



Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
HIV Care and Treatment Program

Oregon Client Acuity Scale Worksheet

"Confidential- this form must always be saved on a secure network accessible only by Ryan White funded staff"

Client name _____ Date of assessment _____ Total points _____ Assigned acuity level _____

Clients are assigned to a level if they meet one or more of the criteria listed within each level.
Point values are different for different Life Areas by page.

Psychosocial assessment (part A)

Life area	Level #1 (1 point)	Level #2 (2 points)	Level #3 (3 points)	Level #4 (4 points)
Basic needs Level _____ Points _____	<input type="checkbox"/> Food, clothing and other sustenance items available through client's own means. <input type="checkbox"/> Has ongoing access to assistance programs that maintain basic needs consistently. <input type="checkbox"/> Able to perform activities of daily living (ADL) independently.	<input type="checkbox"/> Sustenance needs met on a regular basis with occasional need for help accessing assistance programs. <input type="checkbox"/> Unable to routinely meet basic needs without emergency assistance. <input type="checkbox"/> Needs assistance to perform some ADL weekly.	<input type="checkbox"/> Routinely needs help accessing assistance programs for basic needs. <input type="checkbox"/> History of difficulties in accessing assistance programs on own. <input type="checkbox"/> Often w/o food, clothing or other basic needs. <input type="checkbox"/> Needs in-home ADL assistance daily.	<input type="checkbox"/> Has no access to food. <input type="checkbox"/> Without most basic needs. <input type="checkbox"/> Unable to perform most ADL. <input type="checkbox"/> No home to receive assistance with ADL.
Transportation Level _____ Points _____	<input type="checkbox"/> Has own or other means of transportation consistently available. <input type="checkbox"/> Can drive self. <input type="checkbox"/> Can afford private or public transportation.	<input type="checkbox"/> Has minimal access to private transportation. <input type="checkbox"/> Needs occasional assistance with finances for transportation.	<input type="checkbox"/> No means via self/others. <input type="checkbox"/> In area under or un- served by public transportation. <input type="checkbox"/> Unaware of or needs help accessing transportation services.	<input type="checkbox"/> Lack of transportation is a serious contributing factor to current crisis. <input type="checkbox"/> Lack of transportation is a serious contributing factor to lack of regular medical care.
Risk reduction Level _____ Points _____	<input type="checkbox"/> Abstaining from risky behavior by safer practices. <input type="checkbox"/> Client has good understanding of risks.	<input type="checkbox"/> Occasional risk behavior (<i>unsafe behaviors of any type <=20% of the time</i>). <input type="checkbox"/> Client has fair understanding of risks.	<input type="checkbox"/> Moderate risk behavior (<i>unsafe behaviors of any type >20-50% of the time</i>). <input type="checkbox"/> Client has poor understanding of risks. <input type="checkbox"/> Client with mild/moderate A&D, MH, or relationship barriers to safer behavior.	<input type="checkbox"/> Declines to answer. <input type="checkbox"/> Significant risk behavior (<i>unsafe behaviors of any type >50% of the time</i>). <input type="checkbox"/> Client has little or no understanding of risks. <input type="checkbox"/> Client with significant A&D, MH, or relationship barriers to safer behavior.
Health insurance/medical care coverage Level _____ Points _____	<input type="checkbox"/> Has insurance/medical care coverage. <input type="checkbox"/> Has ability to pay for care on own. <input type="checkbox"/> Enrolled in CAREAssist.	<input type="checkbox"/> Client needs information and referral to insurance or other coverage for medical costs.	<input type="checkbox"/> Case management assistance needed in accessing insurance or other coverage for medical costs (<i>such as prescription drug coverage</i>). No medical crisis.	<input type="checkbox"/> Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis. <input type="checkbox"/> Not currently eligible for insurance or public benefits. Unable to access care.

Client name: _____

Life area	Level #1 (1 point)	Level #2 (2 points)	Level #3 (3 points)	Level #4 (4 points)
Self sufficiency Level _____ Points _____	<input type="checkbox"/> Independently always follows up on referrals. <input type="checkbox"/> Able to complete forms independently. <input type="checkbox"/> Able to live within financial means. Never needs financial assistance. <input type="checkbox"/> Does not burn bridges. Is able to access services eligible for and are available.	<input type="checkbox"/> Sometimes requires assistance in following-up on referrals. <input type="checkbox"/> Sometimes requires assistance in completing forms. <input type="checkbox"/> Needs financial assistance 1-2 times per year. <input type="checkbox"/> Access to some limited services.	<input type="checkbox"/> Follows-up on referrals with difficulty. <input type="checkbox"/> Difficulty completing forms. <input type="checkbox"/> Needs financial assistance 3-6 times per year. <input type="checkbox"/> Difficulty accessing services.	<input type="checkbox"/> Never follows-up on referrals. <input type="checkbox"/> Unable to complete forms. <input type="checkbox"/> Routinely needs financial assistance 6+ times per year. <input type="checkbox"/> Burns bridges. Majority of services not available.

Life area	Level #1 (1point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
Housing/living arrangement Level _____ Points _____	<input type="checkbox"/> Living in housing of choice: clean, habitable apartment or house. <input type="checkbox"/> Living situation stable; not in jeopardy.	<input type="checkbox"/> Living in stable subsidized housing (<i>public housing, private subsidized housing, or secure Section-8 voucher</i>). <input type="checkbox"/> Safe & secure nonsubsidized housing, but choices limited due to moderate income. <input type="checkbox"/> Housing is habitable, but requires limited improvements. <input type="checkbox"/> Housing is in jeopardy due to projected. Financial strain (>30 days); needs assistance with rent/utilities to maintain housing. <input type="checkbox"/> Living in long-term (>3 mo.) transitional rental housing.	<input type="checkbox"/> Formerly independent person temporarily residing with family or friends. <input type="checkbox"/> Eviction imminent. <input type="checkbox"/> Living in temporary (<3 mo.) transitional shelter. <input type="checkbox"/> Housing is in jeopardy due to immediate projected financial strain (<30 days); needs assistance with rent/utilities to maintain housing.	<input type="checkbox"/> Needs assisted living facility; unable to live independently. <input type="checkbox"/> Home uninhabitable due to health and/or safety hazards. <input type="checkbox"/> Recently evicted from rental or residential program. <input type="checkbox"/> Homeless (<i>living in emergency shelter, car, on street/camping, etc...</i>).
Mental health Level _____ Points _____	<input type="checkbox"/> No history of mental illness, psychological disorders or psychotropic medications. <input type="checkbox"/> No need for counseling referral.	<input type="checkbox"/> History of mental health disorders/treatment in client and/or family. <input type="checkbox"/> Level of client/family stress is high. Needs emotional support to avert crisis. <input type="checkbox"/> Need for counseling referral. <input type="checkbox"/> Depression, functioning. <input type="checkbox"/> Has some trouble getting along with others.	<input type="checkbox"/> Experiencing an acute episode and/or crisis. <input type="checkbox"/> Severe stress or family crisis re:HIV; need for mental health assessment. <input type="checkbox"/> Depression, not functioning. <input type="checkbox"/> Requires significant emotional support. <input type="checkbox"/> Significant trouble getting along with others.	<input type="checkbox"/> Danger to self or others. <input type="checkbox"/> Needs immediate psychiatric assessment/evaluation. <input type="checkbox"/> Active chaos or problems due to violence or abuse. <input type="checkbox"/> Requires therapy, not accessing it.
Addictions Level _____ Points _____	<input type="checkbox"/> No difficulties with addictions including: alcohol, drugs, sex, or gambling. <input type="checkbox"/> Past problems with addiction; >1yr. In recovery. <input type="checkbox"/> No need for treatment referral.	<input type="checkbox"/> Past problems with addiction; < 1 year in recovery.	<input type="checkbox"/> Current addiction but is willing to seek help in overcoming addiction. <input type="checkbox"/> Major addiction impairment of significant other. <input type="checkbox"/> Past problems with addictions; <3 months in recovery.	<input type="checkbox"/> Current addiction; not willing to seek or resume treatment. <input type="checkbox"/> Fails to realize impact of addiction on life/indifference regarding consequences of substance use.

RN assessment (part B)

Life area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
Knowledge of HIV disease Level _____ Points _____	<input type="checkbox"/> Verbalizes clear understanding about disease.	<input type="checkbox"/> Some understanding verbalized. <input type="checkbox"/> Needs additional information in some areas.	<input type="checkbox"/> Little understanding. <input type="checkbox"/> Needs counseling or referral to make informed decisions about health.	<input type="checkbox"/> Ignorant of HIV disease progression, etc. Unable to make informed decisions about health.
Adherence Level _____ Points _____	<input type="checkbox"/> Adherent to medications as prescribed for more than 6 months without assistance. <input type="checkbox"/> Currently understands medications. <input type="checkbox"/> Able to maintain primary care. <input type="checkbox"/> Keeps medical appointments as scheduled. <input type="checkbox"/> Not currently being prescribed medications.	<input type="checkbox"/> Adherent to medications as prescribed with minimal assistance. <input type="checkbox"/> Keeps majority of medical appointments.	<input type="checkbox"/> Adherent to medications and treatment plan with regular, ongoing assistance. <input type="checkbox"/> Doesn't understand medications. <input type="checkbox"/> Misses taking or giving several doses of scheduled meds weekly. <input type="checkbox"/> Misses at least half of scheduled medical appointments. <input type="checkbox"/> Takes long/extended "drug holidays" AMA. <input type="checkbox"/> Takes non- HIV systemic therapies without MD knowledge.	<input type="checkbox"/> Resistance/minimal adherence to medications and treatment plan even with assistance. <input type="checkbox"/> Refuses/declines to take medications against medical advice. <input type="checkbox"/> Medical care sporadic due to many missed appointments. <input type="checkbox"/> Uses ER only for primary care. <input type="checkbox"/> Inability to take/give meds as scheduled; requires professional assistance to take/give meds and keep appointments.
Medical needs Level _____ Points _____	<input type="checkbox"/> Stable health with access to ongoing HIV medical care. <input type="checkbox"/> Lab work periodically. <input type="checkbox"/> Asymptomatic in medical care.	<input type="checkbox"/> Needs primary care referral. <input type="checkbox"/> HIV care referral needed-stable. <input type="checkbox"/> Short-term acute condition; receiving medical care. <input type="checkbox"/> Chronic non-HIV related condition under control with medication/treatment. <input type="checkbox"/> HIV symptomatic with one or more conditions that impair overall health.	<input type="checkbox"/> Poor health. <input type="checkbox"/> HIV care referral needed-ASAP. <input type="checkbox"/> Needs treatment or medication for non-HIV related condition. <input type="checkbox"/> Debilitating HIV disease symptoms/infections. <input type="checkbox"/> Multiple medical diagnoses. <input type="checkbox"/> Home bound; home health needed.	<input type="checkbox"/> Medical emergency. <input type="checkbox"/> Client is in end-stage of HIV disease. <input type="checkbox"/> Intensive/complicated home care required. <input type="checkbox"/> Hospice services or placement indicated.
Nutrition Level _____ Points _____	<input type="checkbox"/> No signs of wasting syndrome or obvious physical maladies. <input type="checkbox"/> No abdominal pain reported. <input type="checkbox"/> No significant weight problems. <input type="checkbox"/> No problems with eating. <input type="checkbox"/> No problems with nausea or vomiting or diarrhea. <input type="checkbox"/> No need for nutritional intervention.	<input type="checkbox"/> Unplanned weight loss in the past 6 months. <input type="checkbox"/> Requests assistance in improving nutrition. <input type="checkbox"/> Occasional episodes of nausea, vomiting or diarrhea.	<input type="checkbox"/> Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies < not advanced >. <input type="checkbox"/> Abdominal problems reported. <input type="checkbox"/> Changes in eating habits in the past 3 months. <input type="checkbox"/> Chronic nausea, vomiting and/or diarrhea.	<input type="checkbox"/> Visual assessment shows advanced signs of wasting syndrome or other obvious physical maladies. <input type="checkbox"/> Acute abdominal pain. <input type="checkbox"/> Severe problems eating. <input type="checkbox"/> Acute nausea, vomiting and/or diarrhea. <input type="checkbox"/> Significant weight loss in past 3 months.

<p>Oral health</p> <p>Level _____</p> <p>Points _____</p>	<p><input type="checkbox"/> Is currently in active dental care.</p> <p><input type="checkbox"/> Has seen dentist in past six months.</p> <p><input type="checkbox"/> No complaints of mouth, tongue, tooth or gum pain and teeth and gums appear healthy as observed during assessment.</p> <p><input type="checkbox"/> Client reports practicing daily oral hygiene.</p>	<p><input type="checkbox"/> Does not have a regular dentist.</p> <p><input type="checkbox"/> No dental insurance.</p> <p><input type="checkbox"/> Has not seen a dentist in more than 6 months.</p> <p><input type="checkbox"/> Client reports not practicing daily oral hygiene.</p> <p><input type="checkbox"/> Dentures need adjusting, but still able to eat.</p>	<p><input type="checkbox"/> Reports episodic pain and/or sensitivity in teeth, gums or mouth.</p> <p><input type="checkbox"/> Missing days from work because of problems with teeth, gums or mouth.</p> <p><input type="checkbox"/> Client reports difficulty interacting with others because oral health problems negatively impact self-esteem.</p> <p><input type="checkbox"/> Observed appearance of dark, discolored teeth; missing teeth; bleeding, red gums; other problems with mouth.</p> <p><input type="checkbox"/> Client reports episodic or moderate difficulty eating.</p>	<p><input type="checkbox"/> Current tooth, gum or mouth pain and severe discomfort.</p> <p><input type="checkbox"/> Very few or no teeth.</p> <p><input type="checkbox"/> Observed appearance or client report of decayed teeth; white, hairy growth or creamy, bump-like patches; oral lesions or bleeding from gums/teeth.</p> <p><input type="checkbox"/> Client reports significant difficulty eating due to oral health problems.</p> <p><input type="checkbox"/> Client has difficulty talking because of oral health problems.</p>
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Acuity level guidelines

Level 1: 13-22 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Annual face-to-face nursing reassessment and psychosocial rescreening.
- Documentation in progress notes or CAREWare case notes.
- Ongoing nurse consultation as needed.
- Nurse and psychosocial Care Plan developed, appropriate intervention identified and ongoing follow-up provided.
- Care Plan Form (DHS 8400) updated annually.

Level 2: 23-42 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Annual face-to-face nursing reassessment and psychosocial screening.
- Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client's current status.
- Ongoing nurse consultation as needed.
- Nurse and psychosocial Care Plan developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

Level 3: 43-63 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Minimum annual face-to-face nursing reassessment and psychosocial re-screening.
- Minimum contact (telephone or face-to-face) every 30 days.
- Minimum evaluation of goals, activities and outcomes every 30 days.
- Nurse must be consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of every 90 days.
- Nurse and psychosocial Care Plan (Care Plan form) developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

Level 4: 64-84 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Minimum annual face-to-face nursing reassessment and psychosocial rescreening.
- Minimum contact (telephone or face-to-face) every 2 weeks.
- Minimum evaluation of goals, activities and outcomes every 2 weeks.
- Nurse is consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of every 30 days.
- Nurse and psychosocial Care Plan (Care Plan form) developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

Exceptions: * At the discretion of the Nurse Case Manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release. The Nurse Case Manager may assign an overall acuity of 3 or 4 if a client is assessed a level 3 or level 4 in the "Medical Needs" life area. Follow-up standards for these acuity levels will apply.