be necessary for re-admission to be considered, with the reviewing agency making documented recommendations to prevent a reoccurrence.

6. Death

In the event of a client's death, local procedures regarding closure of a file shall be initiated. Agencies are strongly encouraged to utilize local resources for the "affected" of the deceased, as well as for their own staff's and volunteers' bereavement counseling.

Whenever possible, the case manager should meet with the client in a face-to-face interview prior to discharge. If a face-to-face meeting is not possible, the case manager should attempt to talk with the client by phone. If no verbal contact is possible, the case manager must send a certified letter to the client's last known address to notify the client of discharge.

There may be instances where there is disagreement about the discharge, i.e., the client threatens the safety or confidentiality of others. If the client disagrees with the case manager regarding the reason for discharge, the client shall follow the agency grievance procedures for resolution. This process shall include the agency case manager, client, and administrative staff.

DOCUMENTATION REQUIREMENTS:

- A discharge summary must be placed in each client's file within 30 days of discharge. This summary shall include:
 1. Client's name
 2. Date services began
 3. Special client needs
 4. Services needed/actions taken
 5. Date of discharge
 6. Reason for discharge
 7. Referrals made at time of discharge

- A written discharge notice which simply indicates the fact of discharge, not a summary, may be forwarded to external service providers, with whom the agency has been authorized by the client to share information, within 30 days of the discharge.

HIV/AIDS CASE MANAGEMENT STANDARDS: OVERALL QUALITY ASSURANCE

DEFINITION: Overall Quality Assurance assures the delivery of consistently high quality case management by providing ongoing improvement in service delivery in increasingly efficient and effective practices.

PROCESS:

The quality assurance effort for both Comprehensive and Supportive Case Management providers will consist of the following elements, at a minimum:

1. Agency descriptions of and protocols for HIV/AIDS case management that incorporate the Greater Hampton Roads HIV/AIDS Case Management Standards.
2. A written description of the case management model being used by the agency (for example, Service Broker Model, Comprehensive Model, Interdisciplinary Team, etc.). Agencies may choose the model which best fits their capabilities. However, they must be able to show how they are implementing the chosen model in their practice.
3. Specific training for all agency service providers who perform case management tasks.
4. Supervision for staff members or volunteers involved in case management to include routine performance and consumer record reviews. Frequency of supervision should be appropriate to the level of case management provided. For example, a caseload of all Comprehensive Case Management clients would require more frequent review than a caseload of all Limited Case Management clients. If an agency does not have a person on site that is qualified to provide clinical review of case management records and clinical supervision of case managers, the agency is required to provide this service through arrangements with an outside agency. The Virginia HIV/AIDS Resource and Consultation Center will provide assistance with clinical supervision activities to those agencies without resources to do so, and may be contacted at (800) 525-7605.
5. Regular presentation of cases by case managers to peers and supervisors to plan and refine interventions.
6. Internal and external reviews (see accompanying standards for "Quality Assurance Site Visits").
7. Formal collection, analyses and application of consumer satisfaction indicators to include, at a minimum, annual consumer satisfaction measurement.

Elements 1 - 3 will be implemented prior to the initiation of HIV/AIDS case management services.

Elements 4 - 7 will be implemented within one year of initiating HIV/AIDS case management services.

Case Management agencies are encouraged to develop linkages with HIV testing sites that will facilitate the referral of persons newly diagnosed with HIV into case management services.

DOCUMENTATION REQUIREMENTS:

All case management agencies will keep an ongoing record of quality assurance activities performed, findings, recommendations, actions taken and results. The record will include:

- Results of consumer satisfactions surveys
- Actions taken to improve services resulting from consumer satisfaction surveys
- Other areas needing improvement, including actions taken, results of actions and impacts of improvement on later activity.

HIV/AIDS CASE MANAGEMENT STANDARDS: QUALITY ASSURANCE SITE VISITS

DEFINITION: Periodic internal and/or external reviews to identify areas of strength and areas in need of improvement.

PROCESS:

Internal – The agency will conduct an internal review at least every 24 months, during years when there is no external review. The review will be conducted by agency staff but the team may include outside persons such as grantee staff. The team must include the agency’s case management supervisor. The internal team will review 10% of active and closed cases for compliance with the Greater Hampton Roads HIV/AIDS Case Management Standards.

External – An external review will be conducted at least every 2 years. Grantee will assemble a team of independent external reviewers. The team will review a minimum of 10% (or 10 records whichever is greater) of active and closed cases for compliance with the Greater Hampton Roads HIV/AIDS Case Management standards.

DOCUMENTATION:

Internal – Reviewers will prepare a summary report which must include, at a minimum:

- Date of the review
- Number of charts reviewed
- List of participants
- A summary of findings
- Signature of the leader of the review team

A copy of the report must be kept in the agency’s Quality Assurance file along with any follow-up done to correct problems found during the review. This file will be made available to the external review team on their next visit.

| External – Reviewers will prepare a written report which details findings of the team.

APPENDIX A

COMPREHENSIVE LIST OF AREAS THAT CAN BE USED FOR ASSESSMENT

The Assessment section of these Standards lists the minimum areas that must be reviewed during and Assessment. Many case managers include other areas in their assessments. This Appendix contains a comprehensive list of issues that may be of concern to clients.

COMPREHENSIVE LIST OF AREAS THAT CAN BE USED FOR ASSESSMENT

1. Client health history, health status, and health-related needs, including but not limited to:
 - HIV disease progression
 - tuberculosis
 - hepatitis
 - sexually transmitted diseases
 - other medical conditions
 - OB/GYN, including current pregnancy status
 - ability to adhere to medical and medication treatment plans
 - allergies to medications
 - dental care
 - vision care
 - home care
 - current health care providers; engagement in and barriers to care
 - clinical trials
 - complementary therapy.
2. Client's status and needs related to:
 - nutrition
 - financial resources and entitlements
 - housing (including results of home visit to assess living situation)
 - transportation
 - support systems
 - identity (e.g. gender identification, sexual orientation, age, race, etc.)
 - translation services
 - identification of children and separate assessment of children's needs
 - identification of friends, family or others who are affected by clients HIV status
 - parenting needs
 - partner notification needs
 - HIV disclosure status/issues
 - alcohol/drug use/smoking history and current status
 - mental health
 - domestic violence

- legal needs (e.g. health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes)
 - activities of daily living
 - knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission
 - employment/education.
3. Additional information:
- client strengths and resources
 - other professionals or providers serving client

APPENDIX B

TOOL FOR ASSESSING BARRIERS

This tool is provided as an example only. It may be adopted and or revised by case management providers. Utilizing a form for assessing barriers to care is not required by the Case Management Standards. However, some case managers find this type of tool to be helpful when doing initial assessments.

BARRIERS TO FOLLOW-THROUGH WITH MEDICAL CARE

Indicate each barrier mentioned by the client during this contact. Mark the barrier as “mentioned” whether the client emphasized the barrier or only briefly mentioned it. (Note: This list should not be read as a list.)

	Barriers to Care	Client Mention of Barrier
	Logistics	
1.	Didn't have a way to get there/ transportation problem	
2.	Costs too much/no insurance coverage	
3.	Haven't been able to find the right doctor or clinic	
4.	Homelessness	
5.	Didn't know where to go	
6.	Too far to go	
	Shame/Fear/Hopelessness	
7.	Don't want my employer to know	
8.	Don't want my insurance to know	
9.	Don't want my family/friends to know	
10.	Family, friends, others would disapprove of seeking help	
11.	Too embarrassed	
12.	Afraid to find out what they had	
13.	Thought treatment would be unpleasant/painful	
14.	Fear of being treated rudely or unkindly	
15.	Feel too hopeless	
16.	Didn't think anyone could help	
	Drugs/Alcohol	
17.	Not ready, I still want to use alcohol and/or drugs	
	Not Ready	
18.	Felt well/had no symptoms	
19.	Not ready for treatment	
20.	Putting it off	
21.	Just didn't want to deal with it	
22.	Didn't want treatment	
23.	Treated self	
	Doctor/Clinic	
24.	Too difficult to get admitted to care	
25.	Clinic hours not convenient	
26.	Care was not available when needed	
27.	Had to wait too long to get an appointment	
28.	Had to wait too long in clinic	
29.	Could not get an appointment	
30.	Doesn't like doctors or clinics	
31.	Didn't know what kind of doctor to see	
32.	Don't want to be around sick people	
	Afraid won't understand	
33.	I won't understand what's going, I don't speak English	
34.	Afraid because I don't have citizenship	
35.	Don't have proper identification	
36.	Won't understand what's going on, doesn't read or write very well	
	Too busy/No time	
37.	Too busy taking care of someone else right now (child, parent, someone who is sick)	
38.	Child care not available	
39.	Couldn't take time off work	
40.	Other:	

Case Manager Signature: _____

APPENDIX C

SAMPLE REASSESSMENT TOOLS

These tools are provided as examples only. They may be adopted and or revised by case management providers to simplify the reassessment process. Agencies are also free to utilize their own forms so long as the form captures all the required information.

RYAN WHITE REASSESSMENT FORM

NEED	Indicate Need (✓)	COMMENT
Medical care provider		
Insurance		
Medication		
Medication Adherence		
Adherence to medical care/appts.		
Employment		
Mental Health Treatment		
Substance Abuse Treatment		
Safer sex Education		
IDU harm reduction		
Stable housing		
Stable finances		
Transportation		
Vision Care		
Nutrition (special diet or supplements)		
Literacy issues/primary language		
Social support (partner/friends)		
Family support		
Legal issues (i.e., recent incarceration, probation, parole)		
Legal planning (i.e., living will, power-of-attorney, guardianship of children)		
Knowledge of HIV/AIDS disease process – HIV 101		

Case Manager Signature: _____ Date: _____

CASE MANAGEMENT NEEDS ASSESSMENT

Name:	Newly Dx'd? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Needs Level	Lowest				Highest				
Dimension	1	2	3	4	Notes				
Physical Health	Asymptomatic	Minimal	Moderate	Significant					
Mental Health	No History	Treatment	Failed Treat	Serious					
Substance Abuse	Never	Prior Treat	Periodic	Frequent					
Basic Needs	Independent	Some Asst	Limited	Unable					
Living Situation	Self-managed	Ltd problems	Unsafe	Homeless					
Financial Resources	Stable	Adequate	Inadequate	None					
Vocational	Employed	Temporary	Unemploy ed	Unable					
Legal Affairs	None	Needs help	Reqs. Asst	Full asst.					
Transportation availability	Consistent	Has access	Irregular	None					
Support System	Reliable	Questionable	During crisis	None					
Self-sustaining Activities	Regular	Needs	Resist	Isolated					
Other Agency Linkages	None	Inadequate	Barriers	Mult. Probs					
Adherence	100%	Occasional	Frequent	Serious					
Other									

Medication Adherence	
Started Taking Meds	
What helps most taking meds on time?	
Problems taking meds:	
Last dose missed	
Med(s) problems/side effects	
Viral load and CD4 values	Don't know <input type="checkbox"/> Approximately <input type="checkbox"/> Know exactly <input type="checkbox"/>

Significant Findings	
Refer to Case Management? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Staff Signature	Date:
Consumer Signature	Date:

APPENDIX D

Sample Documentation Formats

This Appendix includes sample formats for an ISP, Supportive Case Management Issues List and Supportive Case Management Documentation.

These tools are provided as examples only. They may be adopted and or revised by case management providers. Agencies are also free to utilize their own forms so long as the form captures all the required information

CLIENT'S CARE PLAN

THIS CARE PLAN IS PROVIDED AS A SAMPLE ONLY FOR ISP DEVELOPMENT FOR THE VDH HIV/AIDS CASE MANAGEMENT STANDARDS. APPLICABILITY MAY VARY BY AGENCY.

Client Goal(s):

1. To establish coverage under Medicaid

Medical Outcome(s):

1. Access to third party payment
2. Access to medical care

List Active Barriers, Current or Potential:

1. Client's fear of HIV disclosure
2. Client's unfamiliarity with Medicaid application process
3. Transportation challenges

Client Name: JOHN SMITH

Birth date: 00/00/00

ID Number: 123456

Physician: DR. JONES

CM: MARY DOE

Appointments:

Reassessment Date:

Discharge Date and Reason:

Action Steps	Person(s) Responsible	Target Date	Results	Medical Outcome (Date)
GOAL: #1 1. Client will complete Medicaid application. 2. Application will be mailed to DSS. 3. Call DSS in 45 days from submission to check status. 4. Client will receive education and orientation to Medicaid covered services, including medical transportation.	Smith with help of Doe Doe Smith, helped by Doe as needed. Doe	1/5/08 1/15/08 3/1/08 3/15/08	Application completed on 1/6/08	M.O. #1: 1/1/08: Baseline: 3 1/6/08: 2 M.O. #2: 1/1/08: Baseline: 2

By signing I acknowledge that I am enrolled in case management services and participated in my service plan development and review. I agree to participate in activities to reach my established goals. I have received a copy of the care plan.

Client's Signature

1/1/08

Date

CM Signature

Date

Client's Signature

Date

CM Signature

Date

SUPPORTIVE CASE MANAGEMENT ISSUES LIST

Client Name John Doe Date _____

Case Manager _____

ISSUES IDENTIFIED

Issue	Date Identified	Outcome Measure to be used	Initial Outcome score	Case Manager's Initials	Client's Initials	Date Issue Resolved
Lack of transportation	2/9/2007	Access to medical care	2			
Assistance with paying for medications	2/9/2007	Adherence to medications	3			
Assistance with paying for medical care and making appointments	3/15/2007	Access to medical care	2			

This is only one possible format for recording supportive case management actions. Agencies may choose any format they prefer, including the use of narrative progress notes, that captures all the required information.

SUPPORTIVE CASE MANAGEMENT DOCUMENTATION FORM

Identified Need Medication Co-pays
 Approval _____

Client _____

Expected Medical Outcome(s) Adherence to Medications or treatment plans

Initial Score for Medical Outcome 1 _____

Date: 9/1/2006

DATE	ACTION TAKEN	FOLLOW-UP	OUTCOME SCORE	COMMENT	CM SIGNATURE
9/1/2006	Authorized payment for 3 months of Sustiva, Truvada and insulin	Client picked up medication at XYZ Drugs on 9/8		no gap in medication	
11/15/2006	Contact from client. Has lost some medications, needs replacements. Will be out of meds tomorrow. Called doctor for prescription. Authorized payment for 2 month supply of meds. Information on adherence given	Client picked up meds on 11/15.	2	Need to follow up in one month. Reinforce importance of medications and adherence.	

This is only one possible format for recording supportive case management actions. Agencies may choose any format they prefer, including the use of narrative progress notes, that captures all the required information.

APPENDIX E

About Acuity Scales

An “Acuity Scale” is a tool that can be used to measure the intensity and severity of a client’s condition. This can be useful in guiding the case manager’s assessment and client progress, and can help identify serious problems that need attention. While an Acuity Scale can be a helpful tool, it should be used in the context of a full psychosocial assessment, as it can be challenging to try to accurately quantify human behavior and human need.

Acuity Scales can be impacted by factors particular to a geographical area or a community. VDH supports the development of Acuity Scales that meet regional and community need and does not feel that a singular statewide scale is required at this time. However, it is important to have a level of confidence in the Acuity Scale used, and to periodically assess its appropriateness and usefulness. To assist with this process, the following criteria are recommended to guide evaluation of Acuity Scales:

Acuity Scale Assessment Guidance Questions

Suggestion: Pull a sample of client files (10 files or 10% of caseload) from both Comprehensive and Supportive Case Management levels and assesses the following:

- 1) What is the distribution of acuity levels across the client population? Are the majority of clients receiving a similar score? Does this make sense when looking at the client’s overall assessment?
- 2) How do service units correlate to acuity levels? Are clients with high acuity scores actually requiring high numbers of services units?
- 3) What do “typical” clients look like in each of the acuity levels? What are common issues, and what are differences?
- 4) For clients that may not “fit” the acuity scale, what are their needs and issues? Why don’t they “fit”? Do any patterns emerge?
- 5) What are case managers’ perspectives on and recommendations about the acuity scale? Where does the scale work well? How does the scale work poorly? How can the scale be improved?

A variety of Acuity Scales are used nationwide and in Virginia. If you would like more information or examples of these tools, contact the Division of Disease Prevention’s Health Care Services Unit at (804) 864-7964.

