RHODE ISLAND
HIV TCM
CASE MANAGEMENT
TOOLBOX

Accompaniment to RI HIV Targeted Care/Case Management Provider Manual

- Intake
- Assessment
- Acuity
- Care Plan

Version 1.0
PR0119 03.15.17

HIV TARGETED CARE/CASE MANAGEMENT TOOLBOX

Introduction

The components of the Rhode Island HIV Targeted Case Management (TCM) programs are varied and allow for clients to receive intensive case management from a qualified practitioner. It is our intent and statewide goal to create consistent methodologies for practice that include tools associated with the services provided.

A case management agency and case managers practicing in Rhode Island, shall be credentialed (see provider and staff credentialing in the Provider Manual), held to clear standards of care and service; collect performance measures and other metrics; adhere to practice guidelines; monitor progress of clients such that an Acuity Index is maintained and assists with client gravity and transitions; and be required to understand the varied payers and their terms for eligibility and billing across programs - such as Medicaid Fee For Service, Medicaid Managed Care (Expansion population) and for Ryan White Part B case management.

As a result, this HIV TCM Tool-Box provides necessary aspects of practice the state requires for case management practitioners, including Intake, Assessment, Acuity/Severity Index, and Care Plans.

Rhode Island has determined that HIV TCM case management is a valuable, efficient, effective service, via:

□ Augmenting the clinical aspects of medical adherence as a result of primary and specialty care,
□ Providing early access to human and social services,
□ Identifying the need for and providing linkage to preventive services, such as HIV, HCV and STI testing, vaccinations, needle exchange programs, opioid overdose prevention via Narcon, etc.,
□ Providing solid, consistent, and appropriate referrals to critical areas, including behavioral health services and recovery programs,
□ Diverting costly and possibly unnecessary events like emergency room visits, hospitalizations, and long term care,
□ Insuring effective services and coordination for those services for recently released inmates,
□ Improving access to complex health systems and necessary components associated with hierarchy of client needs (e.g., housing, behavioral health services, domestic violence support, sex worker support services, emergency services, food, etc.), and,
□ Improving specific, measurable health outcomes associated with the HIV Continuum of Care and those outcomes associated with other chronic diseases that may be co-occurring.

Staff Training

The state of Rhode Island shall require all funded case management providers to train and educate all of their case managers across the specific practice areas and tools. These tools will create a consistent, measurable program response across Medicaid Fees for Service, Medicaid Managed care (Expansion Population) and Ryan White Part B funded providers, such that, clients will experience consistent methods of practice and providers can measure, monitor and compare progress across the system.

Aside from tools, there are some contemporary, critical, healthcare delivery components that need to be integrated into TCM practice. To start, many of these new practice elements are associated with the Patient Protection and Affordable Care Act. Simply, it is now that time for case managers to vigorously pursue opportunities for their clients to insure all eligible individuals have the ability to purchase and/or receive health insurance. In addition, once the client has insurance, case managers are now in a critical position to assist clients in navigating through the myriad of benefits and create opportunities for clients to receive full benefits and services when needed.

Another contemporary, critical integration strategy for case management organizations is to embrace and fully engage in the measurement of key health and quality performance measures (outcomes) associated with client case management and the care and treatment of the client. While TCM is not a medical intervention, it is meant to assist in the adherence of clients across the continuum of care. In addition the measurable outcomes associated with HIV prevention and care (e.g., HIV testing results, the HIV Continuum of Care, etc.) and other healthcare metrics that are essential to providing case management services, are now expected to be integrated into the case management practice.

Contemporary, Critical Components of TCM Practice

Vigorously Pursue and Knowledge Base of the Marketplace: The new healthcare landscape shall present numerous opportunities for insurance coverage for your clients. Now that these opportunities exist case managers are found in the fore front of assisting their clients in finding, acquiring and maintaining health insurance options their clients selected. This is an essential element of practice and must be taken seriously throughout encounters with the clients. Having knowledge of all available options for those clients that are eligible for insurance coverage is at the crux of good case management today. In addition, reassessing a client's eligibility for insurance is also a critical practice element of TCM.

Closely related to the pursuit of health insurance is the assistance to enroll clients in either private insurance, premium assistance, Medicaid or Medicare programs. Oftentimes you shall hear that this type of assistance is referred to as linkage and coordination. A buzz word used often is "navigation." The purpose of navigation is to streamline entry into and utilization of care for those newly diagnosed with HIV (and to insure high risk negatives get enrolled and are provided with necessary prevention services when appropriate), those new to care or those re- engaging in care. The case management program should ensure that these clients are successful in their initial entry or re-entry into services, especially primary care services. As resources permit, this may require intensive client

health system education, practical assistance in obtaining information for the client and attending appointments with the client.

Monitoring Outcomes and Results: The goal of Rhode Island's TCM program *is to coordinate social and human services so that we improve health outcomes and the quality of life for HIV-infected individuals.* These outcomes should be tracked both at a program and individual level. Improved outcomes are concrete evidence of successful case management efforts. Programs are expected not only to track improvements or changes in their clients' environmental and social situation but also document their clinical progress with essential data (e.g., laboratory results) for the clinical team affiliated with the client. For example, TCM clients on anti-retroviral treatment with an increase in viral load, and/or a client drops out of care, should be flagged and discussed with all the client's clinical providers so as to address any barriers associated with medical adherence. Information obtained can be used to re- evaluate interventions and refocus efforts. Case managers are not medical specialists, yet must be aware of changes in the client's finances, access/availability to medical care, access to housing, and other factors in order to maintain a high level of quality case management.

Insuring Retention and Re-engagement of Clients into Care, ART, and Viral Suppression: HIV TCM case managers must insure that clients are monitored for retention in care, re-engagement, if appropriate, Antiretroviral therapy (ART) and viral suppression. Minimizing clients being lost to care is related to the acuity/severity index and monitoring for any changes in client life events is critical to this feature of practice. This must be a routine part of service provision. A client is considered lost to care when the client has not attended core medical service appointments for a period of 6 months or more. Often this will be referred to as the medical visit frequency measure. Depending on the client's care plan, this may include medical care, substance abuse counseling, dental care, substance use/mental health counseling, etc. Re-engagement into care is the responsibility of the entire health care community. However, HIV TCM case managers maintain a unique relationship with clients and are well-positioned to guide clients back into care. HIV TCM case management providers are encouraged to develop internal policies to both retain and re-engage clients in care.

Prevention and Harm Reduction: Core HIV prevention and harm reduction messages should be included in routine contact with the client. Linkages should be made to programs that reinforce risk screening; provide condoms and other safer sex products; prevention-for-positive programs and to needle exchange services. Particular attention must be given to known sero-discordant partners, where by counseling related to PReP, PEP and other prevention components are integral to case management services.

HIV Case Management Components and Guidelines

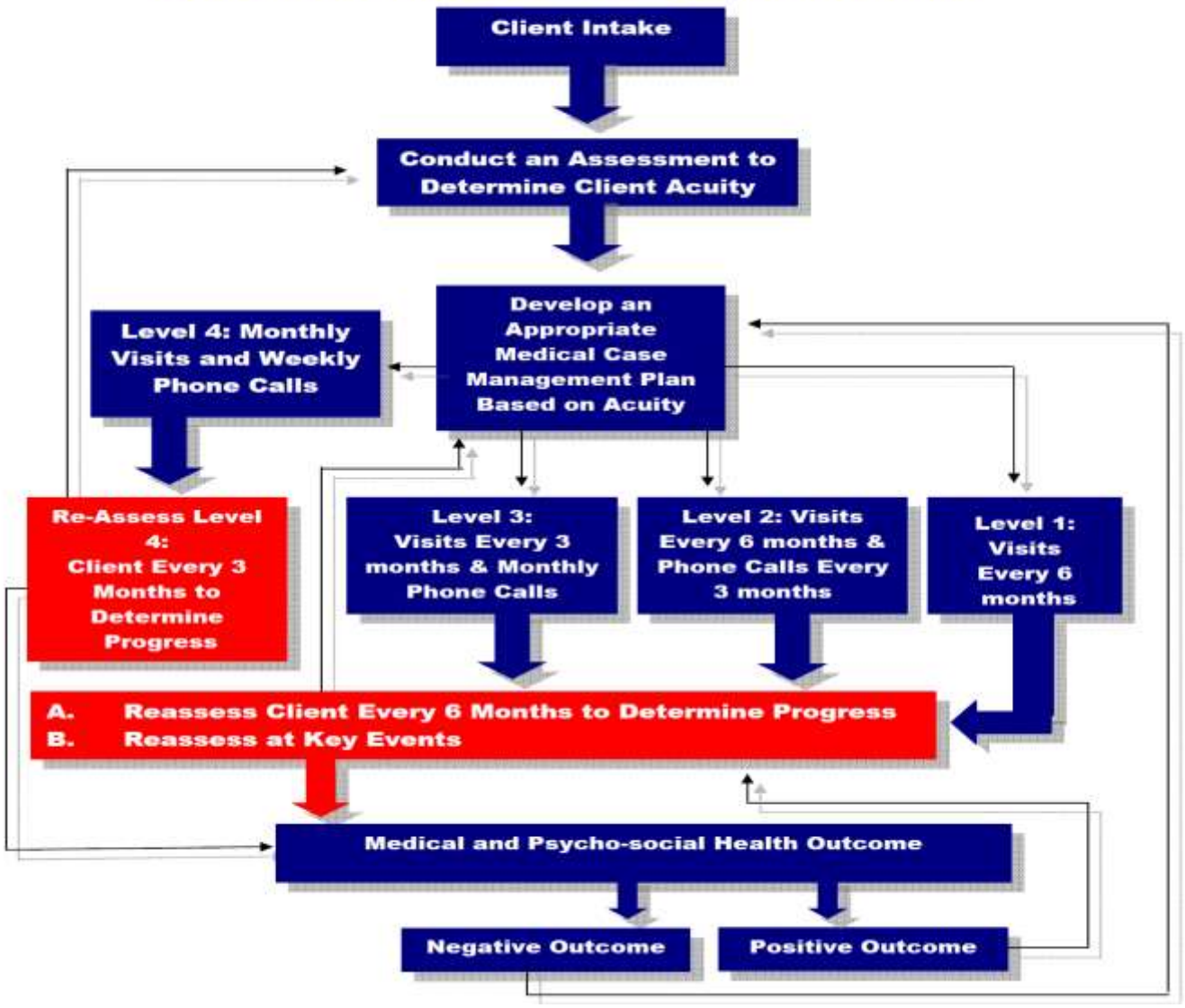
Disclosure for Social Support: It has been documented that the acquisition of social support, especially from family members, is important for client adherence to any medical or human services regimen. Case managers should employ strategies to support safe disclosure and promote the development of social support networks for clients as part of routine service provision.

Standard Operating Procedures: This should include protocols for a range of TCM program responsibilities such as customer service, satisfaction, client needs assessments, response to client calls and appropriate and complete documentation of required elements.

Quality Performance Measurement, Improvement and Evaluation of Case Managers, Client Outcomes, and Services Provided: TCM programs should have strategies for supervision and quality management of the case managers in the program. In addition, the clients that case managers serve must be tracked across significant quality performance measures, and other metrics. Programs should have systems in place to monitor and improve the performance of case managers as well as the performance measures collected for each client and the services provided.

Professional Development for CM Staff: All case managers should be supported to acquire the skills, competencies, and/or develop the abilities necessary to improve their performance. This includes HIPAA rules governing confidentiality, basic HIV knowledge, client rights and responsibility, Patient Protection and Affordable Care Act benefits, enrollment and eligibility, cultural competency, equity, social determinants, medication education and treatment adherence training.

The Medical Case Management Operational Model



- **Initial intake**
- **Assessment of Service Needs** (*including the use of the acuity scale*);
- **Development of a comprehensive, individualized Care Plan;**

1. *Linkages* and coordination of services required to implement the plan;
2. Client monitoring to assess the efficacy of the plan; and
3. Periodic [reassessment] and adaptation of the plan as necessary over the life of the client *based on medical and psychosocial outcomes*.

In this section each of these steps is expanded upon and key points are emphasized.

Intake

Definition and Purpose

Intake occurs when either the case manager or another staff member gathers demographic and social information from the client. Intake allows for the initiation of TCM activities and then a comprehensive assessment can be performed. It is often performed at the initial visit. At intake, the client's eligibility for HIV/AIDS health care payer programs is also evaluated. Verification of insurance status, accessing insurance, financial status and documentation of that status, and other basic elements associated with "getting started" may happen in this phase.

Intake Process

Intake can be performed at the same time as the comprehensive assessment, but often occurs separately, and it is advisable that upon referral, an Intake occur within three business days. Each potential client must go through an intake process. Individuals in crisis must be further assessed to determine what immediate interventions are appropriate; either within the agency or by immediate linkage to external service

Intake & Determining Eligibility

Central to the intake process is determination of eligibility for various HIV/AIDS health care payer programs. **Clients' eligibility should be assessed for all available payer programs – Medicaid (fee for service, managed care and demonstration programs) Medicare and as a last resort, programs funded through the payer of last resort Ryan White**. Minimum eligibility criteria for several publicly funded payer programs include an HIV/AIDS diagnosis; residency in Rhode Island, and an income verification. Eligibility should be reassessed every six months to insure stability of services.

Assessment of Service Needs - Client Assessment

Definition and Purpose

The assessment is the systematic gathering of information from, and the discussion of information with, the client (or legally authorized representative) by the case manager. The information is analyzed and synthesized in order to identify the client's needs, health and human service, psychosocial, and environmental needs. The case manager will use this information to develop a plan that addresses these needs in the order of priority. It is important to couple the Assessment with the Acuity Index such that the case manager can isolate the order of attending to needs.

The purpose of the assessment is to identify the extent to which the client's needs are not being met; **to assess,** the ability of the client or the client's social network to meet these needs; **to determine**, the need for improved coordination of services that are currently used by the client; **to determine,** the capacity of the medical and human services network to address the needs; **to define,** the intensity of TCM services needed by the client; **to ensure,** continued progress in meeting client needs and identifying new issues through re-assessment; and begin **to organize,** how to measure and track**,** all the required elements in the assessment and care plan..

The Assessment Process

The assessment process is divided into two: 1) the eliciting of information and 2) assigning clients to management levels using the Acuity Scale. In order to perform the assessment at least one face-to-face interview must occur with the client to elicit information. Information may also be obtained from secondary data sources such as client records, and/or or other information from health and human service professionals. ***During the assessment, critical flags or triggers are identified as well as other competing needs, such as housing, social services and transport.***

The client's poly (multiple) conditions should be noted, adherence and medication history, and current ability to adhere to medication and/or other regimens should be assessed. The sample TCM comprehensive assessment tool in this document can help facilitate the elicitation of comprehensive information. When assessing any area of need, any identified deficiency should be included as an action item in the client's TCM care plan.

A Reminder: The assessment must be completed within 30 days of intake. Any client assessed and found to require:

- An intensive level of case management must receive services immediately.
- A moderate level of case management must receive services within 10 days after the assessment.
- A basic level of medical case management must receive services within 15 days after assessment.

Assessment Tool

The TCM Comprehensive Assessment Tool serves to elicit the information necessary to assign an acuity score to each client and to develop the TCM Service Plan. It is a companion document for the Acuity Scale. With the acuity score the case manager can then place the client within an acuity level/management level on the Acuity Scale that then determines the intensity of TCM services that the client receives.

The suggested TCM Assessment Tool and the Acuity Scale are divided into seven categories. These are:

- **Access to health care/human services programs**
- **Health status**
- **Treatment adherence**
- **HIV knowledge**
- **Behavioral health**
- **Children/Families**
- **Environmental Factors**

Metrics and Performance Measures shall be recorded from these variables. With this tool the case manager can collect the information necessary in these seven categories to accurately assess a client and place them in the appropriate management level needed for intervention.

These seven categories fall into three broad subject areas: Demographic and Access to Care 2) Health/Human Services, and 3) Behavioral and Psychosocial. The Demographic questions are as stated, and the Access to Care questions help to determine if the client has access to care and if not, what the possible barriers are. Here, "Access" describes the client's need and income eligibility for health benefit programs and support services to assist him/her in establishing, maintaining and participating in medical care, treatment services and/or other services. The purpose of the questions that are grouped under "Access to health care/human services programs" is to gather information related to clients' retention in care, achievement of positive health outcomes, as well as other human services outcomes that are relevant to the case management of the client. When assessing any area, case managers should include any identified deficiency as part of client's service plan. Achieving viral suppression should be priority in the service plan. The Behavioral and Psychosocial area evaluates clients' needs related to mental health, substance use, recovery, and social situations. Any identified deficiency in the Behavioral and Psychosocial Area should be referred to appropriate personnel either in the intake agency or to a specialized service agency. Case managers will coordinate the linkage to ensure that services were received.

Rhode Island

HIV Case Management Assessment Form

Client Demographics: This section only needs to be completed once if the agency is a multi-service agency and updated at each reassessment point (every 6 months).

1. Name (First, MI, Last)		2. Date of birth	
3. What is your preferred name		4. Social Security Number	

5. Marital Status

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

6. Phone Info	Are a	Number	May we leave a message?	May we leave the agency name?
a. Home Phone				
b. Cell Phone				
c. Alternate Phone				

7. Race and Ethnicity

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

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

Emergency Contact Information

9. Emergency Contact Person					
a. Phone			b. Cell phone		
c. E-Mail			d. Relationship		
e. Is this person aware of your HIV status?	☐ Yes	☐ No	f. Is your partner aware of your HIV status?	☐ Yes	☐ No
10. Alternate Contact Person					
a. Phone			b. Cell phone		
c. E-Mail			d. Relationship		
e. Is this person aware of your HIV status?	☐ Yes	☐ No	f. Is your partner aware of your HIV status?	☐ Yes	☐ No

Medical Home

11. Are you receiving treatment for your HIV	☐ Yes	☐ No	a. If "Yes," what is the clinic name	

Function Area 1: Access and Support

12. Are you receiving a clinician or doctor who can treat your HIV	☐ Yes	☐ No	a. If "yes" what is the doctor's name?	
13. Year of HIV diagnosis	14. Mode of Transmission			
15. Date of last medical visit				
a. Did you keep the appointment?	☐ Yes	☐ No	a. If "No" why not?	
16. Are you changing clinics?	☐ Yes	☐ No	If "yes," why?	
17. When is your next appointment date?				
18. What is the reason for your visit?				
19. Were you referred for services	☐ Yes	☐ No	a. If "yes" by whom?	

20. 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)

21. Do you have any other medical conditions (hypertension, diabetes, heart disease?)	☐ Yes	☐ No	If "Yes," please describe?

23. Do you currently have health insurance?

a. If "yes," what type □ Yes □ No

I. Medicaid/ OHP # □ Standard □ open Care
II. Private insurance ID # □ Plus □ Managed Care
III. Medicare A or B
IV. OMIP #
V. DC Alliance
VI. Veteran's Benefit Insurance #

b. Does your insurance have benefit limits? □ Yes □ No
If "Yes," what are the limits

a. what is the premium amount per month

b. How much is you co-payment per prescription

c. Does your insurance cover □ Medications □ Doctor Visit □ Dental Visit

c. what is your dental insurance number:

24. Are you enrolled in any type of Medicaid spend-down program?	□ Yes	□ No
a. If "yes," what is the spend-down amount?		
25. Are you enrolled in the AIDS Drug Assistance Program (ADAP)?	□ Yes	□ No
a. If "Yes," what is your number?		

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

22. Have you ever been hospitalized for an HIV-related illness or opportunistic infection? **a. If "yes,"** **I. Last date** **II. Illness or Diagnosis** **III. Where were you hospitalized or treated?**	□ Yes	□ No

Cultural / Linguistics

26. What language(s) do you read or write?		☐ Speak	☐ Read	☐ Write
		☐ Speak	☐ Read	☐ Write
27. Do you need a translator or interpreter (including an American Sign Language Interpreter)?			☐ Yes	☐ No
28. Amount of Education or schooling completed?				
☐ 6th Grade or Less	☐ Between 7th and 12th	☐ High School Diploma or GED	☐ Vocational or Technical Training	
☐ College Degree	☐ Postgraduate work	☐ Postgraduate degree	☐ Other	
29. Are you able to complete forms independently?			☐ Yes	☐ No
30. Do you have any religious beliefs that may prohibit you from taking any medication?			☐ Yes	☐ No
31. Do you have any belief prohibiting				
a. Blood Transfusion?			☐ Yes	☐ No
b. Participating in medical research?			☐ Yes	☐ No
c. Any specific medical procedure?			☐ Yes	☐ No
d. Other (Specify)			☐ Yes	☐ No
32. Do you prefer to be assessed by any particular				
a. Gender? (Specify			☐ Yes	☐ No
b. Age? (Specify)			☐ Yes	☐ No
33. Do you want us to be aware of any religious or cultural beliefs or practices that may affect your receiving care?			☐ Yes	☐ No
a. If "Yes," describe				
34. Are there any other things of which health care providers should be made aware?			☐ Yes	☐ No
a. If "Yes," describe				

Transportation

35. Do you have access to transportation for health care and other HIV-related support service appointments?			☐ Yes	☐ No
a. If "Yes," what types of transportation do you use?				
☐ Personal car	☐ Public Bus	☐ Metro Train	☐ Other	
☐ Van Service	☐ Taxi Service	☐	☐	
36. Do you need financial assistance with transportation?			☐ Yes	☐ No
37. Do you have physical disabilities that impede your access to public transportation?			☐ Yes	☐ No
38. Do you have any other disability that could impede your use of public transportation (Bus or trains)			☐ Yes	☐ No
a. If "Yes," what disability				
39. Do you have access to transportation for health care or support services not associated with HIV care?			☐ Yes	☐ No
40. If "yes" to transportation needs, make appropriate referral to benefits program				

Social Support

41. What do you do to socialize?				
42. What type of support system do you have?				
☐ **Family**	☐ **Friends**	☐ **Neighbors**	☐ **Peers**	☐ **Support Group**
☐ **FaceBook**	☐ **MySpace**	☐ **Twitter**	☐ **None**	☐
43. Do you believe you have an adequate support system			☐ **Yes**	☐ **No**
a. If yes				
ii Have you told anyone you have HIV?			☐ **Yes**	☐ **No**
iii Whom have you told (by relationship)?	•			
44. Are your supports aware of your HIV diagnosis?			☐ **Yes**	☐ **No**
a. If "No," do you need help to disclose your HIV status?			☐ **Yes**	☐ **No**
b. If "yes" to need help to disclose, make appropriate referral to support and healthy relationship groups				

Function Area 2: Health Status

Section 1: Activities of Daily Living

45. 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	Does Not Do
a. Bathing				
b. Dressing				
c. Grooming				
d. Oral Care				
e. Toileting				
f. Transferring				
g. Walking				
h. Climbing Stairs				
i. Eating				
j. Shopping				
k. Cooking				
l. Managing Medications				
m. Using the Phone				
n. Housework				
o. Doing Laundry				
p. Driving				
q. Managing Finances				

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

Section 2: HIV Disease Progression

Laboratory Values: A verbal report from the client of his or her laboratory results is not sufficient for documentation. To obtain the client's laboratory results, the medical/non-medical case manager can either ask that the client sign an information release and have the medical provider fax it to the medical case manager OR ask the client to bring a photocopy given to them by the medical providers.

Opportunistic Infections

46. Are you on Prophylaxis (preventive medication) for an opportunistic infection	**☐ Yes**	**☐ No**

a. If "Yes," please provide information below

Opportunistic Infection	Drug for Prophylaxis	Dose

47. 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 carinii 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
Cancer							
AIDS Dementia complex	☐ Yes	☐ No		☐ Yes	☐ No	☐ Yes	☐ No
Peripheral Neuropathy (pain, numbness and tingling of the feet or hands)	☐ Yes	☐ No		☐ Yes	☐ No	☐ Yes	☐ No

Hospitalizations

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

a. If "Yes," please provide information below

Date	Reason for Hospitalization	Hospital

Section 3: Co-Morbid Diseases

50. Have you ever been told you have any conditions, illnesses or diseases other than HIV? [For example, hypertension, diabetes, heart disease, hepatitis?]	**☐ Yes**	**☐ No**

a. If "Yes," please provide information below

Disease	Date of Diagnosis	Treatment Received	Treatment Completed

Section 4: Oral Health Needs

Oral problems are very common in people with HIV. People living with HIV often have oral conditions that arise because of their weakened immune systems

51. When was the last time you saw a dentist?		
52. Do you have a regular dentist you visit?	**☐ Yes**	**☐ No**
a. If "Yes," who is the dentist?		

53. How often do you brush your teeth?					times per	
54. Do you have a toothbrush?					☐ Yes	☐ No
55. Do you have dentures?					☐ Yes	☐ No
a. If "No," do you need dentures?					☐ Yes	☐ No
56. Do you have one or more dental bridges?					☐ Yes	☐ No
a. If "No," do you need one or more bridges?					☐ Yes	☐ No
57. Have you ever been diagnosed with any oral conditions, illnesses or diseases?						
a. Oral herpes	☐ Yes	☐ No	b. Apthous or Canker Sores		☐ Yes	☐ No
c. Ulcers	☐ Yes	☐ No	d. Hairy leukoplakia		☐ Yes	☐ No
e. Thrush	☐ Yes	☐ No	f. Warts		☐ Yes	☐ No
g. Dry Mouth	☐ Yes	☐ No	h. Tooth Decay		☐ Yes	☐ No
i. Abscesses	☐ Yes	☐ No	j. Other		☐ Yes	☐ No
k.	☐ Yes	☐ No	l.		☐ Yes	☐ No
58. Are you currently receiving treatment?					☐ Yes	☐ No
59. Do you have pain, sensitivity or other discomfort with your teeth, gums or elsewhere in your mouth?					☐ Yes	☐ No
a. If "Yes," does this pain, sensitivity or discomfort affect your intake of food, drink or medications					☐ Yes	☐ No
60. Have you noticed any changes in your teeth, gums or elsewhere in your mouth?					☐ Yes	☐ No

Section 5: Nutritional Needs

61. Current Weight		62. Current Height	

63. Have you gained or lost a significant amount of weight in the last				
a. Thirty Days (One Month)	☐ Yes	If "Yes," how much		☐ No
b. Sixty Days (Two Months)	☐ Yes	If "Yes," how much		☐ No
c. One Hundred and Eighty Days (Six Months)	☐ Yes	If "Yes," how much		☐ No

64. Describe the reasons for the significant gain or loss of weight?		
•		
65. Are you being treated for a weight gain or loss problem?	☐ Yes	☐ No
a. If "Yes," what is the medication?	•	
66. Are you receiving medical nutrition therapy (from a licensed or registered clinical dietician or nutritionist)?	☐ Yes	☐ No
67. Are you receiving nutritional counseling (from someone who is NOT a licensed or registered clinical dietician or nutritionist)?	☐ Yes	☐ No
68. Are you taking nutritional or vitamin supplements? (Examples are Boost, Ensure, vitamins)	☐ Yes	☐ No
a. If "Yes," which supplements?		
b. If "Yes," who prescribed them?		
69. Do you need assistance with food?	☐ Yes	☐ No
70. Do you currently receive assistance with food from any of the programs listed below?		
a. Food Stamps?	☐ Yes	☐ No
b. Home delivered meals?	☐ Yes	☐ No

c. Home delivered groceries?	☐ Yes	☐ No
d. Food bank?	☐ Yes	☐ No
e. Emergency food vouchers?	☐ Yes	☐ No
f. Other?	☐ Yes	☐ No
71. Do you have any physical problems that make it difficult to eat?		
a. Mouth Problems?	☐ Yes	☐ No
b. Swallowing problems?	☐ Yes	☐ No
c. Food Allergies?	☐ Yes	☐ No
d. Nausea?	☐ Yes	☐ No
e. Vomiting?	☐ Yes	☐ No
f. Diarrhea?	☐ Yes	☐ No
g. Taste Alteration?	☐ Yes	☐ No
72. Do you have any diet restrictions	☐ Yes	☐ No
a. If "Yes," what are they?		
73. Do you have any other problems with food?	☐ Yes	☐ No
74. Have you ever been diagnosed with wasting syndrome?	☐ Yes	☐ No

Function Area 3: Treatment Adherence

Section 1

75. Do you have any current prescriptions for medications?	☐ Yes	☐ No
76. Are you taking any medications? (AntiRetroviral or ARV and any other prescribed medications) If 'NO', skip to question 93	☐ Yes	☐ No

a. 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	

77. How do you take your medications?	☐ Self Administered	☐ Given by Another

78. Please rate your ability to take your medications as prescribed over the last seven days

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

79. Do you forget to take your medications?	☐ Yes	☐ No
a. If "Yes," when was the last time you missed a dose?		

b. 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?	

c. How many doses do you think you have missed over the past month?			
d. 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	☐ Problems swallowing	
☐ I take a drug holiday or break from taking pills (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:	
e. What do you do when you miss a dose?	•		
80. What will make it easier for you to take your medications:			
•			
81. How do you receive your medications?			
☐ Pick up at pharmacy	☐ Delivered by pharmacy	☐ Pick up at doctor's office	
82. Do you have difficulty getting your medications?		☐ Yes	☐ No
a. If "Yes," what type of problems?	•		
83. Is cost a problem to getting your medications?		☐ Yes	☐ No
84. Have you ever run out of your medications?		☐ Yes	☐ No
85. Whom do you call to fill or refill a prescription?	Name:		
	Phone number:		
86. Where do you keep your medications?	•		
87. Do you believe they are safe?		☐ Yes	☐ No
88. Would you feel the need to hide your medications from anyone?		☐ Yes	☐ No
89. How many people in your life know about your HIV?			
☐ All of them	☐ Some of Them	☐ One Person	☐ None
90. 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
91. Have you ever participated in a medication or treatment adherence program?		☐ Yes	☐ No
92. Are you interested in participating in a medication or treatment adherence program?		☐ Yes	☐ No
If "Yes," include in service plan and link to a treatment adherence specialist or program.			
93. Are you taking herbal or alternative therapies?		☐ Yes	☐ No
94. Are you taking over the counter (OTC) medications?		☐ Yes	☐ No
a. If "Yes," what are the names and reasons for taking the herbal, alternative or over the counter medications			

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

Section 2

95. Identify the side effects that you know you are experiencing that are associated with HIV medications	
a.	**b.**
c.	**d.**
e.	**f.**
g.	**h.**

96. 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
a. Diarrhea					
b. Nausea					
c. Vomiting					
d. Constipation					
e. Headache					
f. Skin Rash					
g. Bad Dreams or Confusion					
h. Fever					
i. Taste Alteration					
j. Discoloration of skin or nails					
k. Numbness or Tingling Pain of Peripherals					
l. Drowsiness					
m. Loss of Sex Drive					
n. Other					
o. Other					

97. What have you done about the side effects?

-

Section 3

98. When was your last appointment with your primary medical care provider?	

99. How often are your appointments with your primary medical 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

100. How many appointments related to you health care (with your medical doctor, clinic, etc.) would you say you have missed in the last

a. Thirty (30) Days		b. Sixty (60) Days		c. Four (4) months	
d. Six (6) Months		e. Twelve (12) Months		f.	

101. What are some of the reasons for missing your appointments

-

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

-

All identified deficiencies in treatment adherence should be included in the case management service plan.

103.	**What is your most recent viral load?**				
a.	**Date**		**b. Result**	**c. Next Scheduled**	
	☐ Self-Report		**☐ Laboratory Report**		
104.	**What is your most recent CD4 count?**				
a.	**Date**		**b. Result**	**c. Next Scheduled**	
	☐ Self-Report		**☐ Laboratory Report**		

105.	**Describe ways or methods of treatment adherence aids being used**	
a.	**Pill Count Discussions**	•
b.	**Prescription refill checks**	•
c.	**Direct observation therapy**	•
d.	**Diaries**	•
e.	**Electronic Monitoring**	•
f.	**Family Reporting**	•

Function Area 4: Health Knowledge

Section 1: Health Literacy

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

Section 2: HIV Knowledge

109.	**What is HIV?**	•
110.	**What is AIDS?**	•

111.	**You can get HIV from the following**		
a.	**Sharing needles and/or works**	**☐ True**	**☐ False**
b.	**Tattoos**	**☐ True**	**☐ False**
c.	**Piercing body parts**	**☐ True**	**☐ False**

d. Vaginal sex	☐ True	☐ False
e. Anal sex	☐ True	☐ False
f. Oral sex	☐ True	☐ False
g. Mosquitoes carrying infected blood	☐ True	☐ False
h. Kissing	☐ True	☐ False
i. Breast feeding	☐ True	☐ False
j. Shaking hands	☐ True	☐ False

112. Why is it important to get your viral load measured?	•
113. Why is it important to get your CD4 count measured??	•

If deficiency is identified, intervene as a teachable moment

Function Area 5: Behavioral Health

Section 1: Mental Health Screening

A. Mini-Mental Status screening (See form at the end of this Assessment tool)

B. Client Diagnostic Questionnaire (CDQ) (See CDQ at the end of this Assessment tool)

Check All That Apply

- ☐ Indication of 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

114. Do you drink alcohol?	☐ Yes	☐ No
a. If "Yes," have you ever felt you should cut down on your drinking?	☐ Yes	☐ No
b. Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
c. Have you ever felt bad or guilty about your drinking?	☐ Yes	☐ No
d. Have you ever had 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 with alcohol addiction services
- ☐ Interventions noted in medical case management service plan

115. Have you used recreational drugs during the past twelve months?	☐ Yes	☐ No
a. 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 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 /							
Cannabis			□ O	□ N	□ S	□ NV	□ IV
Hallucinogens			□ O	□ N	□ S	□ NV	□ IV
More than one							

116. How often do you use?	□ Daily	□ 2 – 3 times per week	□ Once a week	□ Once a month	□ Occasionally

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

123. What was your longest period of voluntary abstinences from this major substance?

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

a. How many months ago did this abstinence end?	
124. How many times have you had alcohol delirium tremens (DT)?	
125. How many times have you overdosed on drugs?	
126. How many times have you been treated for	
a. Alcohol abuse?	
b. Drug abuse?	
127. Of the times you have been treated, how many of were for detoxification only?	
a. Alcohol?	
b. Drug?	

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

a. Name of center		
b. Type of Treatment	□ In-Patient	□ Out-Patient
c. How long did it last?		
d. Did you complete it successfully?	□ Yes	□ No
129. Have you ever been evaluated for alcohol or drug use before today?	□ Yes	□ No

130. How important to you now is treatment for

a. Alcohol problems	□ Not Important	□ Neutral	□ Very Important
b. Drug problems	□ Not Important	□ Neutral	□ Very Important

Check All That Apply

- ☐ Indication of need for substance abuse assessment or intervention
- ☐ Client should be referred and linked with substance abuse services
- ☐ Interventions noted in medical care management plan

Section 3: Harm Reduction

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

133. How often would you say you engage in sex

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

134. Do you use protection while having sex?	☐ Yes	☐ No
a. If "No," why not?	•	

b. If "Yes," what type of protection do you use?

☐ Condom	☐ Dental Dam	☐ Saran Wrap	☐ Latex Gloves	☐ Withdrawal Mechanism	☐ Nothing

135. How often do you use protection?

☐ All the time	☐ Sometimes	☐ Only with partners other than Significant Other	☐ Never

136. Have you ever had a sexually transmitted infection (STI?)	☐ Yes	☐ No

a. If "Yes," what type of STI did (or do) you have?

☐ Gonorrhea	☐ Syphilis	☐ Chlamydia	☐ Genital Warts
☐ Genital Lice	☐ Herpes	☐ Human Papilloma Virus (HPV)	☐ Other:

b. When was the most recent STI?	☐ Within the last six months	☐ Within the last year	☐ More than a year
c. Where did you receive treatment?	☐ In a doctor's office	☐ In a free clinic	☐ Other:

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

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 care management plan

Function Area 6: Children and Families

144.	Do you have any children living with you?	☐ Yes	☐ No
a.	If "Yes," how many?		
b.	What are their ages?		
c.	What is your relationship to the children?		
d.	Do any of the children have special needs	☐ Yes	☐ No
e.	Are any of the children HIV-positive?	☐ Yes	☐ No
i	If "Yes," how many are HIV-positive?		
ii	Where do they receive care?		
iii	Who is the physician?	Name:	
		Contact Info:	
145.	Do need assistance with disclosure of your status to the children?	☐ Yes	☐ No
146.	Do you need assistance with caring for the children?	☐ Yes	☐ No
147.	Do you need assistance with permanency planning? [Explain "permanency planning."]	☐ Yes	☐ No
148.	Do you need assistance with locating parenting classes?	☐ Yes	☐ No
149.	Do you have adult dependent(s) living with you?	☐ Yes	☐ No
a.	If "Yes," how many?		
b.	What is your relationship to the adult dependent(s)?		
c.	Do you need assistance in caring for the adult dependent(s)?	☐ Yes	☐ No
d.	Are you presently going through a crisis as a result of your 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 care management plan

Function Area 7: Environment

Section 1: Domestic Violence

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

Check All That Apply

- ☐ **The client has observable bruises over his or her body**
- ☐ **Client needs a domestic violence intervention**
- ☐ **Client is referred and linked to domestic violence services**
- ☐ **Interventions noted in medical care management plan**

Section 2: Living Situation

154.	**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**	
155.	**If homeless, do you need help finding a shelter?**		☐ **Yes**	☐ **No**
156.	**Are you in subsidized housing?**		☐ **Yes**	☐ **No**
157.	**Are you at risk of losing housing?**		☐ **Yes**	☐ **No**
158.	**How long have you been at your current address?**			
159.	**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" services**
- ☐ **The client has immediate housing need**
- ☐ **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 care management plan**

Section 3: Financial

160.	**Do you have income?**		☐ **Yes**	☐ **No**
161.	**For each source of income, please provide the amount of income per month**			
a.	**Employment**	$		
b.	**Worker's Compensation**	$		
c.	**SSI and/or SSDI**	$		
d.	**Unemployment**	$		
e.	**TANF**	$		
f.	**Other**	$		
g.	**Other**	$		
h.	**Other**	$		
	TOTAL	$		
162.	**Are you able to meet your basic monthly needs?**		☐ **Yes**	☐ **No**
163.	**Are you able to buy food for the month?**		☐ **Yes**	☐ **No**
164.	**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 programs**
- ☐ **Interventions noted in medical care management plan**

Section 4: Legal

165.	**Have you ever been incarcerated?**	☐ **Yes**	☐ **No**
166.	**Do you have any current…?**		
a.	**Outstanding warrants?**	☐ **Yes**	☐ **No**
b.	**Civil charges?**	☐ **Yes**	☐ **No**
c.	**Criminal charges?**	☐ **Yes**	☐ **No**
d.	**Probation?**	☐ **Yes**	☐ **No**
e.	**Parole?**	☐ **Yes**	☐ **No**
f.	**Child Protective Custody?**	☐ **Yes**	☐ **No**
	D **If "Yes," are you in danger of losing your children?**	☐ **Yes**	☐ **No**
		☐	☐
167.	**Are there any other legal issues that would involve the courts?**	☐ **Yes**	☐ **No**
a.	**If "Yes," describe**		
168.	**Are you registered with the criminal justice department – of any jurisdiction**	☐ **Yes**	☐ **No**
a.	**If "Yes," describe**	•	
169.	**Do you need a referral for legal assistance?**	☐ **Yes**	☐ **No**
170.	**Do you have…?**		
a.	**A power of attorney?**	☐ **Yes**	☐ **No**
b.	**A will?**	☐ **Yes**	☐ **No**
c.	**A "living will"?**	☐ **Yes**	☐ **No**
d.	**A medical power of attorney??**	☐ **Yes**	☐ **No**
e.	**Burial arrangements?**	☐ **Yes**	☐ **No**
171.	**Are you a United States citizen?**	☐ **Yes**	☐ **No**
172.	**Do you need help with obtaining identification papers?**	☐ **Yes**	☐ **No**

Mini-Mental Status Examination

The Mini-Mental Status Examination offers a quick and simple way to quantify cognitive function and screen for cognitive loss. It tests the individual's orientation, attention, calculation, recall, language and motor skills.

Each section of the test involves a related series of questions or commands. The individual receives one point for each correct answer.

To give the examination, seat the individual in a quiet, well-lit room. Ask him/her to listen carefully and to answer each question as accurately as he/she can.

Don't time the test but score it right away. To score, add the number of correct responses. The individual can receive a maximum score of 30 points.

A score below 20 usually indicates cognitive impairment.

The Mini-Mental Status Examination

Name: _____ DOB: _____

Years of School;_____ Date of Exam: _____

Orientation to Time	Correct	Incorrect
What is today's date?	☐	☐
What is the month?	☐	☐
What is the year?	☐	☐
What is the day of the week today?	☐	☐
What season is it?	☐	☐

Total: ____

Orientation to Place		
Whose home is this?	☐	☐
What room is this?	☐	☐
What city are we in?	☐	☐
What county are we in?	☐	☐
What state are we in?	☐	☐

Total:____

Immediate Recall

Ask if you may test his/her memory. Then say "ball", "flag", "tree" clearly and slowly, about 1 second for each. After you have said all 3 words, ask him/her to repeat them – the first repetition determines the score (0-3):

Ball	☐	☐
Flag	☐	☐
Tree	☐	☐

Total: ____

Attention

A) Ask the individual to begin with 100 and count backwards by 7. Stop after 5 subtractions. Score the correct subtractions.

93	D	D	
86	D	D	
79	D	D	
72	D	D	
65	D		Total:

B) Ask the individual to spell the word "WORLD" backwards. The score is the number of letters in correct position.

D	D	D	
L	D	D	
R	D	D	
O	D	D	
W	D	D	
			Total

Delayed Verbal Recall

Ask the individual to recall the 3 words you previously asked him/her to remember.

Ball	D	D	
Flag	D	D	
Tree	D	D	
			Total:

Naming

Show the individual a wristwatch and ask him/her what it is. Repeat for pencil.

Watch	D	D	
Pencil	D	D	

Repetition

Ask the individual to repeat the following:

"No if, ands, or buts" D D

3-Stage Command

Give the individual a plain piece of paper and say, "Take the paper in your hand, fold it in half, and put it on the floor."

Takes D D

Folds D D

Puts D D

Reading

Hold up the card reading: "Close your eyes" so the individual can see it clearly.

Ask him/her to read it and do what it says. Score correctly only if the individual actually closes his/her eyes. D D

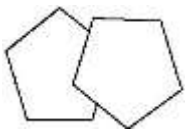
Writing

Give the individual a piece of paper and ask him/her to write a sentence. It is to be written spontaneously. It must contain a subject and verb and be sensible.

D D

Copying

Give the individual a piece of paper and ask him/her to copy a design of two intersecting shapes. One point is awarded for correctly copying the shapes. All angles on both figures must be present, and the figures must have one overlapping angle.



D D

Total Score:

*1. Agency/ Program:*_____ *2. Interviewer* _____

*3. Today's Date:*____!____!____ *4. Client ID:* |__|__|__|__|__|__|__|__|__|__|

Month/ Day/ Year

*5. Client Name or Initial:*_____

Instructions to interviewer:

This questionnaire is designed to facilitate the recognition of the most common mental health problems found in HIV/AIDS primary care or other service settings: mood, anxiety, alcohol and drug abuse, PTSD and thought disorder. Since the questionnaire relies on respondent self-report, definitive diagnoses must be verified by a clinician, taking into account how well the client understood the questions in the questionnaire, as well as other relevant information from family, client records, or other sources.

1. Interviewer instructions are printed in bold italics. Questions that you ask or statements that you make to the client are printed in plain type. Read questions as written. Additional probes may be used to ensure client understanding of the question or explore ambiguous answers.
2. For anything other than a "yes/no" answer, read the answer categories. The interviewer may need to assist the client in answering within the categories given. Never choose an answer category based on what you think the client means by their spoken response.
3. Be sure that the client is reporting symptoms experienced within the specified time period: past 4 weeks, past 6 months, or in some instances, past 30 days.
4. Within each module, proceed sequentially from question to question unless instructed either to skip to another question or to go to the next page.
5. At the end of each diagnostic module is a shaded area with instructions for scoring Positive Screen for each disorder. Scoring can be done by the interviewer or left for office use only.
6. A Summary Sheet is provided to record "positive screen" or "positive for syndrome" in the spaces provided for each diagnostic module. If no positive screen in any module, indicate in the space provided on the top of the summary sheet.
7. Space is also provided for interviewer observations and comments. Interviewer should write as detailed as possible description of positive answers to questions especially on psychosis screen. Where known, additional information that may account for symptoms (e.g. medical condition) or history of prior episodes or treatment should be indicated

---

8. If Client indicates current suicidal feelings or becomes emotionally upset or agitated during interview w, please follow agency protocol for contacting your supervisor.

The CDQ is based on the PHQ which was developed by Robert L Spitzer, MD, Janet B W Williams, DSW, Kurt Kroenke, MD, et al, and is a modification of the PRIME-MD, which was developed with an unrestricted educational grant from Pfizer, Inc. Adaptation for use by SPNS/ HOPWAProgram Projects by Angela Aidala, PhD and Jennifer Havens, MD with the assistance of Jeffrey Johnson, PhD, Peter Walsh, MD, Cevdet Tosyali, MD, Ezra Susser, MD, and Sally Dodds, PhD, LCSW. For information about using this instrument contact Angela Aidala, PhD, Columbia Scho9I of Public Health, 600 W 168th, New York, NY 10032. Phone: (212) 305-7023, email:aaa1@columbia.edu

Client Introduction

This questionnaire will help us better understand problems that you may have. We ask these questions of everyone so that we can get a better picture of the kind of help or support we could provide for you. Please try to answer every question. All your answers are be completely confidential.

Overview

1. Thinking about the past six months, that is about this time in *(reference date 6 months prior to interview),* how have things been going for you in terms of your mood or feelings? Were there any periods when you were very sad or depressed? How about any times when you were very nervous, frightened, or worried about things? Were there times when you were so active or hyper that you couldn't slow down?

2. Did anything happened to you during that time that had anything to do with your feeling (acting) this way (sad, anxious, hyper etc... refer to symptoms)? Anything that was especially hard or stressful for you?

3. During the past six months did you talk to anyone about emotional problems, your nerves or the way you were feeling or acting? *If YES,* Whom did you talk to? *(Probe)* Did you talk to professional person like a doctor or counselor? What did they say about it?

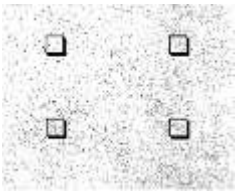
Interviewer: *If client describes symptoms or treatment history, let him/her know that you will be talking about this in more detail later in the interview. All screening and appropriate symptom questions must be asked even though topic was discussed in overview.Confirm answers already known.*

CDQ2

Now some questions about your moods and feelings. During the last month (past 4 weeks) was there a time

When.

	No, Not at all	Several days	More than half the days	Nearly every day
1. You were feeling sad, down, depressed, or hopeless? *IF **YES,*** How often did you feel that way? ……	O	O		
2. You had little interest or pleasure in doing things? *IF **YES,*** How often did you feel that way? ……	O	O		



*If **client answers "No, Not at all" to both questions, go to next page***

3. When did you began to feeling this way (the most recent time)? … _____

4. How long did it last- was it as long as 2 weeks? …….. O No

D Yes

During that time, how often were you (have you been) bothered by:

	No, Not at all
5. Trouble falling or staying asleep? Or sleeping too much?	O
6. Feeling tired or having little energy? ……	D
7. Poor appetite? Or overeating? ……	D
8. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	O
9. Trouble concentrating on things, such as reading the newspaper, watching television, or listening to someone give you directions? ……	D

	Several days	More than half the days	Nearly every day
10. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? ……..…….. D	❑	❑	❑
	❑	❑	❑
11. You had thoughts that you would be better off dead or thoughts of hurting yourself in some way? .....O	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Maj Dep Syn if 2 weeks (Q4) is "yes" (AND) answer to question 1 or 2 is shaded (AND) 5+ of answers to any of Q. 1, 2, 5 - 11 are shaded; Other Dep Syn same but only 2+ of the answers to Q. 1, 2, 5 - 11 are shaded

CDQ3

Now some questions about anxiety.

	YES	NO
1. In the last 4 weeks, have you had an anxiety attack- Suddenly feeling fear or panic?	D	D

*If **client answers "NO" go to next page***

2. Has this ever happened before?	D	D
3. Do some of these attacks come suddenly out of the blue-that is, in situations where you don't expect to be nervous or uncomfortable?	D	D
4. Do these attacks bother you a lot? Are you worried about having another attack?	O	O

Think about your last really bad attack.

5. Were you short of breath?	O	O
6. Did your heart race, pound, or skip?	D	D
7. Did you have chest pain or pressure?	D	D
8. Did you sweat?	O	D
9. Did you feel as if you were choking?	O	O
10. Did you have hot flashes or chills?	O	O

11. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? ..... O O

12. Did you feel dizzy, unsteady, or faint? ..... O D

13. Did you have tingling or numbness in parts of your body? ..... O O

14. Did you tremble or shake? ..... O O

15. Were you afraid you were dying? ..... D D

Pan Syn if answers to Q. 1,2,3 and 4 are 'Yes' (AND) 4+ symptoms during an attack (Q. 5-15)

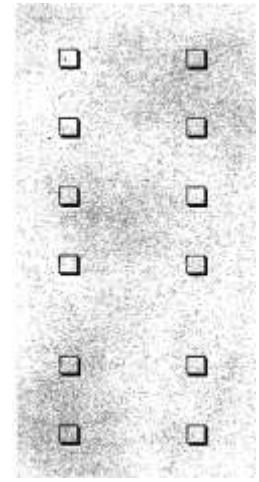
CDQ4

Over the last 4 weeks, how often have you been bothered by:

	No, Not at all	Several days	More than half the days	Nearly ever
1. Feeling nervous, anxious, on edge, or worrying a lot about different things?	D	D		

*If **client answers "Not at all" go to next page***

2.	Feeling restless so that it is hard to sit still?	D	D	
3.	Getting tired very easily?	D	D	
4.	Muscle tension, aches, or soreness?	D	D	
5.	Trouble falling asleep or staying asleep?	D	D	
6.	Trouble concentrating on things, such as reading a newspaper, watching TV or listening to someone give you directions?	D	D	
7.	Becoming easily annoyed or irritable?	D	D	



Other Anx Syn if answer to Q. 1 is shaded (AND) 3+ answers to Q. 2-7 are shaded.

Next are some questions about drinking alcohol and use of other substances. We ask these questions as part of everyone's health profile. Everything you tell me is strictly confidential and protected.

1. During the past six months, how often do you drink beer, wine or liquor?

Never	Less than 1x month	Monthly	Weekly	3x Week	Everyday
D	D	D	D	O	D

If client never drinks alcohol, go to last alcohol question - Q.13 next page

2. How many drinks do you usually have on those days when you drink?

One	Two	Three	Four	Five	More than five
D	D	D	D	D	D

Have any of the following things happened to you more than one time in the last 6 months, that is from ( ) until today?

(fill in date 6 mo prior to interview

	YES	NO
3. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health?	D	D
4. You drank alcohol, were you high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities?	D	D
5. You missed or were late for something important because you were drinking or hung over?	D	D
6. You had a problem getting along with other people while you were drinking?	D	D
7. You drove a car after having several drinks or after drinking too much?	D	D

AleAbu if 1+ answers to Q. 3-7 are Yes (OR) 5+ drinks a day weekly or more often

During the PAST 30 DAYS, that is, since this time in (_____) ...

(Month prior to interview)

8. How many days did you have anything alcoholic to drink? _____

If client never drank alcohol past 30 days, go to last alcohol question - Q.13 below

During the past 30 days...

	YES	NO
9. Have you thought you should cut down on your drinking alcohol?	❑	❑
10. Has anyone complained about your drinking?	❑	❑
11. Have you felt guilty or upset about your drinking?	❑	❑

12. Was there a single day in which you had five or more drinks of beer, wine or liquor ..... D Yes D No

ASK EVERYONE

13. Did you or anyone close to you ever think you had a problem with alcohol? ..... D Yes D No

Alc Abu 30 day

if 2i: answers to questions 9-12

Now here are some questions about drug use. *(Remind client of confidentiality)*

Remember that everything ng you tell me is strictly confidential and protected

Have you ever used any of the following drugs, even one time...

GO DOWN THE ENTIRE LIST, then go back and for any drug used, ask about use past six months

	Ever used (drug)?		*If YES for any drug ask* During the PAST SIX MONTHS, how often did you use					
	Yes	No	Never	Less month	Monthly	Weekly	Week	Every day
1. Marijuana, hashish (pot, reefer)	D	D	D	D	D	D	D	D
2. Cocaine	D	D	D	D	D	D	D	D
3. Crack, freebase	D	D	D	D	D	D	D	D
4. Heroin, speedball	D	D	D	D	D	D	D	D
5. Methadone without a prescription or more than a doctor told you to	D	D	D	D	D	D	D	D
6. Sedatives or tranqu ilizers (downers) without a pre- scription or more than a doctor told you to	D	D	D	D	D	D	D	D
7. Stimulants (uppers, speed, ice) without a pre- scription or more than a doctor told you to	D	D	D	D	D	D	D	D
8. Hallucinogens (PCP, angel dust, ecstasy, mushrooms, LSD	D	D	D	D	D	D	D	D

9. Sniffed or inhaled anything to get high

(poppers, sprays, glue) . . . D D D D D D D D

IF EVER USED ANY DRUG: *Yes* *No*

10. Have you ever had a drug injected or skin popped with a needle, even one time? D D

IF EVER USED NEEDLE:

11. Have you had a drug injected or skin popped with a needle at any time during the past six months? D D

If No Drug Use IN 6 MONTHS go to PAGE 11 Trauma

CDQ8

Ask all clients who have used any drug in past 6 mos.

Have any of the following things happened to you more than one time in the last 6 months, that is from ( ) until today?
Fill in date 6 mo. prior to interview

	YES	NO
12. You used drugs. Even though a doctor suggested that you Stop using because of a problem with your health?	O	O
13. You used drugs, were high or hung over from drugs while you were working, going to school, taking care of children or other responsibilities?	O	D
14. You missed or were late for something important because you were using drugs or hung over?	O	D
15. You had a problem getting along with other people while you were using drug?	O	O
16. You drove a car after using drugs	O	O
17. You had legal problems because of drug use	O	D

DRUG ABU if 1+ answers to Q 12 - Q 17 are Yes (OR) Heroin, Coke/Crack or Methamphetamine 3+ per week

CDQ9

During the PAST 30 DAYS, that is, since this time in ( ) ...

Month prior to interview

How many days did you use...?

14. Marijuana..... |__|__|

15. Cocaine..... ..... |__|__|

16. Crack ..... |__|__|

17. Heroin or speedball..... |__|__|

18. Sedatives, Downers..... |__|__|

19. Stimulants, Uppers..... |__|__|

20. Hallucinogens..... |__|__|

21. Inhalants ..... |__|__|

If client never used any drug past 30 days, go to next page

During the past 30 days...	YES	NO
22. Have you thought you should cut down on your drug use?	O	O
23. Has anyone complained about your drug use?	O	O
24. Have you felt guilty or upset about your drug use?.....	O	O
25. Have you used any drug 3 or more times a week or more often?	O	O

Dru Abu 30 day if 2+ answers to questions 22-25 are Yes

CDQ10

ASK EVERYONE

Now some questions about terrible or frightening things that may have happened to you.

People often have traumatic experiences. I mean terrible, frightening events. I am going to read a list of some possible events that sometimes happen to people. Please tell me if you ever experienced..

	YES	NO
1. A serious accident or fire at home or at your job.....	D	D
2. A natural disaster such as hurricane, major earthquake, flood, or other similar disaster	D	D
3. Direct combat experience in a war.....	D	D
4. Physical assault or abuse in your adult life by your partner.....D		D
5. Physical assault or abuse in your adult life by someone other than your partner	D	D
6. Physical assault or abuse as a child.....	D	D
7. Seeing people hitting or harming one another in your family when you were growing up .....**D**		D
8. Sexual assault or rape in your adult life.....	D	D
9. Sexual assault or rape as a child.....D		D
10. Seeing someone physically assaulted or abused.....D		D
11. Seeing someone seriously injured or violently killed.....D		D
12. Losing a child through death.....	D	D
13. Any other terrible or frightening thing that may have Happened to you. (Specify) _____	D	D

If client answers "NO" to all questions go to Page 13, PSY

If client answers "YES" to one or more questions go to the NEXT PAGE

If client answers "YES" to <u>ONLY ONE</u> event listed on the previous page, Ask Q. 1A

1A. You have told me about the time (name event).

I would like to ask you a little more about this event ..... ***skip to Q.2***

If client answers "YES" to <u>MORE THAN ONE</u> event on the previous page, Ask Q. 1 B

1B. You have told me about a number of things that have happened to you.Which of these events was the most terrible or frightening for you? *(specify event or series of related events the client names)*

I would like to ask you a little more about this event (series of events)...

2. How frightened were you...

D	D	D	D	D
Not at all	Just a little	Bad	Very Bad	Scared to Death

During the past six months.

3. Do you keep remembering it even when you don't want to?.	D	D
4. Do you have nightmares about it?		
5. Do things that remind you of it make you very upset?	D	D
6. Do you ever have flashbacks - a sudden feeling that the event was happening all over again?	D	D
7. Do you worry a lot that it might happen again?	Yes	No
	Yes	No
8. Do you avoid things that remind you of it?	Yes	No
9. Do you sometimes have trouble remembering exactly what happened??	Yes	No

10. Do you feel alone even when with other people, or feel cut off from people? Yes No

11. Do you feel numb or like you no longer have strong feelings for anything? ..... Yes No

12. Are you jumpy or on guard when there is no reason to be? ..... Yes No

---

PTS Syn if answer to 2 is "Bad" or worse (AND) 1+ answers to Q 3-6 (AND) 2+ answers to Q.8-11 ar

---

Now I am going to ask you about some beliefs and feelings that some people have. Some people have these feelings and beliefs after they have been drinking alcohol or taking drugs. I would like to know if you have ever had some of these beliefs or feelings during the PAST 4 WEEKS (30 days) when you have not been drinking alcohol or taking drugs.

During the past 4 weeks, how often . . .	**Never**	**One Time**	**More than one time**
1. Have you heard noises or voices that other people say they can't hear?	D	D	D
If YES: Tell me what was it that you heard? If a voice: What did the voice(s) say? Did the voice(s) tell you to do anything? What? Is it like the voice is inside your head or coming from the outside? _____			
2. Have you felt that there were people who wanted to harm or hurt you?	D	D	D
If YES: Who are these people? Why do they want to hurt you? Do your fears about this make it hard for you to leave your home or where you usually sleep? _____			
3. Have you ever felt that there was something odd or unusual going on around you? ..... ***If YES:*** Can you tell me something about it? Do you feel like people are plotting against you? Do things seem to have special meaning to you? Like numbers or street signs or something like that? _____	D	D	D
4. Have you had visions or seen things that other people say they can't see? ***If YES:*** Tell me about what you have seen. Does this happen when you are awake? Where does it happen? Are you seeing someone who has recently died? _____	D	D	D

5. Have you felt that you had special powers that other people don't have?. . D D D
If YES: Tell me about these powers. How are they different from what other people can do? How have you used these powers? _____

6. Have you thought that you were possessed by a spirit or the devil? ……...…..….. D D D

If YES: Can you tell me about that? Did the spiriUdevil make you do anything? What? _____

CDQ13

During the past 4 weeks, how often . . .	**Never**	**One Time**	**More than one time**
7. Have you felt that your thoughts were taken from you by some outside or external source?	O	D	D
***If* YES:** Who or what takes your thoughts? How do you think that happens?			
8. Have you had ideas or thoughts that nobody else could understand? ***If* YES:** Tell me about these ideas. How do you know that nobody else can understand?	O	D	D
9. Have you felt that thoughts were put into your head that were not your own? ***If YES:*** What are some of these thoughts? How do you think they get into your head?	O	D	D
10. Have you felt that your mind was taken over by forces you couldn't control?	O	D	D
***If* YES:** Who or what takes control of your mind? How do you think that happens?			

Additional Comments or Observations:

Psy Screen Positive if 2+ answers are shaded (OR) 3+ symptoms one time only. Do not score unless experiences described are implausible and outside of ordinary or culturally supported experiences

CDQ14

These next questions are about different services you may have received *(Confirm information if known)*

1. Have you ever talked to a mental health specialist such as a psychiatrist, psychologist, or specially trained social worker, about emotional problems, your nerves, or the way you were feeling or behaving?

O No O Yes + ***If YES:*** What did the_____(mental health professional) say?

Probe for diagnosis, if any

_____

_____

2. Have you ever been prescribed medications to help with emotional or psychological problems or ways you were feeling or behaving?

O No O Yes **+ *If YES:*** What medication(s)?

_____

_____

3. Have you ever been in the hospital because of emotional or psychological problems or ways you were feeling or behaving?

O No D Yes + ***If YES:*** When was that? Why were you hospitalized?

_____

_____

4. Have you ever had any type of alcohol or drug treatment?

O No O Yes + ***If YES:*** When was that? What type of treatment did you receive?

_____

_____

5. In the past six months, have you received any help for emotional or psychological difficulties like talking to a psychologist or psychiatrist, or taking medicine, or going into the hospital for a while?

Circle all that apply

1. Received outpatient therapy or counseling for psychological problems _____
2. Received alcohol or drug treatment _____
3. Medication (specify) _____
4. Hospitalization _____
5. Other (specify) _____

6. Is there anything else you feel is important to tell me about your moods, feelings, thoughts or ways of behaving during the past six months?

_____

_____

_____

_____

_____

CDQ15

(Optional Demographic Questions)

Finally, we have a few background questions.

1. What is your birthdate?_____/_____/_____

Month/Day/Year

2. Client Gender *(confirm with client)*

1. Male
2. . Female
3. Transgender

3. Which of the following best describes your racial or ethnic background ...

1. White , non-Hispanic
2. Black non-Hispanic
3. Hispanic, Latino
4. Asian , Pacific Islander
5. Native American , Aleutian, Eskimo

Dontread but code if offered

6. Other_____
7. Mixed_____ *codes for 2 ethnicities* I__II__I

4. Where were you born?_____*(Country or state if U.S.)*

5. What language do you prefer to speak? *(choose one)*

1 English
2 Spanish
3 Creole
08 Other *(specify)*_____

6. How far did you go in school? What was highest diploma or degree you have gotten, if any?

1 Under 7 years of schooling
2 Junior high school (7-9th grade)
3 Partial High School (10-11 grade)
4 High School Diploma / GED
5 Some college; community college degree
6 Four year college degree (BA, BS)
7 Completed graduate or professional training
8 Other *(specify)*_____

7. Do you consider yourself...

1 Gay/ Lesbian

2 Bisexual, attracted to both men and women

3 Heterosexual, Straight

4 Not sure/ undecided/ in transition

5 Prefer not to say

8. What was your most recent T-cell or CD4 count?

If client gives a number write it in here or else use codes below 1_1_1_1

01 0-iOO
02 101-200
03 201-300
04 301-500

05 Greater than 500

06 Don't know T-cell count but I was told it was "good"
07 Don't know T-cell count but I was told it was "bad"
88 Don't know T-cell count at all/ Don't recall test result

00 Client has never had T-cell CD4 test

Burns on the inside of the lips (e.g. from smoking crack) ……..…….. Y . . . . . N . . . ... DK

Other comments/ observations:

POST TRAUMA TIC STRESS DISORDER

D Positive on PTSD Screen

Describe traumatic events. Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

PSYCHOSIS

D Positive on Psychosis Screen

Describe symptoms. Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments

TREATMENT EXPEENCE

O Client has had professional mental health treatment or has been prescribed psych medications in the past 6 months

D Client is currently receiving professional mental health treatment or has been prescribed psych medications

Dates of treatment? Was treatment completed? ls/was client adherent to treatment plan? Other comments:

Interviewer Observations

Circle all that describe client based upon your observations during interview.

Manifested inappropriate affect during parts of interview ..... Y ..... N ..... DK

Unusually unkempt or bizarre in appearance ..... Y ..... N ..... DK
So withdrawn into own world that s/he found it hard to answer questions ..... Y ..... N ..... DK

Manifested unusual ways of thinking and reasoning about experiences ..... Y ..... N ..... DK
Apathetic or flat in affect during interview. ..... Y ..... N ..... DK

Nervous and tense during interview.. ..... Y ..... N ..... DK

Intoxicated or under influence of alcohol or drugs. ..... Y ..... N ..... DK
Needle track marks ..... Y ..... N ..... DK

Skin abscesses, cigarette burns, or nicotine stains..... ..... Y ..... N ..... DK

Tremors (shaking and twitching of hands and eyelids) ..... Y ..... N ..... DK

Unclear speech: slurred, incoherent, or too rapid ..... Y ..... N ..... DK

Unsteady gait: staggering, *off* balance ..... Y ..... N ..... DK

Dilated (enlarged) or constricted (pinpoint) pupils. ..... Y ..... N ..... DK
Scratching ..... Y ..... N ..... DK

Swollen hands or feet ..... Y ..... N ..... DK

Smell of alcohol or marijuana on breath ..... Y ..... N ..... DK

"Nodding out" (dozing or falling asleep) ..... Y ..... N ..... DK
Agitation ..... Y ..... N ..... DK

Inability to focus.. ..... Y ..... N ..... DK

CDQ18

Acuity Scale

Definition and Purpose

The TCM Acuity Scale is used to determine a client's "acuity". It is an objective tool used to establish the frequency and intensity of engagement a client requires when receiving TCM services.

Process & Description

The Acuity Scale should be completed at the time of entry into TCM and at predetermined client assessment and reassessment periods during a measurement year.

The Acuity Scale is divided into five parts:

1. Instructions on how to assign a score to a client using the Acuity Scale;
2. Characteristics of the client at each level of management and the amount of client contact required for each level;
3. Description of the Areas of Functioning;
4. Acuity Grid and Areas of Functioning;
5. An "At-a-Glance" table that shows the score ranges for each acuity level and a brief description of some of the components of each level.

Terms defined in the glossary have been italicized throughout the Acuity Scale for easy identification.

Triggers for placement into the highest acuity level on the Acuity Scale

Clients that present to TCM in one of these nine (9) situations will automatically be placed in the Intensive Management level on the Acuity Scale:

- Homelessness
- Peri-incarceration
- Pregnancy without prenatal care
- CD4 count below 200 **and** a viral load above 400
- New diagnosis of HIV
- Untreated mental illness
- New to Antiretroviral therapy
- Not in care/Re-engaging in care
- Non-adherence to HIV medication

These clients will remain at the Intensive management level for a 3-month period in order to address the more immediate needs associated with such higher risk clients. Clients ***may*** be moved to a lower acuity level, if appropriate, after the reassessment has been completed.

How to assign a score to a client using the Acuity Scale

The Acuity Scale is based on a "point" system that reflects the client's needs across a broad spectrum of function areas that include medical, behavioral, and environmental factors. The points on the Acuity Grid range from 1 point (Self-management) to 4 points (Intensive). There are 25 areas of function used to assess the appropriate level of management. ***Within each area of function the point value increases as the client's need for assistance increases.***

- Within each area of functioning place a checkmark in the appropriate management level box to assign a point value to the particular area.
- The medical case manager should make this decision based on client self-report, observation and/or documented evidence.
- The client should be assigned to only one management level for each area of function.
- In certain cases, the client must meet one or more criteria within a management level box in order to receive points. These criteria are connected using the word "**and."**
- If the client must meet only one criterion in a management level box the word **"or"** is used to separate the different criteria.
- If there are observed physical or behavioral indications that are so compelling that they may be potentially harmful or disabling to a client, a higher management level should be assigned to that area of functioning category so that necessary support may be provided to stabilize the client or improve their health status.
- Enter the point(s) assigned to the particular area of functioning on the score line in the far left column on the acuity scale grid.
- At the end of the Acuity scale, add the points to obtain a final numerical score.
- Based on this score assign the client to the appropriate management level using the "at-a- glance" table located in the fourth section of the Acuity Scale.

Characteristics of the client at each level of management and the amount of client contact required for each level

Level 4: Intensive management

A client in this level is considered medically unstable and needs to be engaged on a concerted and consistent basis. The client has a recent history of being *lost to care*, missing medical appointments, has a *viral load* above 400, *CD4 count* below 200 and is non adherent to medication and/or treatment options. The client may have an *opportunistic infection(s)* and other *co-morbidities* that are not being treated or addressed and has no support system in place to address related issues. The client needs to be seen at least once a month and receive phone calls weekly until he/she is stabilized or becomes adherent. **85 to 100 Points**

Level 3: Moderate management

This client requires the medical case manager's assistance to access and/or remain in care. The client is at risk of failing the service plan, risk of becoming *lost to care* and is considered medically unstable without medical case manager's assistance to ensure access and participation in the continuum of care. Support systems are not adequate to meet the client's immediate needs without the medical case manager's intervention. The client needs to be seen at a minimum of once every 3 months and receive at least one (1) phone contact a month. **61 to 84 Points**

Level 2: Basic management

This client is adherent to medical appointments and ARV medications with occasional missed appointments. Most of the time, the client reschedules appointments and is able to communicate by phone when called. The client is in treatment, medically stable with minimal medical case manager's assistance and does not show signs of needing assistance getting access to care. The client needs to be seen at a minimum of once every six (6) months and receive a phone contact at least every 3 months. **36 to 60 Points**

Level 1: Self-management

This client has demonstrated capability of managing self and disease. The client is independent, maintains a medical home, is medically stable, virally suppressed and has no problem getting access to HIV care. This client might need occasional assistance from the medical case manager to update eligibility forms. The client may be seen once within each six (6) month period. **25-35 Points**

Description of Areas of Functioning

Access

Description of the client's need and eligibility for health benefit programs and support services to assist in establishing, maintaining, and participating in medical care and treatment services.

- **Medical Home:** Evaluates the degree to which the client is established and engaged in care with a HIV primary care provider.

- **Health Insurance/Benefits:** Evaluates the client's access to health insurance/benefits that cover medical care services and medications; ability to pay for any applicable *co-payments*, *deductibles*, *premiums* and/or *spend-down requirements* associated with those benefits; and capacity to complete documentation and navigate the systems necessary to maintain health insurance/benefits.

- **Cultural/Linguistic:** Evaluates how the client's cultural beliefs/practices, literacy level, and English language skills affect his/her ability to understand medical information, collaborate with professionals in the health care continuum, access referral resources or degree of participation in ones own care secondary to religious beliefs.

- **Transportation:** Measures the client's access to public and/or private transportation services and the degree to which the availability of transportation impacts the client's ability to attend appointments with core medical services providers.

Health Status

Description of the client's current physical and medical condition, prognosis and ability to meet his/her own basic life and care needs.

- **Activities of Daily Living:** Measures the client's functional status and ability to manage the everyday tasks required to live independently and to routinely use medical care.

- **Disease Progression:** Measures the degree to which HIV disease has compromised the client's immune system, the **need** for acute medical intervention to stabilize the client's health and the level of intervention necessary to help the client achieve and maintain optimal health.
- **Disease Co-Morbidities:** Evaluates the presence of any additional medical diagnoses that may complicate the client's medical care and the impact of these co-morbid diagnoses on the client's overall health stability.

- **Oral Health:** Evaluates the effect of acute and/or chronic oral health problems on the client's overall health and the client's access to oral care health services.

- **Nutritional Needs:** Evaluates the effect of medical illnesses on the client's ability to maintain a healthy weight, the need for medical nutritional counseling to address nutritional problems, and the need for access to additional support systems to purchase food and food supplements.

Health Knowledge

Describes the client'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:** Measures the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

- **HIV Knowledge:** Evaluates the client's understanding of HIV disease, its mode of transmission and prevention and its effects on the body as well as the client's ability to translate this knowledge into healthy behaviors.

Treatment Adherence

Details the client's current and historical adherence to both medical care and treatment *regimens*; assesses any physical, environmental, and/or emotional factors that may directly impact the client's ability to maintain treatment adherence; and determines the level of support the client may need to achieve medically recommended levels of treatment adherence.

- **Medication Adherence:** Explores the client's current level of adherence to his/her ARV medication *regimen* and the client's ability to take medications as prescribed.

- **Appointments:** Explores the client's current level of attendance at appointments for core medical services and his/her understanding of the role of regular attendance at medical and non-medical appointments in achieving positive health outcomes.

- **ARV Medication Side Effects:** Evaluates the degree to which adverse side effects associated with *antiretroviral (ARV)* treatment impact the client's functioning and adherence levels.

- **Knowledge of HIV Medications:** Evaluates the client's understanding of his/her prescribed ARV medication regimen, the role of medications in achieving positive health outcomes and techniques to manage side effects of *ARV medication*.

- **Treatment Support:** Measures the degree to which the client's relationship with family, friends, and/or community support systems either promotes or hinders the client's ability to adhere to treatment protocols.

Behavioral Health

Details any emotional, cognitive, disordered and/or addictive behaviors diagnosed, displayed, or reported by the client and the impact of these behaviors on the client's ability to collaborate with health care professionals and adhere to health care *regimens.*

- **Mental Health:** Evaluates the degree to which diagnosed or perceived cognitive impairment, emotional problems, or disordered behaviors or thinking impact the client's functioning and ability to adhere and participate in medical care as well as the client's access to mental health services to address these issues.

- **Addiction:** Assesses affect of addictive behaviors on the client's functioning and ability to adhere and participate in medical care as well as the client's access to substance abuse treatment services to address these problems.

- **Risk Reduction:** Assesses the client's current engagement in high-risk behaviors including his/her ability to identify past and present HIV transmission risk and willingness to understand, implement and sustain behavioral change.

Children/Families

Describes the client's primary, self-identified familial relationships particularly any individuals dependent on the client for basic life needs; the level of support needed to assist the client in sustaining these primary relationships; and the degree to which these relationships impact the client's ability to adhere to recommended medical practices.

- **Children:** Evaluates the client's role in caring for minor dependents; the impact of care responsibilities on the client's ability to adhere to medical appointments and ARV medication regimens; the impact of the client' health status on his/her ability to provide care for dependent children; and the need for interventions to assist clients experiencing acute illnesses to secure temporary and/or permanent placement for dependent minors.

- **Dependents:** Evaluates the client's role in caring for other dependents; the impact of care responsibilities on the client's ability to adhere to medical appointments and ARV medication regimens; the impact of the client' health status on his/her ability to provide care for dependents; and the need for interventions to assist clients experiencing acute illnesses to secure temporary and/or permanent placement for dependents.

Environmental Factors

Describes the client's current social and physical environment; how contributing environmental factors either support or hinder the client'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**: Gauges the presence of physical, sexual, economic and/or psychological violence by the client's intimate partner and the impact of this domestic violence on the client's safety and ability to adhere to health care treatment.

- **Living Situation**: Evaluates the stability of the client's current residential location, the client's ability to maintain rental and utility payments, the impact of the client's housing situation on his/her ability to access medical care services, and the availability of housing support programs to assist the client in securing a stable residence.

- **Financial**: Measures the degree to which the client's income suffices to meet his/her basic needs and the level of intervention necessary to increase his/her income and promote access to resources such as vocational rehabilitation, education, employment opportunities, entitlement programs, etc.

- **Legal**: Measures the client's current and historical involvement with the correctional system; the client's needs for *advanced directives* including *living will*, will, *durable medical power of attorney* (*DMPOA*) and/or *power of attorney* (*POA*); and the client's need for legal services in order to obtain HIV-related entitlements including disability benefits.

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 Client'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	D Client is not engaged in medical care; **OR** D Client is *newly diagnosed* with HIV and needs assistance navigating the system of care; **OR** D Client uses the ER as their primary care provider.	D Client has been engaged in medical care for less than 6 months; **OR** D Client has had **more than one** reported ER visit in 12 months.	D Client is engaged in medical care more than 6 months but less than 12 months; **OR** D Client has had **at least one** reported ER visit in the last 12 months.	D Client is engaged in medical care for longer than 12 months or longer; And client has had no reported ER visits.

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 *(continued)*				
Health Insurance/ Benefits	D Client is without medical coverage adequate to provide minimal access to care; **OR** D Client is unable to pay for care through other sources and needs immediate medical assistance.	D Client needs assistance to complete applications for *health benefits* (Medicaid, Alliance, ADAP, etc); **OR** D Client needs directions and assistance compiling and completing *health benefit* documentation or application material; **OR** D Client's application(s) for *health benefits* is pending.	D Client has medical insurance but insurance is inadequate to obtain care; **OR** D Client needs assistance in meeting *deductibles, co-payments* and/or *spend-down requirements*; **OR** D Client needs significant active advocacy with insurance representatives to resolve billing disputes.	D Client is insured with adequate coverage to provide access to the full continuum of clinical care including dental and medication services. Client may only need occasional information or periodic review for renewal eligibility.

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)
Transportation **Score____**	D Client 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** D Client has difficulty accessing transportation due to physical disabilities.	D Client has frequent access needs for transportation; **OR** D Client has difficulty accessing transportation due to physical disabilities.	D Client needs occasional, infrequent transportation assistance for HIV related needs; **OR** D Client is unable to understand bus/train schedules or how to manage bus/train transfers.	D Client is fully self-sufficient and has available and reliable transportation; and has no physical disabilities or physical disabilities limiting access to transportation.

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 Status	Describes the Client's current physical and medical condition, prognosis and ability to meet his/her own basic life and care needs.			
Activities of Daily Living (ADL)	D Client is completely dependent on others for all medical care needs; **AND/OR** D Client needs at least 12 hours of supervision a day.	D Client needs assistance in more than 3 areas of *ADL;* **AND/OR** D Client needs *ADL* assistance at least 4 hours a day.	D Client needs assistance in no more than 2 areas of *ADL;* **AND/OR** D Client needs assistance less than 4 hours a day.	D Client 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)
Health Status *(continued)*				
HIV Disease Progression	D Client has a *CD4+ count* less than 200 **and/or** *viral load* more than 400 and not on OI *prophylaxis medication;* **OR** D Client has a current *opportunistic infection* and is not on treatment; **OR** D Client has been hospitalized in the last 30 days.	D Client has a *CD4+ count* between 200 and 350 **and/or** *viral load* more than 400 and not on *ARV medication;* **OR** D Client has a history of an *opportunistic infection* in the last 6 months, and may/may not be on OI *prophylaxis* or *OI* treatment; **OR** D Client has been hospitalized within the last six months.	D Client has a *CD4+ count* between 350 and 500 **and/or** *viral load* more than 400; **OR** D Client has no history of an *opportunistic infection* in the last 6 months and may or may not be on *prophylaxis* or *OI* treatment; **OR** D Client has had no hospitalizations in the past 12 months.	D Client has a *CD4+ count* more than 500 **and/or** is *virally suppressed* or has an *undetectable viral load*; **OR** D *CD4+ count* is more than 200 **AND** is *virally suppressed* or has an *undetectable viral load*; **OR** D Client has no history of *opportunistic infection*, and may or may not be on OI *prophylaxis* or *ARV* medication; and Client 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)
Health Status *(continued)*				
Disease *Co-Morbidities* *(e.g. HTN, DM. CHF, Hepatitis etc)*	D Client has unmanaged *acute or chronic co-morbidities.*	D Client has *chronic co-morbidities* that are not well managed.	D Client *has chronic co-morbidities* that are manageable with minimal medical assistance.	D Client has no *co-morbidities*; **OR** Client has well managed *chronic co-morbidities* and does not need assistance
Oral Health Needs	D Client has no dental provider and reports current tooth or mouth pain and severe discomfort; **OR** D Client reports or TCM observes decayed or rotten teeth; **AND/OR** D Client reports difficulty eating difficulty or taking medication due to oral health problems.	D Client has no dental provider and reports episodic pain and/or sensitivity in teeth; **AND/OR** D Client reports or TCM observes missing teeth; **AND/OR** D Client reports episodic or moderate difficulty eating or taking medication.	D Client does not have a regular dentist or has not seen a dentist in more than six months; **OR** D Client reports not practicing daily oral hygiene and/or Client dentures need adjusting but Client reports no pain or discomfort; and; Client reports no difficulty eating or taking medication.	D Client is currently in active dental care and has seen a dentist within the last six months; **AND/OR** D Client reports practicing daily oral hygiene; **AND/OR** D Client has no complaints of mouth, tongue, tooth or gum pain; and TCM observes and/or Client reports that teeth and gum are healthy.

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 Status *(continued)*				
Nutritional Needs	D Client reports severe eating problems, acute nausea, vomiting, diarrhea, and/or other physical maladies; **OR** D Client reports or TCM observes significant weight loss in the last 3 months; **OR** D Client has a diagnosis of *wasting syndrome*.	D Client reports chronic nausea, vomiting, diarrhea and/or other physical maladies; **OR** D Client reports or TCM has observed weight loss in the past 6 months.	D Client reports changes in eating habits in the past 3 months and requests assistance with improving nutrition; **OR** D Client has occasional episodes of nausea, vomiting or diarrhea; **OR** D Client reports excessive weight gain in the last 12 months.	D Client has no current or past eating problems and does not need any nutritional intervention; **AND/OR** D Client reports and CM has observed no weight loss or excessive weight gain; And Client reports no problems with nausea, vomiting or diarrhea.

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 Client'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	D Client needs repeated oral instruction to understand health information; **OR** D Client cannot translate even basic written prescription/health information into daily *Antiretroviral therapy (ART)*; **OR** D Client does not have the capacity to understand basic health or prescription information; **OR** D Client is *cognitively impaired*.	D Client can read some health /prescription information; **OR** D Client may need assistance to translate complicated prescription/health information into daily *ART*; **OR** D Client is mildly *cognitively impaired.*	D Client can read most basic health/prescription information; **OR** D Client may occasionally need assistance to translate changes in prescription/health information into daily *ART*;	D Client has the capacity to obtain, process and understand health/prescription information; And Client is able to manage complicated *ART* without additional assistance.

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 *(continued)*				
HIV Knowledge	D Client exhibits no understanding of the disease (transmission, prevention and progression) and is unable to demonstrate positive health seeking behavior; **OR** D Client has knowledge of HIV but has a religious belief that inhibits them from accepting traditional medical treatment options.	D Client is unable to articulate an understanding of the disease (transmission, prevention and progression) and needs information to demonstrate positive and health seeking behaviors.	D Client is able to articulate some understanding of the disease (transmission, prevention and progression) but needs additional information to translate knowledge into positive health behaviors.	D Client is able to articulate a clear understanding of the disease (transmission, prevention and progression) and is able to translate knowledge into positive health behaviors.

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)
Treatment Adherence	Details the Client'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 Client's ability to maintain treatment *adherence*; and determines the level of support the Client may need to achieve medically-recommended levels of treatment *adherence*.			
Medication Adherence	D Client reports missing doses of scheduled medication daily and is experiencing on-going *barriers to adherence* and has a viral load of more than 400*;* **OR** D Client refuses to follow prescribed *ARV medication regimen* and has a viral load of more than 400*;* **OR** D Client chooses herbal/alternative drug therapies despite negative health outcomes; **OR** D Client requires professional assistance to take medication.	D Client reports missing doses of scheduled medication weekly and is experiencing on-going *barriers to adherence* and has a viral load of more than 400; **OR** D Client reports choosing to engage in alternative/herbal drug and is medically stable; **OR** D Client just starting on *ARV medication regimen*; **OR** D Client's long-term *ARV medication regimen* is does not appear to be effective.	D Client is a*dherent* to *ARV medication regimen* but may need occasional assistance from TCM to maintain optimum *adherence.*	D Client is *adherent* to *ARV medication regimen* and has a viral load of less than 400; **OR** D Reports missing no more than one (1) dose in a 30 day period; **OR** D *ARV medication* is not indicated at this 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)
Treatment Adherence *(continued)*				
Adherence to appointments **Score_____**	D Client has missed multiple scheduled appointments in last 60 days.	D History of missed 3 or more missed appointments in the last 120	D Client has missed no more than 1 appointment with appropriate rescheduling and appointment kept.	D No history of missed appointments in the last 12 months.
ARV medication side effects **Score_____**	D Client is experiencing severe *side effects* with *ARV medications;* OR D Client has been newly prescribed *ARV medication*.	D Client is experiencing mild *side effects* with *ARV medication*. Days.	D Client has a recent history of *side effects* with *ARV medication*	D No current report of *side effects* with *ARV medications*; OR D ARV medication is not indicated at this 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)
Treatment Adherence *(continued)*				
Knowledge of HIV medication	D Client is unable to identify his/her own *ARV medications*; **OR** D Client has no knowledge of the purpose of his/her *ARV medications*; **OR** D Client has no knowledge of the *side effects* of his/her *ARV medication regimen*.	D Client is able to identify some of his/her *ARV medications* but is unable to identify the purpose of the drugs; **OR** D Client is unable to list more than 2 *side effect* of his/her *ARV medication regimen*.	D Client is able to identify but not name all prescribed *ARV medications*; and Client has some understanding of the purpose of the drugs and; Client is able to list at least 3 potential *side effects* of his/her *ARV medication regimen.*	D Client is able to identify and name all prescribed *ARV medications*; And Client understands the purpose of the drugs; and client is able to list at least 3 potential *side effects* of his/her *ARV medication regimen.* **OR** D ARV medication is not indicated at this 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)
Treatment Adherence *(continued)*				
Treatment Support	D Client reports no support system (no family, friends or peers); **OR** D Client is in imminent danger of being in crisis; **OR** D Client resists referrals and needs assistance with taking medication.	D Client reports inconsistent and/or no dependable support system; **OR** D Client is isolated from families, social groups, and/or may be new to area; **OR** D Client has not disclosed status to family members due to fear of stigma.	D Client reports gaps in availability and adequacy of support system from family and friends; and Client is requesting additional support; and Client has disclosed HIV status to his/her support system.	D Client reports strong support from family, friends and peers; and Client has disclosed HIV status to his/her support system.

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 Client and the impact of these behaviors on the Client's ability to collaborate with health care professionals and adhere to health care regimens.			
Mental Health **Score____**	D Client expresses or exhibits behavior that indicates the Client is a danger to self and/or others; **OR** D Client has been diagnosed with *mental illness* and is not in treatment.	D Client self-reports *mental illness* or history of *mental illness* and is in treatment but is non- compliant with following treatment prescribed.	D Client self-reports *mental illness* or history of *mental illness* and receives treatment and/or is evaluated consistently; and condition is stable.	D Client self-reports no history of *mental illness* and does not exhibit any behavior that may need an assessment.
Addiction **Score____**	D Client self-reports or exhibits behavior of current *addiction* or *substance abuse* and is not willing to seek help*;* **OR** D Client is not willing to resume treatment; **OR** D Client displays indifference regarding consequences related to an *addiction* or *substance*	D Client self-reports *addiction* or *substance abuse* but is willing to seek assistance*.*	D Client self-reports past problems with *addiction* or *substance abuse* with less than 1 year of recovery.	D Client self-reports no difficulties with *addictions* or *substance abuse*; **OR** D Client reports past problems with *addiction* or *substance abuse* with more than 1 year in recovery; **OR** D Client 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)
	abuse.			
Behavioral Health *(continued)*				
Risk Reduction	D Client practices significant *risky behavior* of any type more than 50% of the time; **OR** D Client has significant relationship barriers to safe behavior; **OR** D Client reports recent history of *STI's.*	D Client practices unsafe *risky behavior* of any type more than 20-50% of the time; **OR** D Client has mild relationship barriers to safe behavior; **OR** D Client reports recent history of *STI*'s.	D Client practices unsafe *risky behavior* occasionally, less than 20% of the time; **OR** D Client has no relationship barriers to safe behavior. **OR** D Client reports no recent history of *STI*'s.	D Client abstains from *risky behavior* by safer practices; **OR** D Client declines to answer; **OR** D Client reports no recent history of *STI*'s.

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)
Children/Families	Describes the Client's primary, self-identified familial relationships particularly any individuals dependent on the Client for basic life needs; the level of support needed to assist the Client in sustaining these primary relationships; and the degree to which these relationships impact the Client's ability to adhere to recommended medical practices.			
Children	D Client is in advanced stage of disease and cannot provide care and/or is faced with possibility of losing children.	D Client needs ongoing child care or transition care and may also need assistance with *permanency planning* or parenting classes; **OR** D Client has a child with special needs.	D Client needs assistance in getting access to *permanency planning;* **OR** D Client needs assistance to disclosure HIV status to children; **OR** D Client needs assistance with respite	D Client has no children living with them; **OR** D Client needs no assistance.
Dependents	D Client has dependent(s) living with them; And Client is experiencing a current crisis related to dependents.	D Client has 3 or more dependents living with them; and without TCM assistance the Client may be at-risk of crisis.	D Client has 1-2 dependents living with them; and Client needs minimal or occasional assistance with dependents.	D Client has no dependents living with him/her; **OR** D Client 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)
Environmental	Describes the Client's current social and physical environment; how contributing environmental factors either support or hinder the Client's ability to maintain medical care and achieve positive health outcomes; and the level of external			
Domestic Violence **Score____**	D Client reports that he/she is currently engaged in physically, sexually and/or emotionally abusive relationship and feels life is in danger of violence.	D Client reports that he/she has experienced domestic violence in the past 12 months; **OR** D TCM observes visible evidence that the Client may be at risk.	D Client self-reports a history of domestic violence, but is not in abusive relationship; **OR** D Client is removed from abuser.	D Client self-reports no history of domestic violence.
Living situation **Score____**	D Client is homeless, living in a shelter, sleeping on streets or in his/her car; **OR** DClient is in immediate danger of becoming homeless and needs housing placement ; **OR** D Client is unable to live independently and needs to be placed in assisted living facility.	D Client is in transitional or unstable housing; **OR** D Client is at-risk of eviction, having utility(s) shutoff and/or of losing housing due to financial strain; **OR** D Client needs assistance with rent/utilities to maintain housing.	D Client currently has adequate housing but may need occasional short-term rent or utilities assistance to remain stable.	D Client 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	D Client has no income and cannot currently meet basic needs; **OR** D Client needs immediate emergency intervention to address financial crisis.	D Client has difficulty maintaining sufficient income from available sources to meet basic needs; **OR** D Client requires frequent ongoing referrals from TCM to stabilize income.	D Client's income may occasionally be inadequate to meeting basic needs.	D Client has a steady, stable source of income and is able to meet monthly financial obligations.

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)*				
Legal Issues	D Client is experiencing a crisis involving legal matters; **OR** D Client is incarcerated or recently released from correctional facility; **OR** D Client has a current or extensive criminal history; **OR** D Client is in need of legal	D Client wants assistance completing applicable *advanced directives* (*living will*, *last will*, *power of attorney*, *advanced directives*) including *permanency planning*; and client has recent or current minor legal problems; **OR** D Client has	D Client wants assistance completing applicable *advanced directives* (*living will*, *last will, power of attorney*) and no current legal problem.	D Client has no recent or current legal problems; **OR** D Client does not want assistance with or has completed all applicable *advanced directives* (*living will*, *last will*, *power of attorney*, *advanced directives*).

*Final score:*_____ *Acuity Level of need assigned:*_____

Client signature _____**Date:**

Case manager's signature:_____**Date:**

Care Management Plan

Definition and Purpose

The TCM care plan is a client centered health and social services plan that details the client's needs and goals and documents an action plan to achieve these goals. The identified needs in the plan are based on the findings from the assessment and the Acuity Scale. The TCM care plan provides the basis from which the case manager and the client work to address the client's needs. TCM service plans are intended to facilitate optimal health outcomes.

Process

In developing the plan the case manager should use a "SMART" approach.

Specific: Identified deficiencies during assessment should be addressed one by one. Every issue identified needs a specific objective and activities for direct intervention. Issues should not be grouped. Specific means that the objective is concrete, detailed, focused, well-defined, and straightforward, emphasizes action and clearly communicates what the medical case manager and the client wants to happen.

Measurable: The TCM service plan should have measurable outcomes. If the objective is measurable, it means that the measurement source is identified and medical case manager will be able to track the results of his/her actions and/or interventions and track the progress towards achieving the objective. Measurement is the standard used for comparison. Measurement allows one to know when the objective has been achieved.

Achievable/Attainable: The objectives need to be achievable. If the objective is too far in the future, when a client thinks the goal is too ambitious, he/she will find it difficult to keep motivated and strive towards its attainment. When the goal

seems too unreachable, clients become frustrated and lose motivation. Little increments could be made as reassessments are done. For example, when a client has been abusing alcohol for many years it will be unattainable to stop using alcohol completely in a week.

Result-oriented/Realistic: The client is involved in the planning and development of the TCM service plan and should understand his/her abilities and limitations. The medical case manager should take into consideration whether the objective is realistic given available resources, skills, and time to support the tasks required to achieve the objective.

Time-limited: For effective implementation of intervention a clear timeframe for evaluation is required. Shorter time frames and deadlines will ensure that objectives are followed up actively. Failure of the case manager to set a deadline might reduce the motivation and urgency required to execute the tasks. Deadlines create the necessary urgency and prompt action.

- The case manager should develop the TCM service plan within seven days of assessment.
- The case manager should contact the client within five working days after the development of the TCM service plan to begin implementation of the plan.
- The case manager should develop a TCM service plan with the active participation of the client. It should describe the recommended interventions for at least three barriers to care identified during assessment.
- The TCM service plan should include at least one goal and objective of treatment adherence to help client achieve or maintain suppressed viral load if the client is on anti-retroviral treatment.

Examples of elements within an TCM Care Plan

- Plans for communication with the client's primary medical team and an identified mechanism of feedback to ensure adherence;
- Critical flags of laboratory results and documented viral load and CD4 results;
- Strategies to optimize adherence and assist with disclosure of HIV status for social support;
- Plans for minimize competing needs, such as obtaining housing, access to social services and transport; **A housing plan, if needed, should be incorporated into the TCM service plan;**

- Case management programs are expected to assist clients in need of housing to develop housing plan and make appropriate referrals to housing opportunities available in the community;
- Client education on relevant topics, e.g., management of medication side effects, general health literacy;
- Linkages to prevention with positives programs, needle exchange programs and plans for co-management for mental health and substance abuse clients.

The TCM service plan template can be used to organize the plan. It allows the listing of the identified needs, responsible party, linkages to be made etc. A completed sample can be found in Appendix II.

TCM Care 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

Signature of Client: _____ Date: _____

Signature of Medical Case Manager:_ Date: _____ Signature of TCM Supervisor: _____ Date: _____

TCM Service Plan Implementation & Monitoring

A major part of the work of the case manager is the implementation and monitoring of the service plan. Monitoring requires ongoing contact and interventions with or on behalf of the client to ensure the objectives of the TCM service plan are being addressed. The case manager must assess and monitor the clients' progress, reassess progress at prescribed intervals and modify the plan until all goals are eventually met and the client's health and/or situation improves. In the this phase, medical case managers are responsible for, at a minimum;

- Monitoring changes in the client's condition or circumstances, updating or revising the service plan and providing appropriate interventions and linkages;
- Monitoring laboratory results to know when to initiate urgent dialogue with the client and the client's primary care provider if the client is failing a medication regimen and if needed, devise strategies to optimize adherence. Laboratory results should be reviewed every 3 months to 6 months.
- Ensuring that care is coordinated among the client, caregivers and service providers through collaboration and the exchange of information;
- Conducting ongoing follow-up with clients and providers to confirm linkages, service acquisition, maintenance of services and adherence to services;
- Advocating on behalf of the client with other service providers;
- Empowering clients to develop and utilize independent living skills and strategies;
- Assisting clients in resolving any barriers to using and adhering to services;
- Actively following up on established goals in the TCM plan to evaluate clients progress and determine appropriateness of services;
- Maintaining ongoing patient contact according to the Acuity Scale;
- Actively following up within one business day with clients who have missed a medical case management appointment. In the event that follow-up is not appropriate or cannot be conducted within the prescribed time period, medical case managers will provide justification for the delay.

- Collaborating with the client's other providers for coordination and follow- up and;
- Organizing or participating in **case conferencing** with the interdisciplinary team.

In the implementation of the TCM service plan several of the fundamentals of TCM will be put into practice. These include Treatment Adherence and Linkages and Coordination. These are expanded upon below.

Treatment Adherence

Treatment adherence support includes interventions or special programs to ensure clients are connected to care so the following are monitored; Readiness for, and adherence to, complex HIV/AIDS treatment. This is a core component of case management services.

HIV infection has evolved into a chronic disease with the availability of effective medications. However, medications only work if people take them. Successful treatment of HIV infection requires the cooperation and coordination of a complex network involving the client, his/her social network, professional providers of various disciplines, a health care delivery system designed to meet client needs, and government policies that support these efforts. Treatment success requires the commitment and effort of the entire health care delivery network.

T**CM programs have a responsibility to directly link their clients to treatment adherence services.** An assessment of adherence support needs and client education should begin as soon as a client enters TCM and should continue as long as a client remains in TCM. Treatment adherence support is an on-going process, changing as the client's needs, goals, and medical condition change.

The goal of any treatment adherence intervention is to provide a client with the necessary skills, information and support to follow mutually agreed upon and evidence-based recommendations of their healthcare professionals to achieve optimal health. This includes but is not limited to:

- Taking all medications as prescribed
- Making and keeping appointments

- Overcoming barriers to care and treatment and
- Adapting to therapeutic lifestyle changes as necessary

Studies demonstrate that clients who take their medications exactly as prescribed, 95 percent of the time (i.e., missing only 5 doses out of 100) are more likely to achieve viral suppression, and are less likely to develop drug- resistant mutations. No one intervention is certain to improve treatment adherence but rather, an individually tailored adherence intervention program helps reduce missed doses of medication. **The case manager should reinforce treatment adherence and call and refer to the clinical provider when it appears that the client is not adherent.**

Linkages and Coordination

The term linkage involves the act or process of connecting organizations as well as clients. Once an individual TCM care plan has been developed for the client, services that the case manager's agency does not offer may be required. In such cases a client will need to be linked with another agency to receive that service, and their care, especially if at multiple service points, needs to be coordinated. The case manager is required to coordinate the many services needed**. If a linkage is to be successful and provide the best opportunity for the client to obtain access to the continuum of care, the case manager must facilitate more than a referral. He/she must ensure that the client attends the appointment and the case manager must obtain feedback from the service provider.**

Case managers should:

- Develop an individualized plan that will enable clients to receive a broad array of services as appropriate;
- Ensure that clients are engaged in these services without becoming lost to care; and,
- Coordinate the many services and treatments the clients need into a seamless system of care. This includes follow up of medical treatment, and timely and coordinated access to medically appropriate levels of care. **A main component of the coordination role for the** case manager is the continuous interchange and exchange of patient treatment information between the TCM agency and the clients designated primary medical care provider and other services.

In order to support the linkage and coordination role of the case manager, the agency in which the TCM program is housed is encouraged to identify gaps in services within their organization and reach out to form strong alliances and partnerships with other organizations to breach these gaps according to the specific needs of their identified client populations. A strong linkage includes a defined process for information exchange and feedback and a mutually understood method for enrolling clients in services.

As part of information exchange for the benefit of the client, one approach is using **"interdisciplinary case conferences".** Here, a client's case is discussed amongst all providers that are caring for the patient. It should include both internal and external providers to the TCM program and if possible and appropriate, the client and family members or close support. The goal is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. It can occur face-to-face or by teleconference and at regular intervals or during significant changes in a client's care or situation. Case conferencing is used to identify or clarify issues regarding a client's needs and goals; review activities including progress and barriers towards goals; and map out roles and responsibilities, resolve conflicts and adjust service plans.

Re-engagement of clients into care

A client is considered lost to care when the client has not attended core medical service appointments for appointments for a period of 6 months or more.

Depending on the client's TCM services plan, this may include medical care, substance use counseling, dental care, mental health counseling, etc. Re-engagement is the responsibility of the entire health care community however case managers maintain a unique relationship with clients and are well positioned to guide clients back into care. Case management programs are encouraged to develop internal policies to re-engage clients in care.

Reassessment

The case manager routinely evaluates and monitors the client's progress in achieving goals identified in the TCM services plan. Clients should be reassessed at key events and at 3 months or 6 months according to the acuity level. Any changes in the client acuity level must be documented. Laboratory results should be reviewed at the same time. The reassessment includes re- examination and revision of the TCM service plan as needed. Every area that was identified as being deficient during the initial assessment should be revisited and the impact of any interventions evaluated to either reduce or increase the level of management. During reassessment the case managers should identify short-term goals and objectives for the client and work with the client to ensure that they are met.

Case Closure, Transfer and Termination

Case closure and transfer are a systematic process for de-enrolling clients from medical case management. The process includes formally notifying clients of pending case closures and/or transfers. In the case of transfers, the medical case manager should facilitate the transfer of client's record/information.

Closure

A client's case may be closed to medical case management for one or more of the following reasons:

- All identified goals and objectives are reached
- Client requests to end services
- Client moves out of service area
- Death of a client
- Inability to contact or re-engage client after 12 months of intense re-engagement efforts
- Client is incarcerated for more than six months.

Transfers

A client may be transferred to an interagency or external medical case management provider for the following reasons:

- Client's request
- Case manager's request
- Case manager supervisor determines a transfer is appropriate through routine supervision
- Client relocated out of the agency service area
- Unavailability of medical case manager
- Client admitted to a long-term or residential facility.

In the event of transfers, the case manager should notify the client of new case manager.

- The TCM program should retain all closed files in a secured pre-established location for a minimum of five years.

Termination

This may occur for the following reasons:

- Client exhibits a pattern of abuse/violence of agency staff, property and services
- Client is unwilling to participate in care planning
- Client makes false claims about their HIV diagnosis or falsifies documentation.

The TTCM Program must notify EOHHS, The Medicaid Division within five working days of client's termination and give a detailed reason for termination. All efforts must be made to resolve issues before resorting to termination. These efforts must be well documented.

Monitoring for Outcomes and Results

The goal of an TCM program is to improve health outcomes and the quality of life for HIV-infected individuals. Improved outcomes are concrete evidence of TCM efforts. Programs are expected not only to track their clients' environmental and social situation but also their clinical progress. For example, TCM clients on anti-retroviral treatment with no improvement in CD4 count or decrease in viral load should be flagged and discussed with all the client's providers so as to address any barriers. The TCM program should be able to evaluate the quality of care provided to clients through measuring client outcomes. Information obtained can be used to re-evaluate interventions and refocus efforts. Outcomes should be tracked both at a program and individual level.

Evaluating the performance of case management staff is one of the core functions of a TCM program. Performance is measured by results achieved for the client. This is not to imply that "process" is not important – for example, how many calls were made to or on behalf of the client are necessary steps to achieving a positive outcome for the client - but they are not the desired end result. **As such, with few exceptions, case managers' performance should be evaluated based on the outcomes achieved for the client.** Each client's needs and pace of improvement differ and that must be taken into consideration when examining each situation.

The intended outcomes of TCM for HIV/AIDS clients include greater participation in and the optimal use of the health and social services, increased knowledge of HIV disease, delay of HIV progression, reinforcement of positive health behaviors and an overall improved quality of life. These are not short-term goals, and given the complex needs of clients, achieving them is not a straightforward process. However, the fundamentals of TCM as outlined in this document provide a basis for evaluating actual progress towards these goals.

Processes and documentation expected at every step of TCM should also be evaluated. The case managers' supervisor or other external reviewers can carry out performance evaluation. The performance of the medical case manager can be measured in three ways. First case managers must meet certain requirements in a few core areas. Second, they must possess certain core competencies. Third, specific requirements regarding documentation must be met.

1. Core performance areas
2. Core competencies
3. Processes and documentation worksheet

Core Performance Areas

Core Performance Area	Key Measures
Needs assessment	• Client's needs accurately identified and appropriately prioritized • Barriers to remaining in care identified and prioritized
Linkages and Coordination	• Prioritized services correspond to need assessment findings • Client linked to needed services in less than 30 days • Communication and exchange and feedback of client information is occurring at least every 3 months with primary care and other service providers
Treatment Adherence Support	• Clients receiving treatment adherence support interventions with improvements seen in viral load over time • Case manager tracks current client lab data
Acuity/Management level	• Assigned acuity score is congruent with client situation • Client shows decreasing level of acuity over time • Client is reassessed at predetermined frequencies and plans are updated and implemented accordingly
Monitoring of health outcomes	• Clients client lab data is tracked and concerns elevated and addressed • Regular feedback and communication with clients primary provider is occurring
Retention and Re-engagement of clients	• Clients attendance at medical appointments are tracked and missed appointments are rescheduled within 24 hours; reasons for non-attendance are investigated and addressed • Clients that miss >1 consecutive appointments are elevated to the supervisor and clients are brought back into care.
Other Areas	
Intake Process	• Client eligibility for health and support services (Medicaid, Medicare) assessed. • Client eligibility is reassessed every 3 months • Client is enrolled in a drug access program • Client certification for the health services program is current.

Core Competences

- Conducting sensitive and empathetic interviews
- Relationship building

Conducting sensitive and empathetic interviews

Interviewing skills are crucial in obtaining information from clients. The medical case manager's ability to obtain accurate information depends on his/her ability to communicate and interview clients properly. The use of tools such as 'open ended questions', 'affirmations', 'active listening', 'reflective listening', and 'summarizing' enable clients to share information and make a commitment to participating in their care. For clients who are still engaging in high risk behavior or non-adherent to care, the goal is for the medical case manager to eventually be able to elicit "change talk" and get a commitment for behavioral change during interviews. All these tools are used in client centered motivational interviewing.

A competent case manager should be able to use these tools in everyday interaction with clients. Periodic assessments of a case manager's competency in interviewing should occur by sitting on client sessions (with the client's permission).

Relationship building

Successful TCM depends on the ability to create and maintain a successful client relationship. A good quality relationship is built consciously, systematically and routinely. A key strategy includes having the right mind set to understand the importance of the client relationship. Some of the skills of relationship building are: expressing or exhibiting a caring attitude, reinforcing mutual understanding and trust, constantly reviewing client's needs and ensuring that high quality services are provided. The medical case manager should be able to ask the right questions, demonstrate professionalism, integrity and a caring attitude to demonstrate the ability to maintain high-quality client relationship that results in tremendous benefits.

Building a successful relationship also involves communicating frequently with the client by phone contacts, home visits, hospital visits, face to face, email, or by post. Built over time, a successful relationship has the potential of making clients more comfortable discussing their situation with the medical case manager with whom they have established a trusting relationship. Clients may feel comfortable to discuss intimate issues that could potentially have become a barrier to care.

As a result, clients may become adherent to treatment, if not for the sake of their health, but to please the medical case manager with whom they have forged a bond.

The case manager should demonstrate the ability of building successful relationship with clients.

Methods of obtaining information to measure performance

Chart Reviews of TCM Chart

A representative sample client's files can be reviewed for compliance with best practices and quality of documentation. Evidence of processes carried out in chart should be seen by reviewing the documentation of interventions.

Direct Observation

This is an essential tool for supervision. With the client's permission, the evaluator should periodically sit in during assessment or reassessment of clients. In these sessions, the evaluator can observe firsthand medical case managers use of interviewing skill, and competence of handling questions and concerns of a client. It is imperative that the client's permission is obtained to use this tool.

Each agency's confidentiality policy should be observed.

Client Satisfaction Survey

Information may be collected from clients in the form of a client satisfaction survey. A minimum of five client satisfaction surveys from each case

manager caseload should be performed. The information derived from the surveys should be used in conjunction with other methods to address each medical case manager's performance, improvements and/or shortcomings. Such surveys may be used as a tool for best practice.

Case Reviews

Case reviews may be conducted individually or with the TCM team. Reviews could be prioritized by complexity or difficulty of client cases.

Performance Evaluation for Case Managers: Worksheet for Assessing Documentation

OPERATIONAL AREA	DOCUMENTATION NEEDED	YES	NO	N/A	RATING *(Rate I case manager's competency in completing task).*
					Please circle selection
Intake **The evaluator should ensure that all eligibility documents are signed and in the client's file or electronic record.**	Written documentation of proof of HIV Status				Excellent Good Fair Poor N/A
	Proof of residency				Excellent Good Fair Poor N/A
	Income verification				Excellent Good Fair Poor N/A
	Date of intake				Excellent Good Fair Poor N/A
	Client's demographics				Excellent Good Fair Poor N/A
	More than two emergency contacts with complete addresses, phone numbers and email addresses if				Excellent Good Fair Poor N/A
	Signed consent to receive services				Excellent Good Fair Poor N/A
	Client's rights and responsibility form given				Excellent Good Fair Poor N/A
	HIPAA form signed				Excellent Good Fair Poor N/A
	Consent to release information				Excellent Good Fair Poor N/A
	Client eligibility for health and support payer programs (Medicaid, Medicare) assessed				Excellent Good Fair Poor N/A
	Client enrollment/certification for payer programs is up to date				Excellent Good Fair Poor N/A

OPERATIONAL AREA	DOCUMENTATION NEEDED	YES	NO	N/A	RATING (Rate case manager's competency in completing task).
					Please circle selection
Client Assessment and Use of the Acuity Scale **The supervisor should ensure that the case manager completed the assessment within 30 days of intake.**	Client's needs accurately identified				Excellent Good Fair Poor N/A
	Barriers to remaining in care identified				Excellent Good Fair Poor N/A
	CD4 and viral load documentation				Excellent Good Fair Poor N/A
	Completed acuity scale				Excellent Good Fair Poor N/A
	Assigned level of acuity is congruent with the client's situation				Excellent Good Fair Poor N/A
	Completed scale is signed by the medical case manager and the client				Excellent Good Fair Poor N/A
	Client shows decreasing level of acuity over time				Excellent Good Fair Poor N/A
	Client is reassessed at predetermined frequencies and plans are updated and implemented accordingly				Excellent Good Fair Poor N/A
Care Management Plan	**The TCM service plan is:**				Excellent Good Fair Poor N/A
	Specific				Excellent Good Fair Poor N/A
	Measurable				Excellent Good Fair Poor N/A
	Attainable				Excellent Good Fair Poor N/A
	Realistic				Excellent Good Fair Poor N/A
	Time-limited				Excellent Good Fair Poor N/A

The evaluator should ensure that the TCM service plan has all the necessary components.	Completed TCM services plan on file				Excellent Good Fair Poor N/A
	Date client was seen				Excellent Good Fair Poor N/A
	Identified need/needs				Excellent Good Fair Poor N/A
	Short term goals/Objectives				Excellent Good Fair Poor N/A
	Intervention/Activity/Action				Excellent Good Fair Poor N/A
	Persons responsible for actions				Excellent Good Fair Poor N/A
	Date Review is Due/Timeline				Excellent Good Fair Poor N/A
	Outcome/Referral/Linkages				Excellent Good Fair Poor N/A
	Viral load and CD4 count				Excellent Good Fair Poor N/A
	Signature of medical case manager and client on the TCM service plan				Excellent Good Fair Poor N/A
	Copy of plan given to client				Excellent Good Fair Poor N/A
Reassessments **The case manager should routinely evaluate and follow up clients' progress to determine the need for changes to the plan and services received.** **Evaluators should ensure that reassessment is done in a timely manner.**	Clients are reassessed at key events, at three months and at six months according to protocol				Excellent Good Fair Poor N/A
	Clients TCM service plans are updated per reassessment				Excellent Good Fair Poor N/A
	Clients overall acuity improved by one or more levels				Excellent Good Fair Poor N/A
	Clients overall acuity worsened by one or more levels				Excellent Good Fair Poor N/A
	Clients received the number of visits as indicated by the acuity scale				Excellent Good Fair Poor N/A

Linkages and Coordination **There should be documented evidence that the client utilized the services that he/she was linked to in a timely manner.**	Prioritized services correspond to need assessment				Excellent Good Fair Poor N/A
	Clients received linked services in less than 30 days				Excellent Good Fair Poor N/A
	Supervisor verified that the client was linked to needed services in less than 30 days.				Excellent Good Fair Poor N/A
	Client did not receive services after 90 days of linkage				Excellent Good Fair Poor N/A
	Supervisor followed up to ensure client received services immediately if 90 days has elapsed.				Excellent Good Fair Poor N/A
	Coordination of complex HIV/AIDS care is occurring				Excellent Good Fair Poor N/A
	Linkages/referrals to housing is done when needed				Excellent Good Fair Poor N/A
Medical provider communication **The evaluator should find documentation of feedback and communication with other providers.**	Communication and exchange and feedback of client information are occurring at least every 3 months with primary care and other service providers.				Excellent Good Fair Poor N/A
Treatment Adherence Support **The supervisor should ensure that client's TCM service plan matches identified needs.** **Interventions may include several items.**	Clients receiving treatment adherence support intervention with improvement seen in viral load over time				Excellent Good Fair Poor N/A
	Case manager tracks laboratory data				Excellent Good Fair Poor N/A
	Medication adherence counseling given				Excellent Good Fair Poor N/A

several items.	Access to support groups and social networks				Excellent Good Fair Poor N/A
	Counseling on risk reduction				Excellent Good Fair Poor N/A
	Use of pill boxes in adherence counseling				Excellent Good Fair Poor N/A
	Help with filling prescriptions				Excellent Good Fair Poor N/A
	Enrollment in ADAP				Excellent Good Fair Poor N/A
	Providing access to a medical home				Excellent Good Fair Poor N/A
	Providing access to transportation				Excellent Good Fair Poor N/A

Monitoring Clinical health outcomes **The supervisor should ensure that there is documented evidence of improved health outcome with each client who has been in care for more than six months.**	At least one outcome measure was identified for each TCM services plan objective				Excellent Good Fair Poor N/A
	Outcome measure in progress or achieved				Excellent Good Fair Poor N/A
	Client laboratory data is tracked and concerns elevated and addressed				Excellent Good Fair Poor N/A
	Improved health status				Excellent Good Fair Poor N/A
	Improved CD4 count				Excellent Good Fair Poor N/A
	Decreased viral load				Excellent Good Fair Poor N/A
Missed appointments/No shows: **The supervisor should ensure that case managers document all the calls and rescheduling performed.**	The case manager followed the agency's policy on missed appointments				Excellent Good Fair Poor N/A
	Attendance at medical appointments is tracked.				Excellent Good Fair Poor N/A
	The case manager calls client within 24 hours after missed appointment				Excellent Good Fair Poor N/A
	Reasons for non-attendance investigated and addressed				Excellent Good Fair Poor N/A
	Missed appointments rescheduled within 24 hours				Excellent Good Fair Poor N/A

Retention and re-engagement of clients					
Client Retention in care	Process measures/indicators completed quarterly (To monitor client's progress in participation in the Medical Case				Excellent Good Fair Poor N/A
	More than 5% of medical case manager's case load lost to care				Excellent Good Fair Poor N/A
	More than 95% of medical case manager's case load retained in care				Excellent Good Fair Poor N/A
Reengagement of clients **The medical case manager must initiate the agency policy for any client that has missed >1 consecutive appointments and document attempts until client is**	Agency reengagement process is clearly initiated as seen in client's file				Excellent Good Fair Poor N/A
	Attempts to contact client were made: by phone, face to face, email, mails etc				Excellent Good Fair Poor N/A
	Working contact numbers and addresses for client is on file				Excellent Good Fair Poor N/A
	Client is brought back to care				Excellent Good Fair Poor N/A
Core Competences					
Core Competences **The evaluator should ensure that all case managers acquire skills or abilities necessary to perform TCM.**	**Interviewing skill:** The supervisor should conduct periodic assessment by sitting in a session with the client's permission to assess a case manager's competency in using this skill				Excellent Good Fair Poor N/A
	Relationship Building skills: The supervisor should ensure that the case manager demonstrates				Excellent Good Fair Poor N/A

	the ability of building successful relationship with clients.				
Tools for Performance Evaluation **The evaluator should assess the case manager using the tools for performance evaluation.**	Chart Reviews				Excellent Good Fair Poor N/A
	Direct observation				Excellent Good Fair Poor N/A
	Client satisfaction survey				Excellent Good Fair Poor N/A
	Case reviews				Excellent Good Fair Poor N/A
	Monthly meetings				Excellent Good Fair Poor N/A
	Overall performance appraisal				Excellent Good Fair Poor N/A
Trainings attended	HIPAA rules -confidentiality				Excellent Good Fair Poor N/A
	Basic HIV knowledge				Excellent Good Fair Poor N/A
	Client rights and responsibility				Excellent Good Fair Poor N/A
	Agency grievance procedure				Excellent Good Fair Poor N/A
	Client assessments (including risk categories and interviewing skills)				Excellent Good Fair Poor N/A
	Enrollment and eligibility				Excellent Good Fair Poor N/A
	Cultural competency				Excellent Good Fair Poor N/A
	Medication education and treatment adherence trainings				Excellent Good Fair Poor N/A
	Public and private benefits				Excellent Good Fair Poor N/A
	Continuing education requirements of respective professional boards.				Excellent Good Fair Poor N/A