Medical Case Management Screening Tool

Please attach to client registration or reassessment form

Today's Date:	Client URN:	Assigned Case Manager:
Last Name:	First Name:	Middle Name:

HIV/AIDS MEDICAL APPOINTMENT ADHERENCE SCREENING

1. Does the client have an HIV/AIDS Medical Provider? ☐ Yes ☐ No (provide referral) ☐ Just entering the care system (provide referral)

2. Date of last medical appointment? ____________________________ Date of next medical appointment? ________________________

3. Does the client have a copy of current labs (maximum of 6 months from today's date)? ☐ Yes ☐ No

4. Please check all of the barriers to medical care that the client mentions:

☐ Just entering the care system	☐ Not ready to access care	☐ Afraid
☐ Homelessness	☐ Doesn't want to deal with it	☐ Feels fine/no symptoms
☐ Doesn't know where to go	☐ Couldn't get an appointment	☐ Drugs/Alcohol in the way
☐ Doesn't think it will help	☐ Clinic hours aren't convenient	☐ Child care unavailable
☐ Don't want people to know	☐ Doesn't like the doctors there	☐ No transportation
☐ Language barriers	☐ Lack of proper identification	☐ Other, please specify:

Please assess and work with clients to diminish barriers to care.

Referral provided for medical care? ☐ Yes ☐ No ☐ Client Refused

If yes, where: ____

Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment).

Notes:

HIV/AIDS MEDICATION ADHERENCE SCREENING

1. Is the client currently prescribed HIV/AIDS medication? ☐ Yes ☐ No

2. Does the client currently take their medication? ☐ Yes ☐ No ☐ Sometimes

3. How many doses has the client missed in the last month? ☐ 0 ☐ 1 ☐ 2 or more

If client reports missing doses please ask them why, (check all that apply):

☐ Doesn't want to deal with it/take meds	☐ Lack of social support	☐ Medication regimen too complex
☐ Side effects	☐ Doesn't think meds work	☐ Alcohol and/or Drug Use/Abuse
☐ Depression/Mental Health issues	☐ Can't get refills in time	☐ Other:
☐ Too many pills	☐ Taste of medication	

Please assess and work with clients to diminish barriers to care.

Counseling provided or referral provided for Medication Adherence Counseling? ❑ Yes ❑No ❑ Client Refused

If yes, where : ____

Notes:

NUTRITION SCREENING

1. What is your current weight and height? _______ feet _______ inches ________ weight

2. Without wanting to, have you experienced significant weight loss in the last 6 months? ☐ Yes ☐ No

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3. Are you being treated for medical issues in addition to HIV, such as; diabetes, kidney disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression? ☐ Yes ☐ No ☐ Other: ______________________________

4. Are you experiencing any extreme side effects from your medication such as vomiting, diarrhea or poor appetite (little or no desire to eat)? ☐ Yes ☐ No

5. Do you have access to food? ☐ Yes ☐ No

Referral provided for Medical Nutrition Therapy or other food provider? ☐ Yes ☐ No ☐ Client Refused

If yes, where: ____
Notes:

CAGE SUBSTANCE/ALCOHOL ABUSE SCREENING

Is the client currently in any kind of treatment for substance or alcohol use (includes meeting with a psychologist or counselor, attending group sessions)?
☐ Yes (stop here) ☐ Never used either substance (stop here) ☐ No (complete screening)

1. During the **past month**, have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

2. During the **past month**, have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

3. During the **past month**, have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

4. During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang-over-eye-opener? ☐ Yes ☐ No

If the client answered "yes" to any of the above substance abuse screening questions a referral for substance abuse treatment is strongly encouraged.
Referral provided for Substance or Alcohol abuse? ☐ Yes ☐ No ☐ Client Refused

If yes, where: ____
Notes:

EVALUATION OF MENTAL HEALTH DISORDERS SCREENING TOOL
Questions taken from the Primary Care Evaluation of Mental Disorders Screening Tool

Is the client currently being treated for a mental health problem (includes professional help from psychologist or counselor, attending group therapy sessions taking medication for depression or anxiety)?
❑ Yes (stop here) ❑No (complete screening)

1. During the **past month**, have you been hearing or seeing things that other people don't seem to hear or see? ☐ Yes ☐ No

2. During the **past month**, have you been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑No

3. During the **past month**, have you been bothered by little interest or pleasure in doing things? ❑ Yes ❑No

If the client answered "yes" to any of the mental health screening questions a referral for further screening by a mental health professional is strongly encouraged.

Referral provided for Mental Health Treatment? ❑ Yes ❑No ❑ Client Refused

If yes, where: ____
Notes:

Ryan White Part A Client Acuity Tool

Client Name ___________________________ Date ________________

❑ Initial Assessment ❑ Follow-up Assessment

Barriers	Level 0-1 "0"-no intervention needed. "1"-short term, focused, education/support/referrals.	Level 2 "2" multiple barriers, provide education/support.	Level 3 "3"-Multiple, complicated barriers, and/or is in crisis.	Level
Housing	Stable, clean housing.	Requires short term assistance with/rent, utilities.	Homeless, shelter resident, or frequent moves.	
Finances	Steady, adequate source of income.	Income source is inconsistent or too low to meet basic needs.	Has no income. Is in financial crisis. Consistently unable to meet basic needs.	
Transportation Issues	Has own transportation to get to and from clinic visits.	Some difficulties with access to transportation.	Consistent problems with accessing transportation.	
Social Support/Family Issues	Dependable network/family/friends/partner.	Gaps in support system (family/friends periodically) Pregnant but adherent.	No stable support other than professionals. Family in crisis. Pregnant but not adherent. Fear of disclosure.	
Behavior	Functions appropriately in most settings.	Repeated incidences of inappropriate behavior.	Abuse or threats to others; lack of control.	
Communication Issues	Speak, read and understand English at an adult level.	Some difficulties with speaking, reading and understanding English.	Not able to represent themselves in English. Unable to read or write.	
Cultural Issues	Minimal system barriers	Requires some assistance acclimating to system.	Chooses not to/unable to acclimate to system.	
System Issues	Minimal system barriers.	Needs help accessing the system.	Distrust of system/not accessing services.	
Legal Issues	Client reports no recent or current legal problems; all pertinent legal documents completed.	Needs assistance completing standard legal documents; recent or current legal problems.	Involved in civil or criminal matters; incarcerated or recently incarcerated; undocumented immigrant; unaware of standard documents, i.e. living will.	
Mental Health Issues	No current mental health illness but has a history of mental illness, now stable.	Mild to moderate symptoms or disorders.	Severe symptoms/disorders; long history of mental disorders.	
Substance Use/Abuse	No current use and/or history.	History of abuse and/or intermittent abuse.	Chaotic life, regular substance abuse.	
Side Effects	On medication, having no side effects.	Minimal side effects affecting some quality of life.	Moderate to severe side effects affecting quality of life.	
Adherence History	Reports ability or willingness to adhere to medications.	Reports inconsistent ability to adhere to medications.	Reports inability to adhere to medications. Treatment naïve.	
Educational Issues	Has been informed, able to verbalize basic knowledge of the disease.	Some understanding of the disease.	No understanding of HIV disease. New diagnosis. <18 years of age.	
Medical Needs	Stable health; goes for periodic MD appointments and lab monitoring.	Needs primary care referral. Being seen by MD for short term illness.	Poor health; medical emergency; rapidly deteriorating; with opportunistic infections. Pregnant.	

Comments Section:	**Combined Total**	

If a client scores a 3 in any life categories of Medical Needs, Educational Issues, or Adherence History, a referral to Intensive Medical Case Management is strongly encouraged. If a client scores a 3 in the life categories of Cultural Issues, Educational Issues, Social Support/Family Issues, Housing or Finances, a referral to Moderate Medical Case Management is strongly encouraged.

Client Level Acuity Guidelines:

Acuity Level	*Range*	*Case Management Level*	*Referral Criteria*
Life Area 0-1	15 Points or Less	Medical or Non-Medical Case Management	Self referral as needed
Life Area 1 & 2	16-30 Points	Intensive Medical Case Management-Social	Refer to appropriate community partners
Life Area 2 & 3	31 Points or Higher	Intensive Medical Case Management-Medical	Intensive Medical Case Manager to follow

Signature of Case Manager ____

Individual Service Plan (ISP)

Today's Date:	Client Name:	
Goal #1:		
Case Manager's Tasks	**Client's Tasks**	**Progress Note**
Goal #2:		
Case Manager's Tasks	**Client's Tasks**	**Progress Note**
Goal #3:		
Case Manager's Tasks	**Client's Tasks**	**Progress Note**
Conditions for Assistance: Client will notify case management staff if there is ANY change in income or benefits and provide needed documentation. Client will also notify agency if there is a change in the number of persons in the household or a change in address or phone number.		
Case Management Staff Contact Information:		
Your signature indicates that you feel that the goals stated above were mutually agreed upon and focus on your current needs. Signing below indicates that you have read, understand and will comply with the terms above, your signature also verifies that you have received a copy of your service plan.		
Client's Signature:		Date:
Case Manager's Signature:		Date:

A copy of the completed (signed and dated) form must be given to the client in addition to a copy kept in the client chart.