Standards of Care

Effective January 2015

Regional Trainings
Maribel Santana, Director of Member Services & QA/TA
Tess Dudek, Program Manager

- **Welcome**
  - Maribel Santana, Director of Member Services & QA/TA
- **Goals of the meeting**
  - Identify roles
    - ACT
    - ACT – Independent Evaluator
    - Funder (State & Cities)
  - **Review Tools**
    - Pre-test
    - Standards of Care – Maribel Santana
    - Acuity Index – Tess Dudek, Program Manager
    - Post-test
  - **Q&A & Technical Assistance**
    - TA Request – Website
    - Online training
    - FAQ
    - Q&A
- **Adjourn**

IDENTIFY ROLES - ACT

- Provide administrative support to the independent evaluator
- Collectively ACT and the Independent Evaluator will review and document all Pre-Review materials
- Technical assistance
- Facilitate focus groups
- Staff interviews
- Mediate any requests providers may have as they prepare for their review
- Training on the Standards of Care and the Acuity Index
- ACT is not responsible for providing or processing HMIS data prior to or during the review, or for monitoring DOH/HOPWA contract compliance.

IDENTIFY ROLES – INDEPENDENT EVALUATOR

- (Sheryl Horowitz) is primarily responsible for conducting and the oversight of the ACT review process.
- Lead focus groups and staff interviews.
- Process and analyze all data gathered during the review, and summarize her observations of the program's strengths and weaknesses in the final report.
- The report will outline areas of compliance and noncompliance as well as include a narrative of each section of the domains.
- Following the review season, the evaluator will share trends and best practices from the review season with the CQI committee.

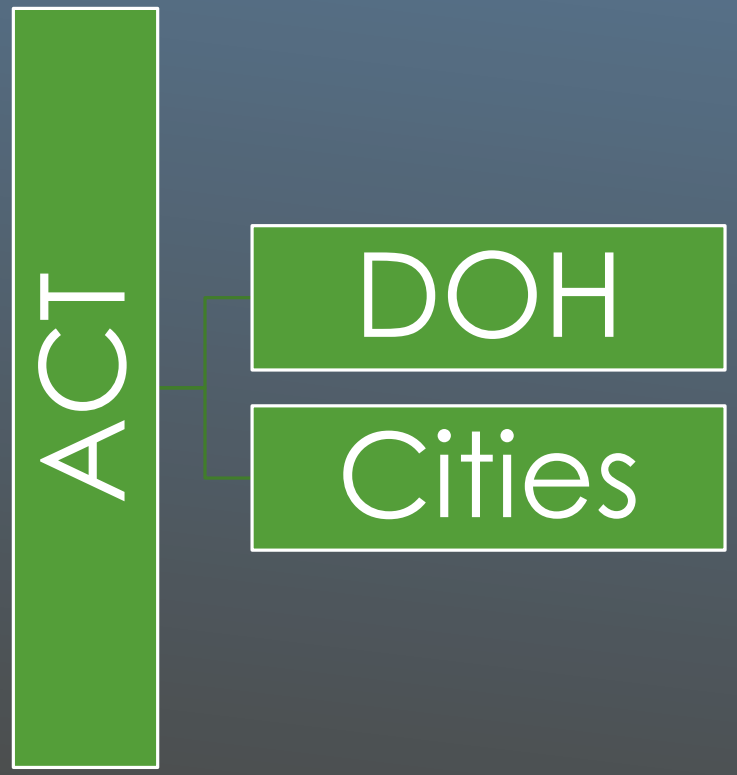
IDENTIFY ROLES - FUNDERS

- Ensure a program's contract compliance.
- Consequently, a funder may choose to conduct their contract review separately.
- The ACT review is NOT a substitute for a contract compliance audit and agencies must be prepared for both the ACT review as well as the DOH/HOPWA review.

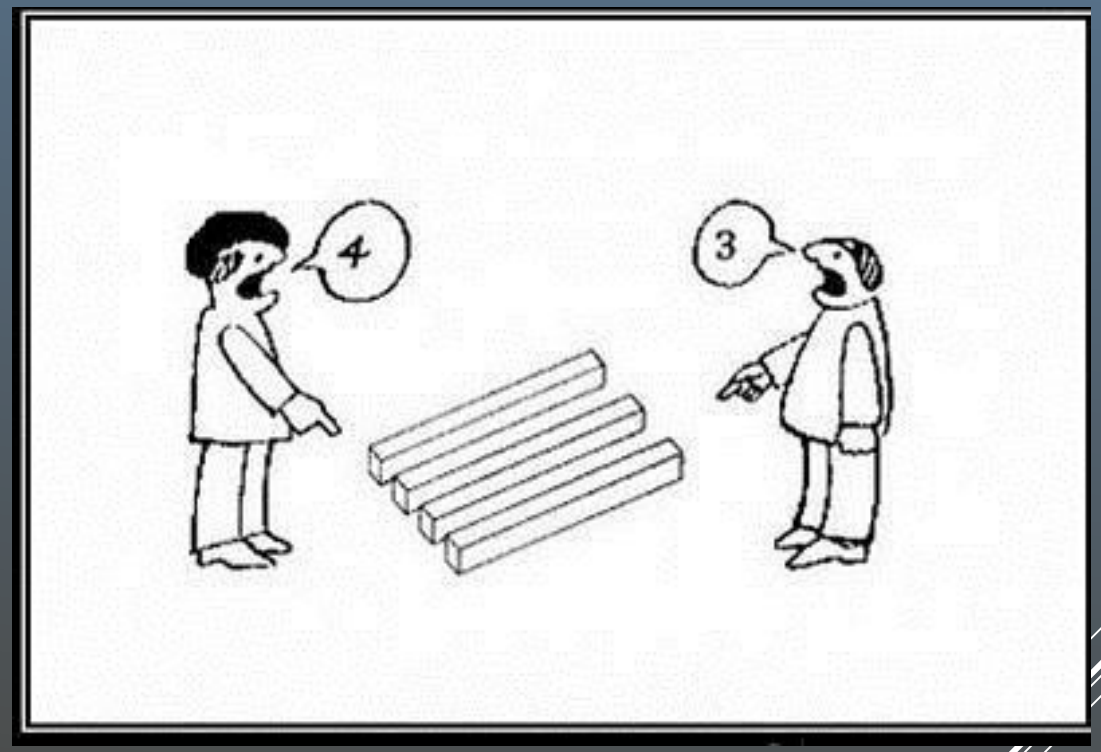
Client Centered
Support Services
CM Services

Admin/ Policy
Critical incident reports
Board minutes
Occupancy
Staffing patterns

TBRA
Financial exhibits
Online income calculator
Rental amounts



ACT WILL FOCUS ON **FIELD STANDARDS** &
FUNDERS WILL FOCUS ON **CONTRACT COMPLIANCE**



Quantitative, number based, objective…

Qualitative, range, interpretations, interviews, subjective

5 NEW THINGS

1. Old Standards, 20% of Active files or 6 records

   New Standards, 10% of Active files or 5 records

2. Before “Sections” (4) After “ Domains” (7)

3. Sections = Points

   Domains = ranges i.e. 80% of files have…, 3 of the 5 elements…

4. Pre-Review Process

5. Staff Interviews

OUTLINE – PART ONE

Program Documents – Packets

Pre-Review Process

On-Site Review Process

Report

Report Layout

Scoring

Scoring Table

Standards of Care

Domains

Questions

PROGRAM DOCUMENTS – PACKETS

- Point of Contact *(return to ACT)*
- Affidavit
- Grievance Policy
- Informed Consent (English/ Spanish)
- Resident Poster
- Calendar
- Standards of Care & Acuity Index http://www.aids-ct.org/qata.html

PRE-REVIEW PROCESS

The provider should submit the following information to ACT at least **4 weeks** before the on-site review:

Materials

- Program information (flier, brochures)
- A blank application form
- Grievance process information
- Client group materials including notifications of meetings, agendas, minutes, etc.
- Current coverage schedule
- Employee evaluation procedure
- A blank copy of the current employee evaluation
- Copy of all staff annual confidential pledges
- Policy on blood borne pathogens and Hepatitis B
- TB Testing, (assign a non-identifying random letter or number for employees including date tested and date read. Exempted or TB screen positive employees should have a note entered with the date of paperwork from doctor clearing them for work.)
- Standard job descriptions for case managers and supervisors
- Program Facilities: copy of documentation regarding: state and local health, fire and building codes,

fire alarm, elevator inspection & Qualified Food Operator certificate (all which apply to your program).

PRE-REVIEW PROCESS

Data *(only de-identified data should be submitted)*

- Program occupancy goal and actual occupancy for each month
- A copy of the most recent HUD APR for the program
- Length of stay for each Client served (including discharges) during the prior year
- Current caseload numbers for each case manager
- Percent of Clients who have an identified primary healthcare provider
- Training hours and courses completed in the prior year for each case manager
- A copy of the results of the most recent consumer survey for the program & copies of surveys

ON-SITE REVIEW PROCESS

The on-site review consists of four parts:

- 1. A **review** of **rejected applications** in the prior year (*if any*)

  Five or 10 percent of **active client charts** (*whichever is greater*)

  All intake charts (up to 2) in the prior year. If there were more than 2 intakes, randomly select 2.

  Chart review of **2 clients discharged** in the prior year
- 2. Focus Group (*up to 10 consumers*)
- 3. Staff interviews (*both program manager and case managers*)
- 4. Observations (*files stored in a secure manner, transportation easily accessible…*)

REPORT – WHAT TO EXPECT

- **When will program receive copies of report?**
  - 5 business days after review completion.
- **How will agency receive reports?**
  - The reports can be mailed or a PDF copy can scanned/ emailed.
- **Who receives copies of the report?**
  - Individual(s) listed on the Point of Contact sheet, Board president & Executive Director
- **Will there be an exit interview?**
  - No exit interview will be conducted.

REPORT LAYOUT

Domains

- There are 7 Main Domains with 4 Sub-sections within each domain, each section is valued at 5 points with a total of 20 possible points.
- There is a “comment” section for each domain. The independent evaluator will expound on each section.

Summary

- Program highlights
- Identified challenges
- Identified technical assistance needs
- Reviewer feedback with Action Plan, *if required*

SCORING TABLE

AIDS CT QUALITY ASSURANCE REVIEW
Scoring

Domain	Available Points	High Quality	Meets Quality	Stronger Focus on Quality Needed
1: Facilitated Access to Housing and Services	20	19-20	17-18	0-16
2: Client Rights, Input and Leadership	20	19-20	17-18	0-16
3: Housing Quality, Health & Safety	20	19-20	17-18	0-16
4: Support Services Design and Delivery: Client-Focused/Client-Centered Services & Client Engagement	20	19-20	17-18	0-16
5: Support Services Design and Delivery: Services that Promote Recovery, Wellness and Community Integration	20	19-20	17-18	0-16
6: Focus on Housing Stability	20	19-20	17-18	0-16
7: Building Internal Quality Assurance Practices, Key Staffing and Coordination	20	19-20	17-18	0-16

SCORING

- Three Categories
  - **High Quality**: Total Score of 133-140 with NO domains needing stronger focus
  - **Meets Quality**: Total Score of 119-132 with no more than 1 domain needing stronger focus
  - **Needs Stronger Quality Focus**: Total Score of 118 or below 2 or more domains needing stronger focus

High Quality (133-140) the agency will not be reviewed the following year.

STANDARDS OF CARE

Note: Anything bold & highlighted in yellow are Pre-Review Materials expected **4 weeks** prior to review.

DOMAIN 1 – FACILITATED ACCESS TO HOUSING & SERVICES

AIDS CT QUALITY ASSURANCE REVIEW

Domain 1: Facilitated Access to Housing and Services

Domain 1	Measures	0	1	2	3	4	5	SCORE
(a) Housing Resource Utilization	**Program Occupancy Rate during the year.** *Agencies are responsible for calculating occupancy from HMIS reports and provide documentation to verify their data.	Occupancy fell below 60 percent for a period of > 2 consecutive months	Occupancy did not fall below 60% for a period of > 2 consecutive months	Occupancy did not fall below 70% for a period of > 2 consecutive months	Occupancy did not fall below 80% for a period of > 2 consecutive months	Occupancy did not fall below 90% for a period of > 2 consecutive months	Occupancy did not fall below 100% for a period of > 2 consecutive months	
(b) Application Process	• **Application process and eligibility criteria are clear**. • **Application process is fully accessible to persons with disabilities.** • Individuals receive a formal notice of approval or denial. • Individuals are notified that they can grieve a denial and are told how to do it. • Applicants come from a variety of sources including hard-to-reach persons.	No elements Present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	
(c)Client Selection Research on client selection	• The program has clearly stated eligibility criteria for admission into the program that are in compliance with funders requirements. • The program uses consistent intake process. • Client selection is first come - first served or based on identified waitlist priorities. • Name, date and referral source are documented in intake forms. • HIV status is provided with original doctor signature and license number.	No elements Present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	
(d) Client Eligibility	Housing and services are for individuals or heads of household who are homeless s, or at-risk of homelessness, and have an HIV or AIDS diagnosis.	Verification of homeless and disability status not present	Verification of homeless and disability status present in ≥20% of files	Verification of homeless and disability status present in ≥40% of files	Verification of homeless and disability status present in ≥60% of files	Verification of homeless and disability status present in ≥80% of files	Verification of homeless and disability status present in 100% of files	

DOMAIN 2 – CLIENT RIGHTS, INPUT AND LEADERSHIP

Domain 2: Client Rights, Input and Leadership

Domain 2	Measures	0	1	2	3	4	5	Score
(a) Client Lease	Clients lease or housing agreement conforms to fair housing laws. (or for shelters and skilled nursing facilities a program agreement)	Not present	Lease or agreement present in ≥20% of files	Lease or agreement present in ≥40% of files	Lease or agreement present in ≥60% of files	Lease or agreement present in ≥80% of files	Lease or agreement present in 100% of files	
(b) Client Guide	There is signed verification of receipt of resident manual.	No Statement	Signed statement in at least 20% of Client files	Signed statement in at least 40% of Client files	Signed statement in at least 60% of Client files	Signed statement in at least 80% of Client files	Receipt in at 100% of Client files	
(c) Client Input	• **Client groups and individuals have regular opportunities to provide input** into program operations and rules, and to voice complaints. • Rules are communicated clearly, consistently enforced, and are distributed to Clients at intake. • There are clearly defined grievance procedures that are communicated to Clients that include review, disposition and decision completed within 30 days of the receipt of the grievance with an additional 15 days, if approved by the agency director, provided the Client is notified. • **Resident satisfaction surveys are completed** annually and program respond to the information provided. • **Clients are proactively notified of their rights** including how to obtain **legal services.**	No elements Present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	
(d) Client Rights	• Client files and charts are securely maintained to ensure protection of confidential information. • Staff advocate with landlords and/or property managers regarding Clients' rights. • **Staff understands the expectation regarding Client rights and has signed staff confidentiality pledges annually.** • All partners involved in the program understand the expectations regarding Client rights and confidentiality. • Protected information is shared only with Client consent.	No elements Present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	

DOMAIN 3 – HOUSING QUALITY, HEALTH & SAFETY

Domain 3: Housing Quality, Health & Safety

Domain 3	Measures	0	1	2	3	4	5	Score
(a) Health and Safety	• **The program complies with the federal Department of Labor Occupational Safety and Health Administration (OSHA) "Enforcement Procedures for the Occupational Exposure to Blood-borne Pathogen Standards", as set forth in 29 CFR 1910. 1030.** • **The program facilities, in compliance with all state and local health, fire and building codes including offices, fire, alarm, *if applicable* elevator has been inspected and Qualified Food Operator certificate available, *if applicable*.** • **The program (a) adheres to a policy and procedure that includes the annual testing of Tuberculosis of all program staff (b) offers immunizations for Hepatitis B to all program staff and (c) has protocols for educating residents about health issues including but not limited to Tuberculosis, Hepatitis B and C.** • Community based services and transportation are easily accessible. • There is adequate space for service delivery, community-building, meetings and property management activities.	No elements Present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	
(b) Assessment of Housing	Staff meet with Clients in their apartments at least every six months and review maintenance, health, safety and quality. Initial inspection will satisfy lead-free housing requirement if children 6 or younger present and if the housing unit was build before 1978. (For Shelters and skilled nursing facilities if this does not apply please rate "5")	Not present	at least 20% of Client files	at least 40% of Client files	at least 60% of Client files	in at least 80% of Client files	in 100% of Client files	

Note on Domain 3A:

- The program adheres to a **policy** and procedure that includes the **annual testing** of Tuberculosis of all program staff,
- **Offers** immunizations for Hepatitis B to all program staff
- **Protocols** for educating residents about health issues including but not limited to Tuberculosis, Hepatitis B and C.

DOMAIN 3

Domain 3	Measures	0	1	2	3	4	5	Score
(c) Emergencies and Critical Incidents	Most critical or reportable incident, by the agency policy are verbally reported to management within 3 hours of incident discovery followed by a written report within 1 business day, with formal management review within 30 to 60 days after verbal report. Housing condition emergencies are addressed within 24 hours of discovery.	Not present	at least 20% of Client files where applicable	at least 40% of Client files where applicable	at least 60% of Client files where applicable	at least 80% of Client files where applicable	in 100% of Client files where applicable	
(d) Child Abuse and neglect	Suspected child abuse/neglect is reported by the provider or collaborating provider via an oral report to DCF as soon as practical but no longer than 12 hours after suspected abuse with a written follow-up report to DCF no longer than 48 hours after the oral report and incident is reviewed by management.	Not present	at least 20% of Client files where applicable	at least 40% of Client files where applicable	at least 60% of Client files where applicable	at least 80% of Client files where applicable	in 100% of Client files where applicable	

DOMAIN 4 – SUPPORT SERVICES DESIGN & DELIVERY

Domain 4	Measures	0	1	2	3	4	5	Score
(a) Client Education and Engagement	**Percent of Clients who agree or strongly agree with "Staff helped me obtain information I needed so that I could take charge of managing my illness" on consumer survey.**	0 – 49%	50-59%	60-69%	70-79%	80-89%	90-100%	
(b) Assessment and Acuity	The most recent assessment is completed, contains all information necessary to plan and provide services, and the acuity index is complete.	0 to 20 % are complete	21-39% are complete	40-59% are complete	60-79% are complete	80-99% are complete	All are complete	
(c) Service Plan	Service plan goals are based on the results of the assessment and acuity index and/or person-centered identified goals.	No service plan goals are present or goals not based on the assessment/ acuity index	Service plan goals based on assessment and acuity index in ≥20% of plans	Service plan goals based on assessment and acuity index in ≥40% of plans	Service plan goals based on assessment and acuity index in ≥60% of plans	Service plan goals based on assessment and acuity index in ≥80% of plans	Service plan goals based on assessment and acuity index in 100% of plans	
(d) Service Provision	• Case manager contacts Clients at least 2 times per month (including at least one face-to-face) or for Clients with less intensive needs an alternate plan of contact approved by supervisor is implemented. • Case managers are flexible in their response to Client meeting times/locations and services provided. Staff make regular attempts using different methods to engage clients who refuse services, to increase likelihood of service participation.	Not present	at least 20% of Client files	at least 40% of Client files	in at least 60% of Client files	at least 80% of Client files	in 100% of Client files	

DOMAIN 5 – SUPPORT SERVICES & DELIVERY

Domain 5: Support Services Design and Delivery: Services that Promote Recovery, Wellness and Community Integration

Domain 5	Measures	0	1	2	3	4	5	Score
(a) Connection to Benefits and Income	**Percent of Clients who maintained or increased their income from all sources during the year.**	0 – 49%	50-59%	60-69%	70-79%	80-89%	90-100%	
(b) Connection to Primary Healthcare	**Percent of Clients who have a primary healthcare provider.**	0 – 49%	50-59%	60-69%	70-79%	80-89%	90-100%	
(c) Evaluating Service Progress	Progress notes reflect activities taken to meet service plan goals.	not present or do not reflect actions taken to meet goals plan goals in < 20 percent of files	Progress notes reflect activities taken to meet service plan goals in at least 20% of Client files	Progress notes reflect activities taken to meet service plan goals in at least 40% of Client files	Progress notes reflect activities taken to meet service plan goals in at least 60% of Client files	Progress notes reflect activities taken to meet service plan goals in at least 80% of Client files	Progress notes reflect activities taken to meet service plan goals in all Client files	
(d) Service Coordination and Connection to Resources	• Case managers assist Clients in identifying and accessing community providers and resources. • Services are well-coordinated with other providers and referrals are documented and tracked in a defined process.	Not present	at least 20% of Client files	at least 40% of Client files	Documented in at least 60% of Client files	at least 80% of Client files	in 100% of Client files	

DOMAIN 6 – FOCUS ON HOUSING STABILITY

Domain 6: Focus on Housing Stability

Domain 6	Measures	0	1	2	3	4	5	Score
(a) Housing Stability	**Percent of Clients who remained in housing or exited to housing – (to non-homelessness). (For shelters and skilled nursing facilities please rate "5" if this is not applicable. Also indicate how many clients were placed in housing during the year.**	0 – 59%	60-69%	70-79%	80-89%	90-99%	100%	
(b) Client Retention	**Of the clients who have been in facility for a year, percent of Clients who have remained in supportive housing for more than one year. (Discharge occurs more than 12 months after intake).(For shelters circle 5 if not applicable)**	0 – 49%	50-59%	60-69%	70-79%	80-89%	90-100%	
(c) Discharge Practices	• Discharged Clients given information regarding discharge grievance procedure. • **Discharge grievance reviews, dispositions and decisions are completed within 30 days of the receipt of the grievance with an additional 15 days, if approved by the agency director, provided the former Client is notified.** • **Clients are not removed from housing without legal eviction proceedings, if a tenant holds the lease. For tenants of programs with agreements this discharge is in accordance with program discharge policy.** • For all discharges, appropriate communication exists with providers, landlord, and others as appropriate. • Program has a comprehensive discharge policy.	No elements Present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	

DOMAIN 6

Domain 6	Measures	0	1	2	3	4	5	Score
(d) Continuity of Support	• The discharge summary includes identification of providers continuing services, reason for discharge, location of new residence if known or feasible, assessment of ongoing needs, and ability to maintain housing. • Client discharge planning occurs at least 3 months in advance of discharge date where possible regardless of the reason for discharge. • There are at least three attempts to follow-up with discharged Clients to determine status regardless of the reason for discharge.	Not present	at least 20% of Client files	at least 40% of Client files	at least 60% of Client files	at least 80% of Client files	in 100% of Client files OR no discharges occurred within the review timeframe	

DOMAIN 7 – BUILDING INTERNAL QUALITY ASSURANCE PRACTICES, KEY STAFFING & COORDINATION

ont Paragraph Styles

Domain 7	Measures	0	1	2	3	4	5	Score
(a) Documentation Quality	• Assessment and acuity index signed and dated by case manager and supervisor. • Discharge summaries signed and dated by case manager and supervisor. • Service plans signed and dated by Client, case manager and supervisor. • Progress notes entered within 1 week of services. • Progress notes include date of service, type of contact, date of note, and person entering note.	Not present	at least 20% of Client files	at least 40% of Client files	at least 60% of Client files	at least 80% of Client files	in 100% of Client files	
(b) Standards for Planning and Documenting Services	• Service plan goals are measurable. • Client input is a part of service plan design. • There is a collaborative relationship which exists and is documented between case managers and other providers and landlord.	Not present	at least 20% of Client files	at least 40% of Client files	at least 60% of Client files	at least 80% of Client files	in 100% of Client files	
(c) Timeliness of Service Provision	• Assessment and acuity index completed within 30 days of entry and repeated at least every 6 months. • The service plan based on the assessment and acuity index developed within 60 days of admission. • Service plans updated/amended at least every six months based upon the most recent assessment. • Progress toward meeting service plan goals and/or person-centered identified goals. is documented at least 2 times per month based on acuity index results.	Not present	at least 20% of Client files	at least 40% of Client files	at least 60% of Client files	at least 80% of Client files	in 100% of Client files	
(d) Staffing	• **Staffing meets the current caseload requirements.** • **Staff with case management responsibilities attend 10 hours or more of case management training during the year.** • **Coverage hours clearly defined and include 24 hour on-call supervision.** • **Case manager and program supervisor job descriptions and qualifications are standardized and contain clearly defined roles and responsibilities.** • **There is a clear and ongoing evaluation of employee performance.**	Not present	One element Present	Two elements present	Three elements present	Four elements present	Five elements present	

REVIEW TEAM – AIDS CT

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DEPARTMENT OF HOUSING

Individual and Family Support Programs Unit of The Department of Housing				
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QUESTIONS

Break

ACUITY INDEX TRAINING
OUTLINE – PART TWO

Purpose of the Acuity Index

Kinds of Information

Timeframe

Completing the Acuity Index

Finalizing the Acuity Index

Point Scales

Acuity Index – Actual form

Questions

PURPOSE

- Help **guide** the tenant and service staff in the development of service plan goals.
- Systematic way to assess a persons level of independence and **improve quality of life**.
- **Assess** Income and benefits, health, and access to supportive services/resources.

TIMEFRAME

- When was the Acuity Index implemented? **January 2015**
- Will I be penalized or expected to complete an Acuity Index for every client on my case load, before January 2015? **NO**

ADDITIONAL IMPACTS

- Exploring other housing options with community-based supports outside of the supportive housing program.

- **The Acuity Index can also be used by supervisors to;**
  1. Determine case load sizes
  2. Identify supervision needs
  3. Evaluate the distribution of work and other employee/agency needs
  4. Track trends in client needs

The Acuity Index also a provides structured way of getting to know the tenant. This information may include:

- Experiences
- Strengths
- Hopes (*plan*) of the tenant

KINDS OF INFORMATION COLLECTED WITH THE A.I.

- The assessment provides information about a person's

1. Housing history

   ***Shelters and skilled nursing facilities are not required to complete the housing section of the Acuity Index or include housing score in the interpretation at the end of the AI.**

2. Income and Benefits
3. Health (Non-HIV)
4. Supportive Services and Resources
5. Parent and Child Services
6. HIV Specific Health & Wellness

TIMEFRAME

- The **initial** Acuity Index must be completed within **30 days.**
- **Follow-up** assessment (Acuity Index) must be completed at least every **6 months.**
- Both the initial and follow-up assessments (Acuity Index) must be **signed** and **dated** by the **staff member** who is directly working with the tenant and the **supervisor.**
- **If a client refuses to participate in the Acuity Index, the case manager should make note of this in the "comments" section, and fill out the HIV Health & Wellness section of the tool.**

COMPLETING THE ACUITY INDEX

- Multiple stages of using the A.I.
- Case manager must gather and examine all supporting documents (assessments and discharge information from other agencies, housing application, and progress notes).

CASE STUDY

- A case manager has gathered information from other sources, has looked at progress notes and has met with the tenant once.
- The case manager had another appointment with the tenant.
- The tenant had to cancel and the assessment and Acuity Index must be completed by tomorrow.

How should the case manager proceed?

RESOLUTION

- The case manager should **move forward** and complete the assessment **<u>noting</u>** any information that is still outstanding or missing. These notes should be made in the comments section of the A.I.
- The case manager should choose the level **based upon the information that is available**. (if a section does not apply (i.e "Parenting and Child Services") provide the maximum level of points)
- Additional information from the tenant can be considered when developing service plan goals and can be noted in progress notes for incorporation in the **next** assessment.

FINALIZING THE ACUITY INDEX

- The assessment must be finalized once a case manager feels that there is enough information to help a tenant develop meaningful service plan goals and within the timeframe established by quality assurance standards.
- Any information that is missing or not applicable must be noted on the comments section. If there is information that is missing that relates to the Acuity Index, the case manager should choose the level that reflects what information is known.
- It is important that no portion of the assessment is left blank and that the Acuity Index is fully complete (unless the client has refused to cooperate).

FINALIZING THE ACUITY INDEX

- The key to completing the assessment is to gather as much information as possible to inform service plan goals.
- In some cases the case manager may not be able to get exact dates and details.
- In these situations, the case manager should move on and complete the assessment without these details.

CASE STUDY

- A client tells a case manager he was hospitalized at some point in 2012, but the case manager does not have any documentation of the visit or record of the client's stay.

What should the case manager record?

RESOLUTION

- In this situation, the case manager should note in the “health” portion of the **initial assessment** that the tenant was hospitalized in 2012 and should use this information to assist in the development of service plan goals. If this is all the information the case manager has, they should work to determine what caused this hospitalization.

NOTES ABOUT THE ACUITY INDEX

- It is important to recognize that the Acuity Index values will change over time – sometimes in a **negative direction**.
- If a tenant's score is high in one area, it may be lower at the next assessment.
- This **does not** necessarily point to an issue with the quality of services, but may simply reflect a change in the needs or experiences of the tenant.

ACUITY INDEX – POINT SCALE

- The Acuity Index categorizes tenant self sufficiency and independence on a four point scale.
- The scale ranges from a 0, representing low self sufficiency and independence, to a 3, representing the highest level.
- The A.I. is divided into six sections; Housing, Income and Benefits, Health (Non-HIV), Supportive Services and Resources, Parenting and Child Services and HIV Specific Health & Wellness.

Acuity Index

Note: Shelters and skilled nursing facilities: Do *not* complete the Housing section or Interpretations at the end. *Do* complete the remaining sections.

Housing	Levels				Tenant Level		Service Plan Goal for Level 0 or 1	
	0	1	2	3	New	Last	Active	Deferred

Note:	Shelters and skilled nursing facilities: Do not complete the Housing section or interpretations at the end. Do complete the remaining sections.
Levels	0-3 (0=low self sufficiency…3=Highest level)
Tenant Level	New= The current score Last=Score from the previous Acuity Index (if this is not the first A.I.)
Service Plan Goal for Level 0 to 1	Require a service plan GOAL
Active or Deferred	Goals can be either active – something that a tenant is working on currently, or deferred – a goal that is identified as important but will be worked on later. Sometimes a service plan goal will address two sections at the same time.

Acuity Index

Note: Shelters and skilled nursing facilities: Do *not* complete the Housing section or Interpretations at the end. *Do* complete the remaining sections.

Housing	Levels				Tenant Level		Service Plan Goal for Level 0 or 1	
	0	1	2	3	New	Last	Active	Deferred
Rent Payment	Rep Payee/Tenant has not paid rent for last 6 months or has only paid on-time 1-3 times in last 12 months	Rep Payee/Tenant has paid rent on-time 4-6 times in last 12 months	Rep Payee/Tenant has paid rent on-time 7-9 times in last 12 months	Rep Payee/Tenant has paid rent on-time every month for the last 12 months				
Utility Bill Payment	Tenant has paid utility bills on-time for 1-3 months in last 12 months	Tenant has paid utility bills on-time for 4-6 months in last 12 months	Tenant has paid utility bills on-time for 7-9 months in the last 12 months	Tenant has paid utility bills on-time for 10-12 months in last 12 months OR utilities are included in rent.				
Rent Arrears	Tenant has outstanding rent arrears and is not willing to set up payment plan	Tenant has more than 6 months of rent arrears and has set up a payment plan	Tenant has less than 3 months of rent arrears and is current on payment plan	Tenant has no rent arrears				
Utility Arrears	Tenant has outstanding utility arrears and is not willing to set up payment plan	Tenant has less than $1000 in utility arrears and has set up a payment plan	Tenant has less than $500 in utility arrears and is current on payment plan	Tenant has no utility arrears				
Safe Living Environment	Tenant had over 5 contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months	Tenant had 3-5 contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months	Tenant had 1-2 contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months	Tenant had no contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months				
Lease *(include all leases if tenant moved)*	Tenant has been in supportive housing less than 12 months OR has held a lease less than 12 months	Tenant has been in a supportive housing program and has held lease for 12-23 consecutive months	Tenant has been in a supportive housing program and has held lease for 24-36 consecutive months	Tenant has been in a supportive housing program and has held lease for over 36 consecutive months				
				Housing Subtotal				

Comments:

Income and Benefits	Levels				Tenant Level		Service Plan Goal for Level 0 or 1	
	0	1	2	3	New	Last	Active	Deferred
Stable/Consistent Source of Cash Income	Tenant has no stable/consistent source of cash income	Tenant has cash income but it is not stable/consistent	Tenant has had stable/consistent cash income for the last 1 – 6 months	Tenant has had stable/consistent cash income for the last 7 or more months				
Benefits	Tenant has no benefits and has not yet applied for benefits	Tenant has applied for benefits but has not yet received them	Tenant has received all benefits entitled to for the last 1-6 months	Tenant has received all benefits entitled to for the last 7 or more months OR is not eligible for benefits				
Employment	Tenant is not employed, is able to work but not seeking employment OR tenant is not able to work and has not received disability benefits	Tenant is not employed, is able to work and is seeking employment/participating in employment services	Tenant is able to work and has been employed for less than 6 months	Tenant is able to work and has been employed for more than 6 months OR tenant is not able to work and receiving disability benefits				
Debt	Tenant debt greater than 50 percent of income and tenant is unable to meet these obligations	Tenant debt is greater than 50 percent of income and tenant is able to meet these obligations	Tenant debt is less than 50 percent of income and tenant is able to meet these obligations	Tenant debt is between 0 and 10 percent of income and tenant is able to meet these obligations				
Health (Non-HIV)								
Mental Health Care Use	Tenant has not had contact with a mental health provider in the past 12 months	Tenant has contact with a mental health provider and has kept less than 50 percent of appointments in the last 12 months	Tenant has contact with a mental health provider and has kept more than 50 percent of appointments in the last 12 months	Tenant has contact with a mental health provider and has kept more than 90 percent of appointments in the last 12 months OR Tenant has no need for mental health services				
Primary/Specialty Health Care Use	Tenant has not had contact with a primary and/or specialty health care provider in the past 12 months	Tenant has contact with a primary and/or specialty health care provider and follows preventive screening and treatment recommendations less than 50 percent of the time	Tenant has contact with a primary and/or specialty health care provider and follows preventive screening and treatment recommendations 50 to 90 percent of the time	Tenant has contact with a primary and/or specialty health care provider and follows preventive screening and treatment recommendations more than 90 percent of the time				

Medication Adherence	Tenant self-reports never taking prescribed medications	Tenant self-reports rarely taking prescribed medications	Tenant self-reports sporadically taking prescribed medications	Tenant self-reports regularly taking prescribed medications OR has no prescribed medications				
Health (continued)	**Levels**				**Tenant Level**		**Service Plan Goal for Level 0 or 1**	
	0	**1**	**2**	**3**	**New**	**Last**	**Active**	**Deferred**
Harm Reduction (such as substance use, gambling, risky sexual and other behaviors)	Tenant does not see behavior(s) as harmful	Tenant acknowledges behavior(s) may be harmful and is contemplating adoption of harm reduction goals	Tenant has set harm reduction goals and has taken some actions to achieve them	Tenant has adopted behaviors to achieve harm reduction goals OR does not engage in harmful behaviors				
Supportive Services and Resources								
Connection to Community Supports	Tenant has no community supports outside of supportive housing program	Tenant has limited community supports and is not interested in attaining others	Tenant has adequate community supports or has limited supports but is interested in attaining others	Tenant seeks out community supports and has many connections including specialized services				
Crisis Intervention	Tenant has required over 5 crisis interventions in the past 12 months	Tenant required 3-5 crisis interventions in the past 12 months and did not work quickly with case manager to identify needs/help	Tenant required 3-5 crisis interventions in past 12 months and worked quickly with case manager to identify needs/help	Tenant required less than 3 crisis interventions in past 12 months and worked quickly with case manager to identify needs/help				
Life Skills	Tenant is unable to independently meet basic needs such as hygiene, food, activities of daily living	Tenant can independently meet a few but not all basic needs such as hygiene, food, activities of daily living	Tenant can independently meet most but not all basic needs such as hygiene, food, activities of daily living	Tenant is able to independently meet all basic needs				
Legal	Tenant has outstanding warrants or has been incarcerated for more than 90 days in the prior year	Tenant has current charges or trial pending, or is noncompliant with criminal justice supervision	Tenant has been fully compliant with criminal justice supervision for less than 12 months	Tenant has been fully compliant with criminal justice supervision for more than 12 months OR has no criminal justice supervision requirements				
Mobility & Transportation	Tenant has no access to public or private transportation	Transportation is available, but is unreliable or unaffordable	Transportation is available and reliable, but limited and/or inconvenient	Transportation is generally accessible to meet basic travel needs				
Income and Benefits; Health; and Supportive Services and Resources Subtotal								

Comments:

Acuity Index Family Section

Parenting and Child Services	Levels				Tenant Level		Service Plan Goal for Level 0 or 1	
	0	1	2	3	New	Last	Active	Deferred
Childcare	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate, supervision is a problem for childcare that is available	Affordable subsidized childcare is available, but limited	Reliable, affordable childcare is available, no need for subsidies				
Children's Education	One or more school aged children not enrolled in school	One or more school-aged children enrolled in school, but not attending classes. Parent is unaware and/or has difficulty addressing children issues without significant case management involvement	Enrolled in school, but one or more children only occasionally attending classes. Parent is aware and/or has difficulty addressing children issues without case management involvement.	Enrolled in school and attending classes most of the time. Parent is aware and addressing children issues.				
Parenting	There are safety concerns regarding parenting skills	Parenting skills are minimal	Parenting skills are apparent but not adequate	Parenting skills are adequate				
Child Welfare Involvement	High level of mandated involvement with child welfare system	Involvement with child welfare system, no resolution of matter/case	Recent involvement with child welfare but matter resolved and closed	No history of child welfare involvement OR involvement was more than 2 years ago				
Children with Special Needs	Children not connected with services	Children connected with services but participation minimal with prompting	Children connected with services with consistent participation with prompting	Children with special needs fully participate in services OR children have no special needs				
				Parenting and Child Services				

Comments:

HIV Specific Health & Wellness	Levels				Tenant Level		Service Plan Goal for Level 0 to 1	
	0	1	2	3	New	Last	Active	Deferred
HIV Awareness/ Education	No real knowledge of HIV and uninterested in HIV education and support	Tenant has limited knowledge of HIV and is not interested in further education	Tenant has adequate knowledge of HIV and has openness to further education but does not seek further education or HIV support	Tenant has substantial knowledge of HIV and regularly seeks HIV updates and connections				
HIV Medication Adherence	Tenant self-reports (or is known as) never taking prescribed medications	Tenant self-reports (or is known as)rarely taking prescribed medications	Tenant self-reports (or is known as) sporadically taking prescribed medications	Tenant self-reports (or is known as) regularly taking prescribed medications OR has no prescribed medications				
HIV Progression	Advanced HIV, with debilitating symptoms, multiple medication (ART) resistance, high risk of opportunistic infections and cancer, CD4 <200 and high Viral Load Viral Load_____ CD4 count _____ Date _____	Symptomatic with one or more conditions requiring treatment including opportunistic infections and cancer low CD4 count >200 and high Viral Load Viral Load_____ CD4 count _____ Date _____	Symptomatic-Flu like symptoms, and monitor with ART treatment and abnormal CD4 and Viral Load Viral Load_____ CD4 count _____ Date _____	Asymptomatic, normal CD4 and Viral Load (monitors the progression) Viral Load_____ CD4 count _____ Date _____				
Transmission Infection Risk (IDU, sharing works, MSM, commercial sex workers, rape, non-professional tattoos, sex without condoms)	Tenant currently engages in high-risk transmission behaviors	Currently engages in occasional high-risk transmission behaviors	Tenant has not engaged in high-risk transmission behaviors in the last 3 months	Tenant does not engage in high risk transmission behaviors for at least 6 months				
				HIV Specific Health & Wellness				

Comments:

- **Shelters and skilled nursing facilities:** The housing section is non-applicable (N/A) Please complete the remainder of the assessment, but do not complete the Acuity Index Interpretation.

Acuity Index Interpretation

Area	Maximum Level	Minimum Level	Ideal Range	Current Level on this Assessment
Housing	18	12	16-18	
Income and Benefits; Health; and Supportive Services and Resources	39	26	35-39	
Parenting and Child Services	15	10	13-15	
HIV Specific Health & Wellness	12	9	10-12	

Interpretation:

- **All applicable levels fall within the ideal range:** Other housing options with community supports should be considered as a short term goal.
- **Applicable levels are at or above minimum but not all fall within the ideal range:** Other housing options with community-based supports should be considered as a long term goal.
- **One or more levels are below the minimum:** Tenant should remain in supportive housing.
- **HIV Specific Health & Wellness:** If any area fall below a 3 tenant should remain in supportive housing.

Signatures

The information in this assessment was collected in good faith and the information contained in this assessment is as accurate as possible.

Case Manager Signature *Date*

Supervisor Signature *Date*