DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Medical Case Management

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Medical Case Management is the provision of a range of customer-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous customer monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the customer's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Customer-specific advocacy and/or review of utilization of services

Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

Residency: The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

1. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
- A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
- Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information

8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of 'no change' when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

COMPREHENSIVE NEEDS ASSESSMENT

The Comprehensive Needs Assessment is an information gathering process to identify customer issues and care needs. It is a cooperative and interactive process between a customer and Medical Case Manager. The Medical Case Manager collects, analyzes, synthesizes, and prioritizes information which identifies customer needs, resources, and strengths for the purposes of developing an Individualized Care Plan (ICP) to address those needs.

Each customer will participate in at least one face-to-face (in-person, video, or telephonic) interview with their assigned Medical Case Manager within ten (10) business days of determining Ryan White eligibility to complete the Comprehensive Needs Assessment.

Customer Assessment is an ongoing process and is used to evaluate progress, identify unresolved and/or emerging needs, guide appropriate revisions in the Individualized Care Plan (ICP), and inform decisions regarding discharge from HIV Medical Case Management (MCM) services and/or transition to other appropriate services. Customer Assessments must also be conducted in the event of significant changes in the customer's life.

COMPREHENSIVE NEEDS ASSESSMENT		
Standard (Function Area)	**Essential Elements for Assessment**	**Measure**
Provider must assess customer for Access to Care and Support *This section describes the customer's needs and eligibility for health benefit programs and support services to assist him/her in establishing, maintaining, and participating in medical care and treatment services.*	• Assess for: • Medical care provider with HIV treatment history, including date of last appointment • Health Insurance and Benefit coverage, including Veteran's status • Income/Financial Resources/Assistance monthly totals (customer &household) • Cultural values and beliefs/practices that may impact access to medical care and services • Linguistic needs, including communication and literacy skills • Access to transportation to medical appointments • Social support and HIV disclosure status	Documentation of assessment in customer's record signed and dated by medical case manager
Provider must assess customer for Health Status *This section captures general aseline health information and identifies health benefits and other*	• Activities of Daily Living (ADLs), including amount of assistance needed. (If receiving home health or personal chore services, include contact information) • HIV disease progression; past opportunistic infections (OI) • Hospitalizations (HIV and non-HIV-related)	Documentation of assessment in customer's record signed and dated by medical case manager

support service providers involved in the customer's care.	• Co-morbid Diseases (such as Tuberculosis and/or Hepatitis) • Allergies • Vaccination history • Oral Health Needs (include date of last visit) • Nutritional status and needs, including Supplemental Nutrition Assistance Program (SNAP) formerly known as food stamps and/or nutritional supplements • Vision care needs, such as problems reading or driving (include date of last visit) • Obstetrics/Gynecology (OB/GYN) Care, including reproductive history and needs (include date of last visit) • Family Medical History • Clinical trials (if engaged, contact nature and sponsor of trial, location, and time period)	
Provider must assess customer for Treatment Adherence *This section identifies past and potential barriers to treatment.*	• Assess for Clinical trials (if engaged, indicate type of trial, sponsor of trial, location, and time period) • Most recent viral load and CD4 count, with dates • HIV Drug-resistance testing • Current and previous Antiretroviral (ARV) regimens and date of initiation of ARV therapy • Previous adverse ARV drug reactions • Previous adverse reactions to drugs used for OI prophylaxis • Treatment Adherence to past regimens and/or appointments, including barriers (physical, emotional and/or environmental)	Documentation of assessment in customer's record signed and dated by medical case manager
Provider must assess customer for Health Knowledge *This section evaluates the customer's knowledge of general health and HIV.*	• Health Literacy • HIV Knowledge: Understanding of HIV and treatment	Documentation of assessment in customer's record signed and dated by medical case manager
Provider must assess customer for Behavioral Health *Behavioral Health details any emotional or cognitive disorder and/or addictive behaviors diagnosed, displayed, or reported by the customer and the impact of these behaviors on the customer's ability to collaborate with health care professionals and adhere to health care regimens.*	• Mini-assessment of current mental health status (e.g., depression, or at risk of harm, etc.). Check to see if medical care staff completed a Global Appraisal of Individual Needs-Short Screener (GAIN-SS) or other mental health and Substance Abuse assessment. If not, use the GAIN- SS (complete GAIN-SS online) or other assessment that has been approved by DOH/HAHSTA that addresses all the following: ○ Familial history of mental health, substance abuse or tobacco use ○ Mental health history/diagnoses ○ Psychotropic medications (name, purpose, and duration) ○ Past psychiatric hospitalizations (when, where, why, and duration) ○ Past and current history of use of any of the following substances: ▪ Street drugs, marijuana cocaine, heroin, methamphetamine, 3,4-	Documentation of assessment in customer's record signed and dated by medical case manager. Include summary of GAIN-SS assessment on file

	Methylenedioxymethamphetamine (MDMA)/ecstasy ▪ Illicit use of prescription drugs ▪ Alcohol ▪ Frequency of use and usual route of administration or length of sobriety ▪ Risk behaviors—drug/needle sharing, exchanging sex for drugs, sexual risk-taking while under the influence of drugs or alcohol ▪ History of mental health and/or substance use disorder treatment and barriers to treatment ▪ Use of tobacco products, include number per day and date started ▪ Past partners notified since HIV diagnosis ▪ History of sexually transmitted infections ▪ Sexual practices—vaginal, anal, and/or oral ▪ Risk behavior assessment, including use of latex or polyurethane barriers, and/or number of partners ▪ Also see risks associated with Behavioral Functions	
Provider must assess customer for status of Children and Families *Describes the customer's primary, self-identified familial relationships particularly any individual's dependent on the customer for basic life needs, the level of support needed to assist the customer in sustaining these primary relationships; and the degree to which these relationships impact the customer's ability to adhere to recommended medical practices;*	• Marital status • Dependent responsibilities: list name, relationship, living arrangements, age, HIV status, HIV disclosure status and status of relationship and backup support plan. • Level of support needed to assist the customer in sustaining their primary relationships • Degree to which their relationships impact their ability to adhere to recommended medical practices	Documentation of assessment in customer's record signed and dated by medical case manager
Provider must assess customer for Social and Physical Environment *Describes the customer's current social and physical environment, how contributing environmental factors either support or hinder the customer's ability to maintain medical care and achieve positive health outcomes, and the level of external support needed to address critical barriers to successful outcomes.*	• Housing information as it impacts customer's access and engagement in medical care services • Employment, including work hours and issues affecting getting to medical appointments or taking medication at work • Current status of health and pharmacy insurance • Level of education /literacy assessment • Family and partner contacts • Stability of personal relationships • Domestic violence screening to determine if customer is perpetrator • Physical and/or Sexual Abuse screening to determine if customer is a victim • Legal Issues, including immigration, guardianship, denial of health insurance or disability benefits, wills, and power of attorney • Living will and health care proxy • Permanency planning for dependent children (for customers with severely advanced disease) • Incarceration history that could affect housing or employment	Documentation of assessment in customer's record signed and dated by medical case manager

ACUITY SCALE

Acuity is the intensity or severity of condition or service need. Using the information collected during the assessment, the medical case manager will complete an acuity scale to determine the intensity level of MCM services/level of care (LOC) and frequency of visits/interactions the customer needs. The LOC must be documented on the Individualized Care Plan (ICP). The acuity scale must address all of the specific areas of functioning as assessed by the comprehensive needs' assessment. As the customer's needs change over time, the medical case manager will reassess them at prescribed increments, to ensure the most appropriate level of care is provided. Acuity scale must be completed for each customer (Medical case manager must use the detailed Acuity Scale attached in the appendix).

ACUITY SCALE		
Standard (Function Area)	**Essential Elements for Assessment**	**Measure**
Provider must complete the acuity scale for each customer per the seven function areas	All the function areas of the acuity scale include 1. Access to Care & Support Services 2. Health Status 3. Treatment Adherence 4. Health Knowledge 5. Behavioral Health Knowledge 6. Children & Families 7. Social & Physical Environment	Documentation of intensity level of MCM services according to acuity scale
Medical case manager and customer signs the completed acuity scale	N/A	Signed acuity scale on file

Acuity Scale "AT-A-GLANCE"

Ranges of Summary Acuity Score				
Points	**Health Status/Medical Condition**	**Support System**	**Management Level**	**Frequency**
25 - 35 Points	Medically stable without Medical Case Management assistance undetectable Viral Load	Able to manage supportive needs without assistance	Self-Management	Face to Face at least once every 6 months for reassessment no phone contact indicated
36 - 50 Points	Medically stable with minimal Medical Case Management assistance	Able to manage supportive needs with minimal Medical Case Management assistance	Basic Management	Face to Face every 6 months with at least one phone contact every 3 months
51 - 74 Points	At risk of becoming medically unstable without Medical Case Management assistance	Support systems are not adequate to meet Client's immediate needs without Medical Case Management assistance	Moderate Management	Face to Face a minimum of every 3 months with at least one phone contact monthly.
75-100 Points OR TRIGGER	Medically unstable and in need of comprehensive Medical Case Management assistance Viral Load > 10,000 copies/ml	Has no support system in place and unable to manage supportive needs without comprehensive Medical Case Management assistance	Intensive Management	Face to Face at least once a month with phone contacts weekly

INDIVIDUALIZED CARE PLAN

The Individualized Care Plan (ICP) should document long- and short-term goals and objectives to improve the customer's health care outcomes. It should be reviewed and modified based on the acuity level identified. Within ten (10) business days of determining Ryan White eligibility, the MCM will develop the Individualized Care Plan with input from customer. Progress notes should document the development of the Individualized Care Plan and whether the customer was offered/received a copy.

In an ongoing interactive process with the customer, problems are identified and prioritized. Identified problems are addressed through a planning process that includes the mutual development of goals, assigned activities and reporting outcomes.

The Individualized Care Plan (ICP) should contain the following:

- Prioritized goals and measurable objectives responding to customer needs and addressing barriers.
- Planning tasks and action steps to be completed to help a customer meet his/her goals with a specified timeframe. The name of the person who will be responsible for the assigned task: either the customer, the Medical Case Manager, or both; should be notated.
- Referrals for support services.
- Documentation of the customer's participation in primary medical care.
- Notation of ongoing HIV education/counseling.
- Customer signature and date, signifying participation with development and agreement with Plan (see sample MCM plan on page 32)

INDIVIDUALIZED CARE PLAN		
Standard (Function Area)	**Essential Elements for Assessment**	**Measure**
Providers must develop ICP for each customer	All identified needs must be addressed	Documentation on customer's records
Provider and customer must agree to prioritize goals	The needs prioritized according to customer's expectations	Documentation on customer's records
ICP must contain measurable objectives for each goal	Reasonable goals	Documentation on customer's records
ICP must have action steps to actualize the objective	Steps must be actionable and personal responsible identified	Documentation on customer's records
ICP must have specific timeframe	Reasonable timeframes identified	Documentation on customer's records
Provider should make referrals for support services in ICP	N/A	Documentation on customer's records
Provider must provide ongoing HIV education/counseling in ICP	N/A	Documentation of education on customer's records

TREATMENT ADHERENCE COUNSELING

The medical case manager is responsible for the provision of treatment adherence counseling to ensure readiness for or adherence to complex HIV/AIDS regimens. Information about the customer's readiness for treatment should be shared with the prescribing physician. Treatment adherence must be incorporated into the Individual Care Plan to support the customer with taking all their medications as prescribed, making, and keeping appointments; addressing barriers to care and treatment; and reducing risky behaviors by encouraging therapeutic lifestyle changes, as necessary. The agency must have clear policies and procedures for missed appointment follow-up, especially with customers who are homeless, peri-incarcerated, pregnant, or report no contact information.

TREATMENT ADHERENCE STRATEGIES TO REINFORCE THROUGHOUT THE MCM PROCESS		
Standard (Function Area)	**Essential Elements for Assessment**	**Measure**
Provider must assess health/pharmacy coverage during Intake to Treatment Adherence Counseling	Assess if the customer has health/pharmacy coverage, such as ADAP, Medicare Part D, or Medicaid, etc. If not, provide with information on available programs and link with entitlement coordinator/benefits specialist or a non-medical case manager for further assistance. Assess if the customer is engaged in HIV medical care. If not, link with a provider or schedule for medical appointment. Assess if the customer has a pharmacy. If not, link with a community pharmacy for filling prescriptions.	Documentation of health/pharmacy coverage in customer's records
Provider must conduct Treatment Adherence needs assessment	Use the treatment adherence section of the biopsychosocial assessment, which can be supplemented with a more in-depth tool. Identify barriers to treatment adherence For customers on ARVs, reinforce adherence	Document identified need/gap in customer's records
Provider must develop Treatment Adherence Individualized Plan	Develop individually tailored intervention strategies to address barriers and maintain optimal adherence. Communicate with the primary care provider.	Treatment adherence individualized plan in customer's records
Provider must implement and monitor Treatment Adherence Plan	Monitor viral load and CD4 count. Educate on adherence to avoid resistance and encourage viral suppression. Use adherence tools to support customer. Assist customers to maintain active status in any health/drug payer programs (e.g., ADAP, Alliance, Medicare Part D, and Medicaid, etc.).	Document viral loads, CD4 counts and adherence educations in customer's records
Provider must conduct re-assessment of customer's Treatment Adherence plan	Ensure re-establishment of access to health and/or drug payer programs (e.g., ADAP, Alliance, Medicare Part D, and Medicaid, etc.) if there has been a lapse in services (customer has been out of care or is out of medication). Ensure customer is recertified in any lapsed health/drug payer programs (e.g., ADAP, Alliance, Medicare Part D, and Medicaid, etc.). Identify new barriers that could influence adherence and incorporate into the Care Plan.	Updated treatment adherence care plan in customer's records

COORDINATION & MONITORING OF MCM INDIVIDUALIZD CARE PLAN (ICP)

There must be at least one documented contact with active customers every 90 days or as dictated by customer need. The medical case manager must monitor the Care Plan and document the customer's progress on their goals.

The customer record should include:

1. Progress notes for each contact
2. Progress notes recording activities on behalf of the customer to implement the Care Plan
3. Progress toward Goals
4. Communication with referring agency i.e., if appointments were kept and medications prescribed
5. Maintain contact with customer by phone or at face-to-face meetings. Depending on customer need
6. Documentation of follow-up for referred services
7. Documentation of follow-up to missed appointments
8. Address emergency situations as they arise.
9. Adjustment to Care Plan if necessary
10. Case conferencing when necessary
11. Crisis intervention when necessary

COORDINATION & MONITORING OF MCM INDIVIDUALIZED CARE PLAN (ICP)	
Standard (Function Area)	**Measure**
Provider must monitor ICP to ensure goals and objectives are met	Document every contact in progress notes Document progress toward Goals
Provider must maintain contact with customer by phone, face-to-face meetings or through any other technology depending on customer need and adhering to the acuity level of care	Documentation of contacts on customer's records

REFERRALS AND LINKAGES

The medical case manager will refer the customer applying for medical, social, financial, housing and/or other needed services as specified in the customer's Individualized Care Plan.

REFERRALS AND LINKAGES		
Standard (Function Area)	**Essential Elements for Assessment**	**Measure**
The medical case manager will refer the customer to agencies for services not available in their organization	Agencies may refer for medical, social, financial, housing and/or other needed services as specified in the customer's Individualized Care Plan	Communication with referring agency (i.e., if appointments were kept and medications prescribed)
Medical case manager may arrange for peer to escort customer to referred agencies depending on the acuity level of customer	N/A	Documentation of follow-up for referred services
The referring provider must write a summary note of the customer's care and the needed services	N/A	Summary note in customer record and send to referring agency

FORMAL REASSESSMENT OF NEEDS

A formal re-examination of the customer's condition needs and resources to identify changes which occurred since the initial or most recent assessment.

The Re-assessment should include:

1. Individualized Care Plan updates must occur at least every six months.
2. Summary of progress in achievement of goals must be documented in customer's file.
3. Review of customer's clinical, financial and support needs to identify changes and/or additional service needs.
4. Multidisciplinary team case conference with other providers, when appropriate.
5. Re-assessment for Nutritional, mental health, oral health, and substance use disorder issues should be completed annually.

TRANSITION & DISCHARGE/CASE CLOSURE	
Standard (Function Area)	**Measure**
Case Closure/Discharge a. Reasonable efforts must be made to retain the customer in services by phone, letter and/or any communication method agreed upon by the customer. b. The provider will make appropriate referrals and provide contacts for follow-up. c. Provider must have a summary of the services received by the customer	The provider must document the date and reasons for closure of the case including but not limited to: service provided as planned, no contact, customer request, customer moves out of service area, customer died, customer ineligible for services, etc. Prepared summary in the customer's record.
Case Transfer a. If the customer is being transitioned, the provider must facilitate the transfer of customer records/information, when necessary. b. The customer must sign a consent to release of information form to transfer records which are specific and date	Provider must document the date and reasons for transfer and transfer summary in customer's records Documentation of signed release of information on customer's records

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

Medical case managers must be able to work effectively with their customers, developing supportive relationships, facilitating access to needed services, and assisting customers in achieving their maximum possible level of independence in decision making. The ability to accomplish these objectives requires specific skills that can best be acquired through education and previous work experience. The required qualifications are as follows:

Medical Case Manager

- Licensure as a Physician, Nurse or Social Worker in the jurisdiction(s) in which services are rendered, and
- A minimum of one (1) year experience working with HIV case management or relevant adult/pediatric community health work- clinical or hospital based

Medical Case Management Supervisor

- Licensure as a Physician, Registered Nurse (RN), Nurse Practitioner (NP), or as an Advanced Level (Graduate/Clinical) Social Worker in the jurisdiction(s) in which services are rendered, and
- A minimum of three (3) years' experience working with HIV case management or relevant adult/pediatric community health work- clinical or hospital based. One (1) year of supervisory experience, preferred.

MEDICAL CASE MANAGER EDUCATION REQUIREMENTS AND TRAINING

The minimum education and/or experience requirements for Medical Case Managers are:

1. All Medical Case Management staff must complete a minimum training regimen within one year of their hire date that includes: (a) HIV Case Management Standards, (b) training in HIV 101 to include HIV disease processes, treatment, testing, legal ramifications to include confidentiality, counseling/referral, and prevention, (c) cultural competency, and (d) AIDS Drug Assistance Program (ADAP)/Insurance training. If newly hired Medical Case Managers have previously obtained all the required training, they do not need to repeat it. Documentation of completion of required trainings must be kept in the Medical Case Manager's personnel file
2. All Medical Case Managers must complete at least 12 hours of continuing education in an HIV-related care program each year. Documentation of completion of continuing education must be kept in the Medical Case Manager's personnel file.
3. All Medical Case Management staff must complete all required training as prescribed by the recipient/administrative agent.

PARA-PROFESSIONALS IN A MEDICAL CASE MANAGEMENT TEAM

Medical Case Managers may be supported by highly skilled para-professionals who provide high-quality services that support the implementation of Medical Case Management Services under the supervision of the Medical Case Manager/MCM Supervisor. These professionals can be integrated into a tiered structure that ensures appropriately provided medical monitoring, planning, advocacy, and linkage to care, including Treatment Adherence services. Some examples are Medical Care Technicians, Assistant Medical Case Managers, etc.

Qualifications for the para-professionals are as follows:

1. Associate's/Bachelor's degree in health or human services related field preferred. High School diploma or GED required.
2. A minimum of 2 years of experience working with persons living with HIV or at high risk of HIV acquisition preferred.
3. Ongoing education/training in HIV-related subjects.

Agency will provide new hires with training regarding confidentiality, customer rights, and the agency's grievance procedure.

V. CLINICAL QUALITY MANAGEMENT

Include at least one performance measure in the clinical quality management program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

VI. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024. The next annual review is July 31, 2025.

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Appendices

Acuity Scale for Adults

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Access	Describes the Customer's need and eligibility for *health benefit* programs and support services to assist him/her in establishing, maintaining, and participating in medical care and treatment services.			
Medical Home **Score_____**	☐ Customer is not engaged in medical care; **OR** ☐ Customer is *newly diagnosed* with HIV and needs assistance navigating the system of care; **OR** ☐ Customer uses the ER as their primary care provider.	☐ Customer has been engaged in medical care for less than 6 months; **OR** ☐ Customer has had **more than one** reported ER visit in 12 months.	☐ Customer is engaged in medical care more than 6 months but less than 12 months; **OR** ☐ Customer has had **at least one** reported ER visit in the last 12 months.	☐ Customer is engaged in medical care for longer than 12 months.
Access *(continued)*				
Health Insurance/ Benefits	☐ Customer is without medical coverage adequate to provide minimal access to care; **OR**	☐ Customer needs assistance to complete applications for *health benefits*	☐ Customer has medical insurance but insurance is inadequate to obtain care;	☐ Customer is insured with adequate coverage to provide access to the full continuum of clinical care including dental and

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____ _	☐ Customer is unable to pay for care through other sources and needs immediate medical assistance.	(Medicaid, Alliance, ADAP, etc.); **OR** ☐ Customer needs directions and assistance compiling and completing *health benefit* documentation or application material; **OR** ☐ Customer's application(s) for *health benefits* is pending.	**OR** ☐ Customer needs assistance in meeting *deductibles, co-payments* and/or *spend-down requirements*; **OR** ☐ Customer needs significant active advocacy with insurance representatives to resolve billing disputes.	medication services. Customer may only need occasional information or periodic review for renewal eligibility.
Access *(continued)*				
Cultural/ Linguistic	☐ Customer is completely unable to understand or function within the continuum of care system; **OR** ☐ Customer is in a crisis situation and in need of immediate assistance with translation services or culturally sensitive	☐ Customer often needs translation services or sign interpretation to operate within the continuum of care or to understand complicated medical concepts.	☐ Customer may need infrequent, occasional assistance in understanding complicated forms; **OR** ☐ Customer may need occasional help from translator or sign interpreters.	☐ Customer has no language problems or barriers and is capable of high level functioning within linguistic/cultural environments.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____	interpreters and advocates.			
Transportation **Score_____**	☐ Customer has no access to public or private transportation (e.g. lives in an area not served by public transportation, has no resources available for transportation options) **AND/OR** ☐ Customer has difficulty accessing transportation due to physical disabilities.	☐ Customer has frequent access needs for transportation; **OR** ☐ Customer has difficulty accessing transportation due to physical disabilities.	☐ Customer needs occasional, infrequent transportation assistance for HIV related needs; **OR** ☐ Customer is unable to understand bus/train schedules or how to manage bus/train transfers.	☐ Customer is fully self-sufficient and has available and reliable transportation; and has no physical disabilities limiting access to transportation.
Health Status	Describes the Customer's current physical and medical condition, prognosis and ability to meet his/her own basic life and care needs.			
Activities of Daily Living (ADL)	☐ Customer is completely dependent on others for all medical care needs; **AND/OR** ☐ Customer needs at least 12 hours of supervision a day.	☐ Customer needs assistance in more than 3 areas of *ADL;* **AND/OR** ☐ Customer needs *ADL* assistance at least 4 hours a day.	☐ Customer needs assistance in no more than 2 areas of *ADL;* **AND/OR** ☐ Customer needs assistance less than 4 hours a day.	☐ Customer is independent in all areas of *ADL* and does not need assistance at any time.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____ _				
Health Status *(continued)*				
HIV Disease Progression	☐ Customer has a *CD4+ count* less than 200 **and** not on OI *prophylaxis medication;* **OR** ☐ Customer has a current *opportunistic infection* and is not on treatment; **OR** ☐ Customer has been hospitalized in the last 30 days (for exacerbation of HIV infection).	☐ Customer has *viral load* more than 400 and not on *ARV medication;* **OR** ☐ Customer has a history of an *opportunistic infection* in the last 6 months, and may/may not be on OI *prophylaxis* or *OI* treatment; **OR** ☐ Customer has been hospitalized within the last six months.	☐ Customer has a *CD4+ count* greater than 200 **and/*or*** *viral load* more than 400 **and/or** on ARV medication; **OR** ☐ Customer has no history of an *opportunistic infection* in the last 6 months and may or may not be on *prophylaxis* or *OI* treatment; **OR** ☐ Customer has had no hospitalizations in the past 12 months.	☐ Customer is on medication and has viral load less than 400 **OR** ☐ Customer has no history of *opportunistic infection*, and may or may not be on OI *prophylaxis* or *ARV* medication; and Customer has no history of hospitalizations.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____ _				
Health Status *(continued)*				
Disease *Co-Morbidities* *(e.g. HTN, DM. CHF, Hepatitis etc.)* **(*Behavioral health not included- see separate section*)** **Score**_____ _	☐ Customer has unmanaged *acute or chronic co-morbidities.*	☐ Customer has *chronic co-morbidities* that are not well managed.	☐ Customer *has chronic co-morbidities* that are manageable with minimal medical assistance.	☐ Customer has no *co-morbidities*; **OR** Customer has well managed *chronic co-morbidities* and does not need assistance with treatment program.
Oral Health Needs	☐ Customer has no dental provider **and/or** reports current tooth or mouth pain and severe discomfort.	☐ Customer has no dental provider **and** reports no dental problems .	☐ Customer has a regular dental provider **but** reports dental problems.	☐ Customer is currently in active dental care (has seen a dentist within the last six months) **and** reports no dental issues.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____				
Health Status *(continued)*				
Nutritional Needs **Score_____**	☐ Customer reports severe eating problems, acute nausea, vomiting, diarrhea, and/or other physical maladies; **OR** ☐ Customer reports or MCM observes significant weight loss in the last 3 months; **OR** ☐ Customer has a diagnosis of *wasting syndrome*.	☐ Customer reports chronic nausea, vomiting, diarrhea and/or other physical maladies; **OR** ☐ Customer reports or MCM has observed weight loss in the past 6 months. **OR** ☐ Customer reports excessive weight gain in the last 6 months	☐ Customer reports changes in eating habits in the past 3 months and requests assistance with improving nutrition; **OR** ☐ Customer has occasional episodes of nausea, vomiting or diarrhea; .	☐ Customer has no current eating problems (e.g. nausea, vomiting or diarrhea) and reports no need any nutritional intervention; **AND/OR** ☐ Customer reports and/or MCM observed no weight loss or excessive weight gain

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Health Knowledge	Describes the Customer's ability to understand his/her current health status and diagnoses as well as his/her ability to comprehend and participate in his/her own health care and treatment.			
Health Literacy **Score_____**	☐ Customer needs repeated oral instruction to understand health information; **OR** ☐ Customer cannot translate even basic written prescription/health information into daily *Antiretroviral therapy (ART)*; **OR** ☐ Customer does not have the capacity to understand basic health or prescription information; **OR** ☐ Customer is *cognitively impaired*.	☐ Customer can read some health /prescription information; **OR** ☐ Customer may need assistance to translate complicated prescription/health information into daily *ART*; **OR** ☐ Customer is mildly *cognitively impaired.*	☐ Customer can read most basic health/prescription information; **OR** ☐ Customer may occasionally need assistance to translate changes in prescription/health information into daily *ART*;	☐ Customer has the capacity to obtain, process and understand health/prescription information; And Customer is able to manage complicated *ART* without additional assistance.
Health Knowledge *(continued)*				
HIV Knowledge	☐ Customer exhibits no understanding of the disease (transmission, prevention and progression) and is	☐ Customer is unable to articulate an understanding of the disease (transmission,	☐ Customer is able to articulate some understanding of the disease (transmission,	☐ Customer is able to articulate a clear understanding of the disease (transmission, prevention and

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____	unable to demonstrate positive health seeking behavior; **OR** ☐ Customer has knowledge of HIV but has a religious belief that inhibits them from accepting traditional medical treatment options. **OR** ☐ Newly diagnosed	prevention and progression) and needs information to demonstrate positive and health seeking behaviors.	prevention and progression) but needs additional information to translate knowledge into positive health behaviors.	progression) and is able to translate knowledge into positive health behaviors.
Treatment Adherence	Details the Customer's current and historical *adherence* to both medical care and ARV regimens; assesses any physical, environmental, and/or emotional factors that may directly impact the Customer's ability to maintain treatment *adherence*; and determines the level of support the Customer may need to achieve medically-recommended levels of treatment *adherence*.			
Medication Adherence	☐ Customer reports missing doses of scheduled medication daily and is experiencing on-going *barriers to adherence* and has a	☐ Customer reports missing doses of scheduled medication weekly and is experiencing on-going *barriers to adherence* and has	☐ Customer is *adherent* to *ARV medication regimen* but may need occasional assistance from MCM to maintain	☐ Customer is *adherent* to *ARV medication regimen* and has a viral load of <u>less</u> than 200; **OR**

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____ _	viral load of more than 200*;* **OR** ☐ Customer refuses to follow prescribed *ARV medication regimen* and has a viral load of more than 200*;* **OR** ☐ Customer chooses herbal/alternative drug therapies despite negative health outcomes; **OR** ☐ Customer requires professional assistance to take medication. **OR** ☐ Not on ARV	a viral load of more than 200; **OR** ☐ Customer reports choosing to engage in alternative/herbal drug and is medically stable; **OR** ☐ Customer just starting on *ARV medication regimen*; **OR** ☐ Customer's long-term *ARV medication regimen* does not appear to be effective.	optimum *adherence.*	☐ Reports missing no more than one (1) dose in a 30 day period;
Treatment Adherence *(continued)*				
Adherence to appointments	☐ Customer has missed multiple scheduled appointments in the last 2 months.	☐ History of 2 or more missed appointments in the last 4 months.	☐ Customer has missed no more than 1 appointment in the last 6 months with appropriate rescheduling and appointment kept.	☐ No missed appointments in the last 6 months.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____				
ARV medication side effects **Score_____**	☐ Customer is experiencing severe *side effects* with *ARV medications;* **OR** ☐ Customer has been newly prescribed *ARV medication*.	☐ Customer is experiencing mild *side effects* with *ARV medication*.	☐ Customer has a recent history of *side effects* with *ARV medication*.	☐ No current report of *side effects* with *ARV medications*; **OR** ☐ **N/A**
Treatment Adherence *(continued)*				
Knowledge of HIV medication	☐ Customer is unable to identify his/her own *ARV medications*; **OR** ☐ Customer has no knowledge of the purpose of his/her *ARV medications*; **OR** ☐ Customer has no knowledge of the *side effects* of his/her *ARV medication regimen*.	☐ Customer is able to identify some of his/her *ARV medications* but is unable to identify the purpose of the drugs; **OR** ☐ Customer is unable to list more than 2 *side effect* of his/her *ARV*	☐ Customer is able to identify but not name all prescribed *ARV medications*; and Customer has some understanding of the purpose of the drugs and; Customer is able to list at least 3 potential *side*	☐ Customer is able to identify and name all prescribed *ARV medications*; And Customer understands the purpose of the drugs; and customer is able to list at least 3 potential *side effects* of his/her *ARV medication regimen.*

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____ _	**OR** ☐ Customer has no knowledge of ARV medication	*medication regimen*.	*effects* of his/her *ARV medication regimen.*	
Treatment Adherence *(continued)*				
Treatment Support **Score**_____ _	☐ Customer reports no support system (no family, friends or peers); **OR** ☐ Customer is in imminent danger of being in crisis; **OR** ☐ Customer resists referrals and needs assistance with taking medication.	☐ Customer reports inconsistent and/or no dependable support system; **OR** ☐ Customer is isolated from families, social groups, and/or may be new to area; **OR** ☐ Customer has not disclosed status to family members due to fear of stigma.	☐ Customer reports gaps in availability and adequacy of support system from family and/or friends; **And** Customer is requesting additional support; **And** Customer has disclosed HIV status to his/her support system.	☐ Customer reports strong support from family, friends and peers; and Customer has disclosed HIV status to his/her support system. **And** Customer is not requesting additional support

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Behavioral Health	Details any emotional, cognitive, disordered and/or addictive behaviors diagnosed, displayed, or reported by the Customer and the impact of these behaviors on the Customer's ability to collaborate with health care professionals and adhere to health care regimens.			
Mental Health **Score_____**	☐ Customer expresses or exhibits behavior that indicates the Customer is a danger to self and/or others; **OR** ☐ Customer has been diagnosed with *mental illness* and is not in treatment.	☐ Customer self-reports *mental illness* or history of *mental illness* and is in treatment but is non-compliant with following treatment prescribed. **OR** ☐ Customer self-reports/exhibits mental health behavior but not linked to treatment.	☐ Customer self-reports *mental illness* or history of *mental illness* and receives treatment and/or is evaluated consistently; and condition is stable.	☐ Customer self-reports no history of *mental illness* and does not exhibit any behavior that may need an assessment.
Addiction **Score_____**	☐ Customer self-reports or exhibits behavior of current *addiction* or *substance abuse* and is not willing to seek help; **OR** ☐ Customer is not willing to resume treatment; **OR** ☐ Customer displays indifference regarding	☐ Customer self-reports *addiction* or *substance abuse* but is willing to seek assistance.	☐ Customer self-reports past problems with *addiction* or *substance abuse* with less than 1 year of recovery.	☐ Customer self-reports no difficulties with *addictions* or *substance abuse*; **OR** ☐ Customer reports past problems with *addiction* or *substance abuse* with more than 1 year in recovery; **OR** ☐ Customer has no need for treatment or no referral is indicated.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
	consequences related to an *addiction* or *substance abuse.*			
Behavioral Health *(continued)*				
Risk Reduction	☐ Customer practices significant *risky behavior* of any type more than 50% of the time; **OR** ☐ Customer reports recent history of STI's in the last 6 months, **OR** ☐ Customer has significant relationship barriers to safe behavior;	☐ Customer practices unsafe *risky behavior* of any type more than 20-50% of the time; **OR** ☐ Customer reports recent history of *STI*'s in the last 6 to 12months. **OR** ☐ Customer has mild relationship barriers to safe behavior;	☐ Customer practices unsafe *risky behavior* occasionally, less than 20% of the time; **AND** ☐ Customer reports no recent history of *STI*'s in the last 12 months **OR** ☐ Customer declines to answer. **OR** ☐ Customer has no relationship	☐ Customer abstains from *risky behavior* by safer practices; **OR** ☐ Customer reports no recent history of *STI*'s in the last 12 months

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____			barriers to safe behavior.	
Children/Families	Describes the Customer's primary, self-identified familial relationships particularly any individuals dependent on the Customer for basic life needs; the level of support needed to assist the Customer in sustaining these primary relationships; and the degree to which these relationships impact the Customer's ability to adhere to recommended medical practices.			
Children **Score_____**	☐ Customer is in advanced stage of disease and cannot provide care **AND/OR** ☐ is faced with possibility of losing children.	☐ Customer needs ongoing child care or transition care and may also need assistance with *permanency planning* or parenting classes; **OR** ☐ Customer has a child with special needs.	☐ Customer needs assistance in getting access to *permanency planning;* **OR** ☐ Customer needs assistance to disclosure HIV status to children; **OR** ☐ Customer needs assistance with respite care/support; parenting classes	☐ Customer has no children living with them; **OR** ☐ Customer needs no assistance.
Dependents	☐ Customer has dependent(s) living with them; And Customer is experiencing a current crisis related to dependents.	☐ Customer has 3 or more dependents living with them; and without MCM assistance the	☐ Customer has 1-2 dependents living with them; and Customer needs minimal or occasional	☐ Customer has no dependents living with him/her; **OR** ☐ Customer needs no assistance with dependents.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____		Customer may be at-risk of crisis.	assistance with dependents.	
Environmental	Describes the Customer's current social and physical environment; how contributing environmental factors either support or hinder the Customer's ability to maintain medical care and achieve positive health outcomes; and the level of external support needed to address critical barriers to successful outcomes.			
Domestic Violence **Score_____**	☐ Customer reports that he/she is currently engaged in physically, sexually and/or emotionally abusive relationship and feels life is in danger of violence.	☐ Customer reports that he/she has experienced domestic violence in the past 12 months; **OR** ☐ MCM observes visible evidence that the Customer may be at risk.	☐ Customer self-reports a history of domestic violence, but is not in abusive relationship; **OR** ☐ Customer is removed from abuser.	☐ Customer self-reports no history of domestic violence.
Living situation **Score_____**	☐ Customer is homeless, living in a shelter, sleeping on streets or in his/her car; **OR** ☐Customer is in immediate danger of becoming homeless and needs housing placement ; **OR** ☐ Customer is unable to live independently and needs to be placed in assisted living facility.	☐ Customer is in transitional or unstable housing; **OR** ☐ Customer is at-risk of eviction, having utility(s) shutoff and/or of losing housing due to financial strain; **OR** ☐ Customer needs assistance with rent/utilities to maintain housing.	☐ Customer currently has adequate housing but may need occasional short-term rent or utilities assistance to remain stable.	☐ Customer is in permanent housing and is not in danger of losing housing.

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Environmental *(continued)*				
Financial **Score**_____	☐ Customer has no income and cannot currently meet basic needs; **OR** ☐ Customer needs immediate emergency intervention to address financial crisis.	☐ Customer has difficulty maintaining sufficient income from available sources to meet basic needs; **OR** ☐ Customer requires frequent ongoing referrals from MCM to stabilize income.	☐ Customer's income may occasionally be inadequate to meeting basic needs.	☐ Customer has a steady, stable source of income and is able to meet monthly financial obligations.
Environmental *(continued)*				
Legal Issues	☐ Customer is experiencing a crisis involving legal matters; **OR**	☐ Customer has current legal problem **and/or** on probation **and** does	☐ Customer has no current legal problem .	☐ Customer has no recent or current legal problems;

Areas of Functioning	INTENSIVE MANAGEMENT LEVEL 4 (4 points)	MODERATE MANAGEMENT LEVEL 3 (3 points)	BASIC MANAGEMENT LEVEL 2 (2 points)	SELF MANAGEMENT LEVEL1 (1 point)
Score_____	☐ Customer is incarcerated or recently released from correctional facility; **OR** ☐ Customer has a current or extensive criminal history; **OR** ☐ Customer is in need of legal services to access *health benefits*. **OR** ☐ Customer has immigration-related legal issues.	not need assistance.	**AND** ☐ Customer wants assistance with completing all applicable *advanced directives* (*living will*, *last will*, *power of attorney*, *advanced directives*).	

Final score:_____Acuity Level of need assigned:

_____

Customer signature: _____ Date:_____

Medical case manager's signature: _____

TRIGGER SECTION	CHECK IF APPLICABLE	ALL INTENSIVE CUSTOMERS COMMENTS
Homelessness	☐	
Peri-Incarceration	☐	
Pregnancy	☐	
CD4 count below 200	☐	
New diagnosis of HIV or VL >10,000 copies/ml	☐	
Untreated mental illness	☐	
New to Antiretroviral therapy	☐	
Not in care/re-engaging in care	☐	
Non-adherence to HIV medication	☐	
Unable to navigate System of Care due to Language	☐	
SUMMARY COMMENT:		

MCM Service Plan

Client Name:_____

Client Address:_____

Overall Goal:_____

Date	Identified Need	Short-Term Goal or Objectives	Intervention /Activity/ Action	Review Date or Timeline	Persons Responsible for Action/	Linkages Needed or Outcome of Intervention

Signature of Client: _____ Date: _____

Signature of Medical Case Manager: _____ Date: _____

Signature of MCM Supervisor: _____ Date: _____

Acuity Scale "AT-A-GLANCE"

Ranges of Summary Acuity Score				
Points	**Health Status/Medical Condition**	**Support System**	**Management Level**	**Frequency**
25 - 35 Points	Medically stable without Medical Case Management assistance undetectable Viral Load	Able to manage supportive needs without assistance	Self-Management	Face to Face at least once every 6 months for reassessment no phone contact indicated
36 - 50 Points	Medically stable with minimal Medical Case Management assistance	Able to manage supportive needs with minimal Medical Case Management assistance	Basic Management	Face to Face every 6 months with at least one phone contact every 3 months
51 - 74 Points	At risk of becoming medically unstable without Medical Case Management assistance	Support systems are not adequate to meet Client's immediate needs without Medical Case Management assistance	Moderate Management	Face to Face a minimum of every 3 months with at least one phone contact monthly.
75-100 Points OR TRIGGER	Medically unstable and in need of comprehensive Medical Case Management assistance Viral Load > 10,000 copies/ml	Has no support system in place and unable to manage supportive needs without comprehensive Medical Case Management assistance	Intensive Management	Face to Face at least once a month with phone contacts weekly

Ascending through the Levels of Case Management

Medical Case Managers play a vital role in supporting customers across the continuum of HIV care and ensure full engagement in care and continual movement toward Viral Load suppression. If customer needs are appropriately met, the level of case management should decrease with time from *Intensive* to *Moderate* to *Basic* to *Self-Management*. The table below shows the recommended duration for each Level of Case Management. These time frames should be used in conjunction with the Service Plan, as a guideline for transitioning customers. In addition, the time frames are designed to minimize the need for case management waiting lists.

Management Level	Recommended Duration at Each Level
Self-Management	Desired level
Basic Management	6 months
Moderate Management	12 months
Intensive Management	18 months

ADMINISTRATION OF GAIN-SS INSTRUMENT

Section 1: Check for Cognitive impairment (Optional)

Cognitive Impairment Screener

Before administering the GAIN-SS screener, it is important to verify that the client has all the necessary literacy and cognitive skill. As impairment is not always obvious, it is recommended to use the modified version of the 10-item Short Blessed Scale of Cognitive Impairment if impairment is suspected.

To administer, ask each question from a through f and circle the code for the error noted. Note that the errors worth different scores or values. Question f alone has a total score of 10 and sub-divided into five sections, if client miss one, a score of 2, if missed two, a score of 4 and so on. Item g is the total score. Total error score greater than 10 means the client is experiencing some degree of cognitive impairment. Interview can be rescheduled or administer instead of allowing self –administration; note that interview might take longer or more difficult, be careful to avoid over interpreting the responses and make a note of clients problems when reporting the results.

Leading statement: "Because we are going to ask you a lot of questions about when and how often things have happened, I need to start by getting a sense of how well your memory is working right now"

	Error Scores
a. What year is it now?	
(Select 4 for any error)	0 4
b. What month is it now?	
(Select 3 for any error)	0 3
Please repeat this phrase after me: John Brown, 42 Mark Street, Detroit	
(No score- used for f below)	
c. About what time is it?	
(Select 3 for any error)	0 3
d. Please count backwards from 20 to 1.	
(20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1)	
(Select 2 for one error, 4 for two or more errors)	0 2 4
e. Please say the days of the week in reverse order	
(Sat, Fri, Thurs, Wed, Tues, Mon, Sun)	
(Select 2 for one error, 4 for two or more errors)	0 2 4
f. Please repeat the phrase I asked you to repeat before	
(John / Brown / 42 / Mark Street / Detroit)	
(Select 2 for each subsection of /text /missed)	0 2 4 6 8 10
g. (Add up scores from a through f and record	/ / /
(If total is greater than 10, the participant is experiencing some degree of cognitive impairment. You can attempt again later if intoxication is suspected, or proceed and take into account when making the interpretation.)	

GAIN SHORT SCREENER (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0

Complete application online at http://www.gainabs.org

What is your name?

First Name | MI | Last Name

What is today's date? MM/DD/YYYY

The following questions are about common psychological, behavioral and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, that you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago 1 or more years ago or never.	Past month	2- 3 months ago	4-12 months ago	1+ years ago	Never
IDScr. 1. **When was the last time** that you had **significant**…					
a. Problems with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?					
b. Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?					
c. Feeling very anxious, nervous, tense, scared, panicked or something or something bad was going to happen?					
d. Becoming very distressed and upset when something reminded you of the past?					
e. Thinking about ending your life or committing suicide?					
f. Seeing or hearing things that no one else could see or hear or hear or feeling that someone could read or control your thoughts?					
EDScr. 2. When was the last time that you did the following things two or more times?					
a. Lied or conned to get things you wanted or to avoid having to do something?					
b. Had a hard time paying attention at school, work, or home?					
c. Had a hard time listening to instructions at school, work, or home?					

	Past month	2- 3 months ago	4-12 months ago	1+ years ago	Never
EDScr. 2. When was the last time that you did the following things two or more times? ***(CONTINUED)***					
d. Had a hard time waiting for your turn?					
c. Were a bully or threatened other people?					
e. Started physical fights with other people?					
f. Tried to win back your gambling losses by going back another day?					
SDScr 3. **When was the last time that**...					
a. You used alcohol or other drugs weekly or more often?					
b. You spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs, (e.g. feeling sick)?					
c. You kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?					
d. Your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home or social events?					
e. You had withdrawal problems from alcohol/other drugs, (e.g. shaky hands, throwing up, having trouble sitting still or sleeping, having to use alcohol or other drugs to stop being sick or avoid withdrawal problems?					
CVScr 4. **When was the last time that you**…….					
a. Had a disagreement in which you pushed, grabbed or shoved someone?					
b. Took something from a store without paying for it?					
c. Sold, distributed, or helped make illegal drugs?					

	Past month	2- 3 months ago	4-12 months ago	1+ years ago	Never
d. Drove a vehicle while under the influence of alcohol or illegal drugs?					
e. Purposely damaged or destroyed property that did not belong to you?					

TDScr. 5

5. Do you have other **significant** psychological, behavioral, or personal problems? Yes ☐ No ☐

Do you want treatment for or help with this problem? (If yes, **please describe).**

6. What is your gender? (If other, please describe below. 1-Male 2-Female 99-Other

7. What is your age in years? _____ years.

7a. How many minutes did it take you to complete this survey? _____ minutes.

Staff Use Only

8. Site ID: _____ Site Name v. _____

9. Staff ID: _____ Staff Name v. _____

10. Client ID: _____ Comment v. _____

11. Mode: 1) Administered by staff 2) Administered by other 3) Self-Administered

13. Referral: MH_____ SA_____ ANG_____ Other_____ 14. Referral codes:_____

15. Referral Comments:

v1._____

v2._____

v3. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4,3)	Past year (4,3,2)	Ever (4,3,2,1)
IDScr	1a - 1f				

	EDScr		2a - 2g								
	SDScr		3a - 3e								
	CVScr		4a - 4e								
	TDScr		1a - 4e								
Complete application online at http://www.gainabs.org											

District of Columbia

HIV Medical Case Management Assessment Form

Client Demographics: (Section to be completed by multi-service agencies and updated at re-assessment).

Name (First, MI, Last)		**Date of Birth**	
What is your preferred name?		**Social Security Number**	

Marital Status

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Telephone	**(Area Code)**	**(Exchange-Subscriber)**	**May we leave a message?**	**May we leave the agency name?**
Home Phone				
Cell Phone				
Alternate Phone				

Race and Ethnicity

☐ African American ☐ Caucasian ☐ Hispanic or Latino/a ☐ Asian American ☐ Native American ☐ Other

Are you a Veteran?	☐ Yes	☐ No
If "Yes," do you receive services through the Veterans Administration?	☐ Yes	☐ No
What are those services?		

Emergency Contact Information

Emergency Contact Person					
Phone			**Cell phone**		
E-Mail			**Relationship**		
Is this person aware of your HIV status?	☐ Yes	☐ No	**Is your partner aware of your HIV status?**	☐ Yes	☐ No
Alternate Contact Person					
Phone			**Cell phone**		
E-Mail			**Relationship**		
Is this person aware of your HIV status?	☐ Yes	☐ No	**Is your partner aware of your HIV status?**	☐ Yes	☐ No

Function Area 1: Access and Support

Medical Home

Are you receiving treatment for your HIV?	**Yes**	**No**	**If "Yes," what is the clinic name?**	
Are you seeing a physician or clinician who can treat your HIV?	**Yes**	**No**	**If "Yes," what is the name of the physician or clinician?**	

Year of HIV diagnosis		**Mode of Transmission**	

Date of last medical visit				
Did you keep the appointment?	**☐ Yes**	**☐ No**		
If "No," why not?				
Are you changing clinics?	**Yes**	**No**	**If "Yes," why?**	
When is your next appointment date?				
What is the reason for your visit?				
Were you referred for services?	**Yes**	**No**	**If "Yes," by whom?**	

Are you currently or have you experienced in the last month any of the following problems? (Check all that apply).

Thrush	**Spiking Fever**	**Skin Problems**	**Fatigue**	**Diarrhea**
Unexplained Weight loss	**Loss of Appetite**	**Headaches**	**Nausea or Vomiting**	**Other (specify)**

Do you have any other medical conditions (e.g. hypertension, diabetes, heart disease?)	**Yes**	**No**
If "Yes," please describe.		
Have you ever been hospitalized for an HIV-related illness or opportunistic infection?	**Yes**	**No**

If "Yes,"

Last Date	
Illness or Diagnosis	
Where hospitalized or treated	

Health Insurance and Benefits

Do you currently have health insurance?			**Yes**	**No**
If "Yes," what type(s)?	**Medicaid/OHP#**		**Standard Plus**	**Open Care Managed Care**
	Private Insurance ID #			
	Medicare A or B			
	OMIP#			
	DC Alliance			
	Veteran's Benefit Insurance #			
	QHP-ACA#			
Does your insurance have benefit limits?			**Yes**	**No**
If "Yes," what are the limits?				
What is the premium amount per month?				
How much is your co-payment per prescription?				
Does your insurance cover:	**☐ Medications?**	**☐ Doctor Visit?**	**☐ Dental Visit?**	
What is your dental insurance number?				
Are you enrolled in any type of Medicaid spend-down program?			**Yes**	**No**
If "Yes," what is the spend-down amount?				
Are you enrolled in the AIDS Drug Assistance Program (ADAP)?			**Yes**	**No**
If "Yes," what is your number?				

Check here if client is not insured, under-insured or unable to pay–address as appropriate

Cultural/Linguistics

What language(s) do you read or write?		**☐ Speak**	**☐ Read**	**☐ Write**
		☐ Speak	**☐ Read**	**☐ Write**
Do you need a translator or interpreter (including an American Sign Language Interpreter)?			**Yes**	**No**

Highest level of education:			
6th Grade or Less	**Between 7th and 12th Grade**	**High School Diploma or GED**	**Vocational or Technical Training**
Undergraduate/ College	**Graduate**	**Post-Graduate**	**Other**

Are you able to complete forms independently?	**Yes**	**No**
Do you have any religious/spiritual beliefs that may prohibit you from taking any medications?	**Yes**	**No**
Do you have any beliefs prohibiting:		
Blood transfusion?	**Yes**	**No**
Participating in medical research?	**Yes**	**No**
Any specific medical procedure(s)?	**Yes**	**No**
Other: (Specify)	**Yes**	**No**
Do you prefer to be assessed by any particular		
Gender? (Specify)	**Yes**	**No**
Age? (Specify)	**Yes**	**No**
Do you want us to be aware of any religious or cultural beliefs or practices that may affect your receiving care?	**Yes**	**No**
If "Yes," describe:		
Are there any other things of which health care providers should be made aware?	**Yes**	**No**
If "Yes," describe:		

Transportation

Do you have access to transportation for health care and other HIV-related support service appointments?	**Yes**	**No**
If "Yes," what types of transportation do you use?		

Personal Vehicle	**Public Transportation**	**Taxi Service**	**Van Service**
Other (Specify)			

Do you need financial assistance with transportation?	**Yes**	**No**
Do you have physical disabilities that impede your access to public transportation?	**Yes**	**No**
Do you have any other disability that could impede your use of public transportation (e.g. bus, Metro or trains)?	**Yes**	**No**
If "Yes," specify the disability?		
Do you have access to transportation for health care or support services not associated with HIV care?	**Yes**	**No**
If transportation needs are evident, make appropriate referrals to benefits programs.		

Social Support

How do you socialize? (Specify activities).	

What type of support system do you have?

Family	**Friends**	**Neighbors**	**Peers**	**Support Group**
Facebook	**MySpace**	**Twitter**	**None**	**Faith-Based Group**

Do you believe you have an adequate support system?	**Yes**	**No**
If "Yes,"		
Have you told anyone you have HIV?	**Yes**	**No**
Who have you told (by relationship)?		
Are members of your support system aware of your HIV diagnosis?	**Yes**	**No**
If "No," do you need help to disclose your HIV status?	**Yes**	**No**

If help is needed to disclose HIV status, make appropriate referrals to support and healthy relationship groups.

Function Area 2: Health Status

Section 1: Activities of Daily Living (ADL)

Check level of function of each activity of daily living listed below. This will help you determine how much assistance is needed.

Function	Independent	Needs Help	Dependent	Not Applicable
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Using the Phone				
Housework				
Laundry				
Driving				
Managing Finances				

If client is dependent or needs help in any area, refer to appropriate programs.

Section 2: HIV Disease Progression

Laboratory Values and Clinical Markers: A verbal report from the client of his or her laboratory results is not sufficient for documentation. To obtain client laboratory results, the Medical Case Manager can either:

Ask the client to sign a *Release of Information* form and have the medical provider fax it to the Medical Case Manager, OR

Ask the client to deliver a photocopy obtained from a Medical Provider.

Opportunistic Infections

Are you on Prophylaxis (preventive medication) for an opportunistic infection?	**Yes**	**No**

If "Yes," please provide information below:

Opportunistic Infection	Drug for Prophylaxis	Dosage

Have you ever been DIAGNOSED with or TREATED FOR an opportunistic infection?

Opportunistic Infection	Diagnosed		Date of Diagnosis	Treatment Received		Treatment Completed	
Bacterial Fungal and Fungal (Thrush, Yeast Infection)							
Cryptococcal Meningitis	Yes	No		Yes	No	Yes	No
Histoplasmosis	Yes	No		Yes	No	Yes	No
Bacterial Pneumonia	Yes	No		Yes	No	Yes	No
PneumoCystis (jirovecii) Pneumonia (PCP)	Yes	No		Yes	No	Yes	No
Toxoplasmosis	Yes	No		Yes	No	Yes	No
Cytomegalovirus (CMV)	Yes	No		Yes	No	Yes	No
Hepatitis C	Yes	No		Yes	No	Yes	No
Mycobacterium Avium Complex (MAC)	Yes	No		Yes	No	Yes	No
Syphilis or Neurosyphilis	Yes	No		Yes	No	Yes	No
Tuberculosis (TB)	Yes	No		Yes	No	Yes	No
Sexually Transmitted Diseases							
Herpes Simplex Virus (Oral, Genital Herpes)	Yes	No		Yes	No	Yes	No
Herpes Zoster Virus (Shingles)	Yes	No		Yes	No	Yes	No
Human Papilloma Virus (HPV, Genital warts, anal or cervical dysplasia, cervical cancer)	Yes	No		Yes	No	Yes	No
Cancers							
AIDS Dementia Complex (ADC)	Yes	No		Yes	No	Yes	No
Peripheral Neuropathy (pain, numbness and tingling of the feet or hands)	Yes	No		Yes	No	Yes	No

Hospitalizations

Have you ever been hospitalized for an HIV/AIDS-related illness or opportunistic infection?	**Yes**	**No**
Have you ever been hospitalized for a non HIV/AIDS-related illness?	**Yes**	**No**

If "Yes," please provide information below.

Date	Reason for Hospitalization	Hospital

Section 3: Co-Morbid Diseases

Have you ever been told you have any conditions, illnesses or diseases other than HIV (e.g. hypertension, diabetes, heart disease, hepatitis)?	**Yes**	**No**

If "Yes," please provide information below.			
Disease	**Date of Diagnosis**	**Treatment Received**	**Treatment Completed**

Section 4: Oral Health Needs

Oral manifestations of HIV may arise in people with HIV disease who have weakened immune systems.

When was the last time you saw a dentist?					
Do you have a dentist that you visit regularly?				**Yes**	**No**
If "Yes," who is the dentist?					
How often do you brush your teeth?				**times per**	
Do you have a toothbrush?				**Yes**	**No**
Do you have dentures?				**Yes**	**No**
If "No," do you need dentures?				**Yes**	**No**
Do you have one or more dental bridges?				**Yes**	**No**
If "No," do you need one or more bridges?				**Yes**	**No**
Have you ever been diagnosed with any oral conditions, illnesses or diseases? (Specify below).					
Oral herpes	**Yes**	**No**	**Aphthous Ulcers or Canker Sores**	**Yes**	**No**
Ulcers	**Yes**	**No**	**Hairy leukoplakia**	**Yes**	**No**
Thrush (Candidiasis)	**Yes**	**No**	**Warts**	**Yes**	**No**
Dry Mouth	**Yes**	**No**	**Tooth Decay**	**Yes**	**No**
Abscesses	**Yes**	**No**	**Other: (Specify).**	**Yes**	**No**
Are you currently receiving Oral Health treatment?				**Yes**	**No**
Do you have pain, sensitivity or other discomfort with your teeth, gums or elsewhere in your mouth?				**Yes**	**No**
If "Yes," does this pain, sensitivity or discomfort affect your intake of food, drink or medications?				**Yes**	**No**
Have you noticed any changes in your teeth, gums or elsewhere in your mouth?				**Yes**	**No**

Section 5: Nutritional Needs

Current Weight		**Current Height**	
Have you gained or lost a significant amount of weight in the last:			
Thirty Days (One Month)?	**Yes**	**If "Yes," how much?**	**No**
Sixty Days (Two Months)?	**Yes**	**If "Yes," how much?**	**No**
One Hundred and Eighty Days (Six Months)?	**Yes**	**If "Yes," how much?**	**No**
Describe the reasons for the significant gain or loss of weight?			
Are you being treated for a weight gain or loss problem?		**Yes**	**No**
If "Yes," what is the medication?			

Are you receiving Medical Nutrition Therapy (from Registered Clinical Dietician or Registered Dietician Nutritionist)?	**Yes**	**No**
Are you receiving nutritional counseling (from someone who is NOT a Registered Clinical Dietician or Registered Dietician Nutritionist)?	**Yes**	**No**
Are you taking nutritional or vitamin supplements (e.g. Boost, Ensure, vitamins)?	**Yes**	**No**
If "Yes," which supplements are you taking?		
If "Yes," who prescribed them?		
Do you need assistance with food?	**Yes**	**No**
Do you currently receive food assistance from:		
Food Stamps?	**Yes**	**No**
Home-Delivered Meals?	**Yes**	**No**
Home-Delivered Groceries?	**Yes**	**No**
Food Bank?	**Yes**	**No**
Emergency Food Vouchers?	**Yes**	**No**
Other?	**Yes**	**No**
Please indicate any of the following physical problems, which make it difficult to eat:		
Mouth Problems	**Yes**	**No**
Swallowing problems	**Yes**	**No**
Food Allergies	**Yes**	**No**
Nausea	**Yes**	**No**
Vomiting	**Yes**	**No**
Diarrhea	**Yes**	**No**
Taste Alteration	**Yes**	**No**
Do you have any dietary restrictions?	**Yes**	**No**
If "Yes," specify:		
Do you have any other problems with food?	**Yes**	**No**
Have you ever been diagnosed with wasting syndrome?	**Yes**	**No**

Function Area 3: Treatment Adherence

Section 1

Do you have any current prescriptions for medications?	**Yes**	**No**
Are you taking any medications? (Antiretroviral (ARV) and any other prescribed medications) If "NO," skip to question 93.	**Yes**	**No**

If "Yes," what medications are you taking

Name of Medication	Purpose of Medication	Dosage	Prescriber	
			Name	
			Phone	
			Name	
			Phone	
			Name	
			Phone	
			Name	
			Phone	
			Name	
			Phone	
			Name	
			Phone	
			Name	

			Phone	
How do you take your medications?	**Self-Administered**		**Received from Another**	
Please rate your ability to take your medications as prescribed over the last seven days.				
Excellent	**Very Good**	**Good**	**Fair**	**Poor**
Do you forget to take your medications?			**Yes**	**No**
If "Yes," when was the last time you missed a dose?				
Have you missed a dose in:				
Twenty-four (24) hours?	**Yes**	**No**	**If "Yes," how many doses?**	
Three (3) days?	**Yes**	**No**	**If "Yes," how many doses?**	
Seven (7) days?	**Yes**	**No**	**If "Yes," how many doses?**	
How many doses do you think you have missed over the past month?				
What are some of the reasons for missing doses of your medication? (Check all that apply)				
I get too busy with other things or simply forget to take pills.	**I am away from home when it is time to take my pills.**		**There is a change in my routine.**	
I feel depressed or overwhelmed.	**I just don't want to take them.**		**I have problems swallowing.**	
I take a drug holiday or break from taking pills (i.e. tired of taking meds).	**I get side-effects that make me stop.**		**I run out of pills.**	
I have too many pills to take.	**I have trouble remembering to eat or not to eat with pills.**		**Other:**	
Other:	**Other:**		**Other:**	
What do you do when you miss a dose?				
What will make it easier for you to take your medications as prescribed?				
How do you receive your medications?				
Pick up at pharmacy	**Delivered by pharmacy**		**Pick up at doctor's office**	
Do you have difficulty getting your medications?			**Yes**	**No**
If "Yes," specify the type of problems.				
Is cost a problem with getting your medications?			**Yes**	**No**
Have you ever run out of your medications?			**Yes**	**No**
Who do you call to fill or refill a prescription?	**Name:**			
	Phone number:			
Where do you keep your medications?				
Do you believe they are safe?			**Yes**	**No**
Do you feel the need to hide your medications from anyone?			**Yes**	**No**
How many people in your life know about your HIV?				
All of them	**Some of Them**	**One Person**	**None**	
How many of the important people/family members in your life are supportive of you taking medications?				
All of them	**Some of Them**	**One Person**	**None**	
Have you ever participated in a medication or treatment adherence program?			**Yes**	**No**
Are you interested in participating in a medication or treatment adherence program?			**Yes**	**No**
If "Yes," indicate in the MCM Service Plan and link to a Treatment Adherence Specialist or Program.				
Are you taking herbal or alternative therapies?			**Yes**	**No**
Are you taking Over-The-Counter (OTC) medications?			**Yes**	**No**
If "Yes," what are the names and reasons for taking the herbal, alternative or OTC medications?				

Herbal	Alternative	OTC	Name of Medication or Therapy	Purpose or Reason for Taking

Section 2

Identify the side effects that you are experiencing that are associated with HIV medications

How much do any of these side effects bother you, or affect your taking anti-retroviral (ARV) medications?

Side Effect	Severe (a lot)	Mild (Somewhat)	A Little	Not at All	Not Sure
Diarrhea					
Nausea					
Vomiting					
Constipation					
Headache					
Skin Rash					
Bad of Vivid Dreams					
Confusion					
Fever					
Taste Alteration					
Discoloration of Eyes					
Discoloration of Skin or Nails					
Numbness or Tingling Pain of Peripherals					
Drowsiness					
Loss of Sex Drive					
Other					

What have you done about the side effects?

Section 3

When was your last appointment with your Primary Care Provider?	

How often are your appointments with your Primary Care Provider?

More often than monthly	**Once every month**	**Once every two (2) months**	**Once every three (3) months**
Once every four (4) months	**Once every five (5) months**	**Once every six (6) months**	**Other**

Indicate the number of missed health care appointments (with your medical doctor, clinic, etc.) in the last:

Thirty (30) Days		**Sixty (60) Days**		**Four (4) months**	
Six (6) Months		**Twelve (12) Months**			

What are some of the reasons for missing your appointments?

What will make it easier for you to keep your appointments?

All identified deficiencies in Treatment Adherence should be included in the MCM Service Plan.					
What is your most recent Viral Load (VL)?					
Date		**Result**		**Next Scheduled**	
Self-Report			**Laboratory Report**		
What is your most recent CD4 T-Cell count?					
Date		**Result**		**Next Scheduled**	
Self-Report			**Laboratory Report**		
Describe ways or methods of treatment adherence aids being used.					
Pill Count Discussions					
Prescription Refill Checks					
Direct Observation Therapy					
Diaries					
Electronic Monitoring					
Family Reporting					

Function Area 4: Health Knowledge

Section 1: Health Literacy

How often do you need help reading the following?				
Written information about how to take care of yourself.	**Always**	**Often**	**Some times**	**Never**
Written information about how to take your medications such as those that appear on pill bottles or on prescriptions.	**Always**	**Often**	**Some times**	**Never**
Written information about side-effects associated with your medications.	**Always**	**Often**	**Some times**	**Never**
Appointment notifications and reminders from your medical providers.	**Always**	**Often**	**Some times**	**Never**
Treatment information from your Dietician, Medical Case Manager, Mental Health Counselor or Substance Abuse Counselor?	**Always**	**Often**	**Some times**	**Never**
How often do you need help with the following?				
Figuring out what time you should take your different medications.	**Always**	**Often**	**Some times**	**Never**
Whether or not to eat when you take your medications.	**Always**	**Often**	**Some times**	**Never**
How confident are you filling out medical forms by yourself?	**Always**	**Often**	**Some times**	**Never**

Section 2: HIV Knowledge

What is HIV?	
What is AIDS?	

You can get HIV from the following:		
Sharing needles and/or works.	**True**	**False**
Tattoos.	**True**	**False**
Piercing body parts.	**True**	**False**
Vaginal sex.	**True**	**False**
Anal sex.	**True**	**False**
Oral sex.	**True**	**False**
Mosquitoes carrying infected blood.	**True**	**False**
Kissing.	**True**	**False**

Breast feeding.	**True**	**False**
Shaking hands.	**True**	**False**
Why is it important to get your Viral Load measured?		
Why is it important to get your CD4 count measured??		

If deficiencies are identified, then educate during a teachable moment.

Function Area 5: Behavioral Health

Section 1: Mental Health Screening

A. GAIN Cognitive Impairment Screener (See form at the end of this Assessment tool).

B. Global Appraisal of Individual Needs- Shorter Screener (GAIN-SS). (See form at end of Screening Tool, Or use the Online Application at *https://www.gainabs.org*

Check All That Apply

Need for Mental Health assessment or intervention.
Indication of cognitive deficits.
Client should be referred and linked with Mental Health services.
Interventions noted in Medical Case Management Service Plan.

Section 2: Addiction Screening

Alcohol Screening (CAGE Questionnaire)

Do you drink alcohol?	**Yes**	**No**
If "Yes," have you ever felt you should cut down on your drinking?	**Yes**	**No**
Have people annoyed you by criticizing your drinking?	**Yes**	**No**
Have you ever felt bad or guilty about your drinking?	**Yes**	**No**
Have you ever had a drink first thing in the morning ("eye opener") to steady your nerves or get rid of a hangover?	**Yes**	**No**

Check All That Apply

Alcohol Screening has two or more "Yes" responses.
Client should be assessed for alcohol abuse.
Client should be referred and linked to alcohol addiction services.
Interventions noted in Medical Case Management Service Plan.

Have you used recreational drugs during the past twelve months?	**Yes**	**No**

If Yes, check all that apply below; if 'NO," skip to question 131.

	No. of days used in the past thirty days	No. of times used in lifetime	Route of Administration (O: Orally, N: Nasal, S: Smoking, NV: Non-Injection, IV: Injection)				
Inhalants			**O**	**N**	**S**	**NV**	**IV**
Opiates/Analgesics			**O**	**N**	**S**	**NV**	**IV**
Crack Cocaine			**O**	**N**	**S**	**NV**	**IV**
Amphetamines			**O**	**N**	**S**	**NV**	**IV**
Meth-Amphetamines			**O**	**N**	**S**	**NV**	**IV**
Marijuana			**O**	**N**	**S**	**NV**	**IV**
LSD or PCP			**O**	**N**	**S**	**NV**	**IV**
Prescription Drugs			**O**	**N**	**S**	**NV**	**IV**
Powder Cocaine			**O**	**N**	**S**	**NV**	**IV**
Heroin			**O**	**N**	**S**	**NV**	**IV**
Methadone			**O**	**N**	**S**	**NV**	**IV**

Barbiturates			**O**	**N**	**S**	**NV**	**IV**
Other: Sedatives, Hypnotics, Tranquilizers			**O**	**N**	**S**	**NV**	**IV**
Cannabis			**O**	**N**	**S**	**NV**	**IV**
Hallucinogens			**O**	**N**	**S**	**NV**	**IV**
More than one substance per day (including alcohol)			**O**	**N**	**S**	**NV**	**IV**

How often do you use?	**Daily**	**2-3 times per week**	**Once a week**	**Once a month**	**Occasionally**

What is your substance/drug of choice?		
Do you consider your alcohol or drug use to be recreational?	**Yes**	**No**
If substance is injected, have you ever shared needles and/or other injection equipment?	**Yes**	**No**
Do you need help to find a needle exchange program?	**Yes**	**No**
Have you ever been hospitalized for substance abuse treatment?	**Yes**	**No**
If "Yes," what hospital?		
Interviewer: Which substances are the major problems?		

What was your longest period of voluntary abstinence from this major substance?

Seven (7) days	**Thirty (30) days**	**Sixty (60) days**	**Never Abstinent**

How many months ago did this abstinence end?	
How many times have you had alcohol Delirium Tremens (DT)?	
How many times have you overdosed on drugs?	
How many times have you received treatment for:	
Alcohol abuse?	
Drug abuse?	
Of the times you have received treatment, how many of them were for:	
Alcohol detox only?	
Drug detox only?	

Please provide the following information about the last time you were in treatment?

Name of Treatment Center		
Type of Treatment	**In-Patient**	**Out-Patient**
How long did treatment last?		

Did you complete treatment successfully?	**Yes**	**No**
Have you ever been evaluated for alcohol or drug use before today?	**Yes**	**No**

How important to you now is treatment for

Alcohol problems?	**Not Important**	**Neutral**	**Very Important**
Drug problems?	**Not Important**	**Neutral**	**Very Important**

Check All That Apply

Need for Substance Abuse assessment or intervention.
Client should be referred and linked with Substance Abuse Services.
Interventions noted in Medical Case Management Service Plan.

Section 3: Harm Reduction

Have you made any changes in your sexual behavior since you were diagnosed with HIV?	**Yes**	**No**
Do you practice safer sex?	**Yes**	**No**

How often would you say you engage in sex?

Daily	**Less than Daily, More than Weekly**	**Weekly**	**Monthly**	**Occasionally:**

Do you use protection while having sex?	**Yes**	**No**
If "No," why not?		
If "Yes," what type of protection do you use?		

Condom	Dental Dam	Saran Wrap	Latex Gloves	Withdrawal	Nothing

How often do you use protection?			
All the time	Sometimes	Only with partners other than Significant Other	Never

Have you ever had a Sexually Transmitted Infection (STI?)	Yes	No

If "Yes," what type of STI did (or do) you have?			
Gonorrhea	Syphilis	Chlamydia	Genital Warts
Genital Lice	Herpes	Human Papilloma Virus (HPV)	Other:

When was the most recent STI?	Within the last six months	Within the last year	More than a year ago
Where did you receive treatment?	Doctor's Office	Free Clinic	Other:

Do you intend to use protection the next time you have sex?	Yes	No
How confident are you that you can successfully insist on using protection with your sex partner, whether they want to, or not?	Very Confident	Not Sure
Do you need help to discuss the subject of HIV with your partner?	Yes	No
Do you need help to disclose your HIV status with other persons with whom you would like to have sex?	Yes	No
Is it important to you that you not pass HIV to your partner?	Yes	No
If "No," why is it not important?		
Would you like some assistance in discussing ways to reduce harm to yourself and others?	Yes	No
Do you need help to locate places to get free condoms?	Yes	No

Section 4: Strengths

What are you good with?		
What are your strengths?		

Check All That Apply

Indication of harm or high risk of harm.
Client should be referred and linked with Harm Reduction programs.
Interventions noted in Medical Case Management Service Plan.

Function Area 6: Children and Families

Do you have any children living with you?	Yes	No
If "Yes," how many?		
What are their ages?		
What is your relationship to the children?		
Do any of the children have special needs?	Yes	No
Are any of the children HIV-positive?	Yes	No
i If "Yes," how many are HIV-positive?		
Where do they receive care?		
Who is the physician?	Name:	
	Contact Info:	
Do need assistance with disclosure of your status to the children?	Yes	No
Do you need assistance with caring for the children?	Yes	No
Do you need assistance with permanency planning? (Explain "permanency planning").	Yes	No
Do you need assistance with locating parenting classes?	Yes	No
Do you have adult dependent(s) living with you?	Yes	No
If "Yes," how many?		

What is your relationship to the adult dependent(s)?		
Do you need assistance in caring for the adult dependent(s)?	**Yes**	**No**
Are you presently going through a crisis as a result of the adult dependent(s)?	**Yes**	**No**

Check All That Apply

Indication of crisis or imminent crisis.
Client should be referred and linked with appropriate programs.
Interventions noted in Medical Case Management Service Plan.

Function Area 7: Environment

Section 1: Domestic Violence

Have you ever…		
Pushed, kicked, slapped, punched, or choked your intimate partner or roommate?	**Yes**	**No**
Threatened to kill or harm your intimate partner or roommate?	**Yes**	**No**
Threatened your intimate partner or roommate with a weapon?	**Yes**	**No**
▪ **Do you have access to a dangerous weapon?**	**Yes**	**No**
Locked your intimate partner or roommate in or out of the house or apartment?	**Yes**	**No**
Called your intimate partner or roommate degrading names, put them down to humiliate them in front of other people or threatened to disclose their HIV status?	**Yes**	**No**
Thought about or tried to hurt yourself or someone else?	**Yes**	**No**
Had an intimate partner or roommate seek medical assistance for health problems resulting from your actions?	**Yes**	**No**
Thought that your intimate partner or roommate's life was in danger?	**Yes**	**No**
Physically, psychologically, economically, or sexually abused your intimate partner or roommate in the last twelve (12) months?	**Yes**	**No**
Has your intimate partner, roommate or other member of your household ever…		
Pushed, kicked, slapped, punched or choked you?	**Yes**	**No**
Threatened to kill or harm you?	**Yes**	**No**
Threatened you with a dangerous weapon?	**Yes**	**No**
▪ **Do they have access to a dangerous weapon?**	**Yes**	**No**
Locked you in or out of the house?	**Yes**	**No**
Called you degrading names, put you down to humiliate you in front of other people or threaten to disclose your HIV status?	**Yes**	**No**
Caused you to seek medical assistance for health problems resulting from violence?	**Yes**	**No**
Do you think your life is in danger?	**Yes**	**No**
Have you been physically, psychologically, economically, or sexually abused in the last twelve (12) months?	**Yes**	**No**
If "Yes,"		
Are you still in the same relationship?	**Yes**	**No**
Did you get counseling during the abuse	**Yes**	**No**
Is there a restraining order against you?	**Yes**	**No**
Is there a restraining order against your partner or other perpetrators?	**Yes**	**No**

Check All That Apply

The client has observable bruises/scars over his or her body.
Client needs a domestic violence intervention.
Client was referred and linked to domestic violence services.
Interventions noted in Medical Case Management Service Plan.

Section 2: Living Situation

In what type of housing do you live			
Rent (home or apartment)	Own Home	Transitional Living Facility	Homeless and Living on street or in car Living in shelter Living with others

If homeless, do you need help finding a shelter?	Yes	No
Are you in subsidized housing?	Yes	No
Are you at risk of losing housing?	Yes	No
How long have you been at your current address?		
Do you have a refrigerator in your current housing?	Yes	No

Check All That Apply

- The client is homeless and considered in need of "Intensive Level" MCM services.
- The client has immediate housing needs.
- Client is referred and linked to housing services.
- Housing stability goals are a part of the Medical Case Management Service Plan.
- Interventions noted in Medical Case Management Service Plan.

Section 3: Financial

Do you have income?		Yes	No
For each source of income, please provide the amount of income per month			
Employment	$		
Worker's Compensation	$		
SSI and/or SSDI	$		
Unemployment	$		
TANF	$		
Other	$		
Other	$		
Other	$		
TOTAL	$		
Are you able to meet your basic monthly needs/expenses?		Yes	No
Are you able to buy food for the month?		Yes	No
Are you able to pay your utility bills for the month?		Yes	No

Check All That Apply

- The client needs financial assistance.
- The client may be eligible for income supplements (SSI, SSDI) and should apply.
- Application for SSI and/or SSDI are part of the Medical Case Management Service Plan.
- Client is referred and linked to Emergency Financial Assistance (EFA) programs.
- Interventions noted in Medical Case Management Service Plan.

Section 4: Legal

Have you ever been incarcerated?	Yes	No
Do you have any current:		
Outstanding warrants?	Yes	No
Civil Charges?	Yes	No
Criminal Charges?	Yes	No
Probation?	Yes	No
Parole?	Yes	No
Child Protective Custody?	Yes	No
☐ If "Yes," are you in danger of losing your children?	Yes	No
Are there any other legal issues that would involve the Judicial System (Courts)?	Yes	No

If "Yes," describe		
Are you registered with the criminal justice system of any jurisdiction for any reason?	**Yes**	**No**
If "Yes," describe.		
Do you need a referral for Legal Assistance?	**Yes**	**No**
Do you have any of the following (Advance Directives)?		
Living Will	**Yes**	**No**
Medical Power of Attorney	**Yes**	**No**
Financial Power of Attorney	**Yes**	**No**
Will and Testament	**Yes**	**No**
Burial Arrangements	**Yes**	**No**
Are you a United States citizen?	**Yes**	**No**
Do you need help with obtaining identification papers?	**Yes**	**No**