

LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS OF CARE

MEDICAL CARE COORDINATION SERVICES

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Exhibit 1 – Sample Consent to Receive Services

Exhibit 2 – Sample Grievance Form

Exhibit 3 – Commission on HIV Patient's Bill of Rights

EXPERT PANEL PARTICIPANTS

Expert Panels December 4, 2007

8:00am – 12:00pm:

- Diane Baumbauer, MPA – Los Angeles Family AIDS Network
- Marvin Belzer, MD, FACP – Children’s Hospital Los Angeles
- Sharon Chamberlain – Common Ground
- David Crain – St. Mary’s CARE Program
- Nettie DeAugustine – Long Beach Health and Human Services
- Susan Forrest – Holly Family Recovery Center
- Brad Land – Consumer
- Alex Sanchez, MD – 5P21/Rand Schrader
- Natalie Sanchez – El Proyecto del Barrio

1:00pm – 5:00pm:

- Lynn Berry, LCSW – AIDS Service Center
- Bill Brown – AIDS Project Los Angeles
- Roxanna Bustamante, RN – AltaMed Health Services Corporation
- Debbie Collins – Long Beach Health and Human Services
- Laura Gazdziak – Office of AIDS Programs and Policy
- Charles Hilliard, PhD – SPECTRUM
- Jeff Goodman – Common Ground
- Ervin Munro, MS – SRO Housing Corporation
- Quentin O’Brien, MA – Los Angeles Gay and Lesbian Center
- Joanne Oliver – Los Angeles Sheriff’s Department
- Mary Orticke – Office of AIDS Programs and Policy
- Brenda Padilla – Bienestar Human Services
- Angelica Palmeros, MSW – City of Pasadena
- Elye Pitts – Wells House Hospice Foundation, Incorporated
- Patricia Serna, LCSW – Long Beach Comprehensive Health Services
- James Skinner – Consumer
- Gilbert Varela, MD, MBA – Central City Community Health Center
- Steve Wilson – Los Angeles Sheriff’s Department

EXPERT PANEL PARTICIPANTS – CONTINUED

Expert Panels December 5, 2007

8:00am – 12:00pm:

- Arron Barba – Venice Family Clinic
- Matt Bosse, MD – City of Pasadena
- Joanne Granai – Antelope Valley Hope Foundation
- Michael Green, PhD – Office of AIDS Programs and Policy
- Louis Guitron, RN – Los Angeles Gay and Lesbian Center
- Margarita Guzman, Esq. – Volunteer, HIV & AIDS Legal Services Alliance
- Scott Howell, MD – AIDS Healthcare Foundation
- Pat Jones, RN – City of Pasadena
- Lee Klosinki, PhD – Center for Community Health
- Deborah Lara, LCSW – East Valley Community Health Center, Inc.
- Jose Martinez, MD – AltaMed Health Services Corporation
- Rich Mathias – AIDS Project Los Angeles
- Elisa Racely – Office of AIDS Programs and Policy
- Vivian Yeh, MD – City of Pasadena
- Kim Woods – Long Beach Gay and Lesbian Center
- Becky Yourex – St. Mary's CARE Program

1:00pm – 5:00pm:

- Eduardo Alvarado, PA – AltaMed Health Services Corporation
- Carla Bailey – Consumer
- Cheryl Barrit, MPIA – Long Beach Health and Human Services
- Eric Daar, MD – Harbor-UCLA Medical Center
- Heather Edney – Cri-Health Incorporated
- Maxine Franklin, RN – Office of AIDS Programs and Policy
- David Giugni – City of West Hollywood
- Elise Johnson, LCSW – Miller Children's Hospital
- Wilbert Jordan, MD, MPH – Oasis Clinic
- Jami Musen, MFT – Common Ground
- Everardo Orozco – Consumer
- Nick Rocca, LCSW – Northeast Valley Health Corporation
- Terry Sayama, MSW – UCLA Medical Center
- Scott Singer, MA, LMFT
- Donna Stidham, RN – AIDS Health Foundation
- Lanet Williams, RN, MSN, PHN – Office of AIDS Programs and Policy
- Mallory Witt, MD, FACP – Harbor-UCLA Medical Center
- Fariba Younai, DDS – UCLA School of Dentistry
- Norma Zapata – City of Pasadena

SERVICE INTRODUCTION

Medical care coordination services are patient-centered activities which focus on access, utilization, retention and adherence to primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. Medical care coordination services espouse a coordinated approach to service provision across the many systems a person living with HIV encounters. Rather than being thought of as a location where care is provided, medical care coordination is an integrated approach to care.

Medical care coordination services shall include:

- Outreach
- Intake
- Comprehensive assessment/reassessment
- Patient acuity assessment
- Comprehensive treatment plan
- Implementation and evaluation of comprehensive treatment plan
- Referral and coordination of care
- Case conferences
- Benefits specialty services
- HIV prevention, education and counseling
- Patient retention services

All programs will utilize available standards of care to inform their services and will operate in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The goals of medical case coordination services for people living with HIV include:

- Coordinating and integrating medical and psychosocial care for HIV positive patients
- Facilitating the coordination and sequencing of primary health care services in order to achieve optimal health outcomes
- Helping patients locate needed health care services
- Assisting service providers in coordinating prevention and care services for patients
- Helping patients understand their medical diagnoses and treatment
- Coaching, educating and mentoring patients and their caregivers how to self-manage their healthcare
- Preventing the further spread of HIV
- Educating patients on how to reduce risks for HIV infection

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- Supporting patients in adhering to medical regimens and drug therapies
- Increasing self-efficacy
- Facilitating access and linkage to appropriate services in the continuum of care
- Increasing access to HIV information and education
- Identifying resources and increasing coordination between providers

Several themes reoccur throughout this Standard:

- Medical care coordination services will respect the dignity and self determination of patients
- Services will be delivered to support and enhance a patient's self-sufficiency
- All services will be based on a comprehensive assessment, around which a comprehensive treatment plan and implementation activities are developed
- Ongoing monitoring of progress are integral to care coordination services
- Medical care coordination staff require specialized training and ongoing patient-care related supervision

The Los Angeles County Commission on HIV and Office of AIDS Programs and Policy have developed this Standard of Care in order to set minimum quality expectations for service provision and to guarantee patients consistent care, regardless of where they receive services in the county. A draft of this Standard will be reviewed by an expert panel, consisting of leading providers and administrators in the field, as well as actual consumers of the service. A final draft of this Standard will be presented to the Commission on HIV for adoption after Public Comment has been received and reviewed.

This draft represents a synthesis of a significant number of published Standards and research. The key source documents included:

- *Proposed Medical Care Coordination Framework*, Los Angeles County Commission on HIV, 10/8/2007
- *Case Management, Medical Service Description*, Office of AIDS Programs and Policy, 2004
- *Case Management, Psychosocial Services Standards of Care*, Los Angeles County Commission on HIV, 2006
- *Medical Outpatient Services Standard of Care*, Los Angeles County Commission on HIV, 2005
- *Benefits Specialty Standard of Care*, Los Angeles County Commission on HIV, 2006
- *Counseling, Testing and Referral Services Standard of Care*, Los Angeles

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SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Medical care coordination services are supervised and overseen by a team consisting of a registered nurse and a master's level patient care manager.

Registered nurses (RN) providing medical care coordination services will be in good standing and licensed in California by the State Board of Registered Nursing. Nurses will practice within the Scope of Practice as outlined in the California Business and Professional Code, Section 2725. (Please see www.rn.ca.gov for more information.)

Patient care managers providing medical case coordination services will possess a Master's in Social Work (MSW) degree or related degree (e.g., Psychology, Human Services, Counseling) from an accredited social work program. Patient care managers will practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (<http://www.naswdc.org/pubs/code/default.asp>) and comply with the Staff Development and Education requirements noted below.

Case workers with medical specialty will possess an LVN license. All case workers providing medical care coordination services will successfully complete OAPP's HIV Case Worker Certification and participate in all required re-certification activities and trainings.

DEFINITIONS AND DESCRIPTIONS

Assessment is a cooperative and interactive face-to-face interview process during which the patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources are identified and evaluated.

Case Closure is the systematic process of disenrolling patients from active medical care coordination services.

Medical Care Coordination integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan.

Medical Care Managers will be licensed registered nurses and be responsible for the patient's clinical needs and will directly track and address all medical components of the comprehensive treatment plan.

Outreach promotes the availability of and access to medical care coordination services to potential patients and service providers.

Patient Care Managers will possess a Master's in Social Work (MSW) degree or related degree (e.g., Psychology, Human Services, Counseling) and are responsible for the patient's psychosocial needs and will track, address and or supervise these components of the comprehensive treatment plan.

Patient Intake is the process that determines a person's eligibility for medical care coordination services.

Reassessment is an opportunity to periodically reassess a patient's needs and progress in meeting the objectives as established within the comprehensive treatment plan.

Service Provider Networks are the local planning networks of providers and other interested parties for service coordination and other purposes in each of the County's eight Service Planning Areas (SPAs).

HOW SERVICE RELATES TO HIV

There are approximately 22,000 people known to be living with AIDS in Los Angeles County. It is estimated that over 54,000 are infected with HIV. Los Angeles County comprises approximately 35% of the total AIDS cases in the state of California (Los Angeles Co, 2007).

The Ryan White CARE Act was developed to build a continuum of care for underserved people living with HIV (Ashman, Perez-Jimenez, & Marconi, 2004). In recent years the HIV epidemic has shifted towards even more vulnerable populations, ethnic minorities, the poor and people living with co-occurring chronic illness, substance abuse and/or mental health diagnoses. As HIV evolves into a chronic illness, treatment of these complicated subpopulations becomes even more challenging, requiring integrated and coordinated approaches to care (Stoff, Mitnick, & Kalichman, 2004). The task of integrating medical services with the necessary support services that these subpopulations require is an ongoing challenge for providers (Gardenier, Neushou, & O'Connor-Moore, 2007). The task is worthwhile—programs that have successfully integrated services using case management and care coordination services have demonstrated improved health outcomes (Goldberg, 2005; Knott, et al., 2006).

Recent changes in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 require that case coordination services further integrate medical care with psychosocial service provision (Wilson, 2006). As a result, the Commission on HIV has completed this literature search on case coordination strategies utilized in the treatment of HIV and other chronic illnesses.

The terminology used for these case coordination approaches are similar and often used inter-changeably. Information below is grouped according to the specific terms found in the literature.

Case Management. The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.” Case managers (or care managers) “serve as a catalyst for quality, cost-effective care by linking the patient, the physician, and other members of the care coordination team, the payer and the community” (Moro & Nash, 2003).

Though definitions for case management vary, there is general agreement that coordination of care is a primary goal. Other activities include linking clients to appropriate services to improve quality of life and to reduce the costs of expensive inpatient care, therein ensuring that more resources will be available for a larger number of people who may need them (Barney, Rosenthal & Speier, 2004).

Case management provides individual care plans for patients who are at risk for
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medical, social and financial challenges. Case managers provide functional assistance to patients and facilitate communication among patients and providers, but often do not possess the training necessary to address complex physiological (or psychological) issues (Krumholz, et al., 2006).

A Wisconsin program (Schifalacqua, Ulich & Schmidt, 2004), led by nurse case managers, collaborated with the patient, physician, pharmacist and social worker to develop the following components:

- Comprehensive functional, social, health and resource assessment
- Interdisciplinary plans of care
- Client education and training in health, disease and self-care behaviors
- Ongoing monitoring of client's health, knowledge and progress toward goals
- Ongoing review of community and medical services throughout the continuum of care
- Ongoing reassessment and revision of care plan as needed, along with expected outcomes
- Discharge planning and transition out of case management

This program was successful both in clinical and financial outcomes, significantly reducing intervention costs and inpatient utilization.

Case management is critical to HIV care because people living with HIV have needs that exceed mere medical care and may include emotional, financial, legal and social problems at some time during their disease process (Sonsel, 1989). The effect of case managers is felt both directly and through their role as gatekeepers to a variety of other supportive services (Messerli et al., 2002).

Case management has been demonstrated as an effective means to address the complex needs of people living with HIV (Katz, et al., 2001; Mitchell & Linsk, 2001). Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services (Gardner et al., 2005). Clients who have contact with case managers report less unmet need for income assistance, health insurance, home care and emotional counseling (Katz et al., 2001).

Connecting clients to resources is time-consuming and complex, often involving a mix of advocacy and mediation (Chernesky & Grube, 2000). In addition to linking clients to services, case managers assist their clients in developing personal support systems, often using themselves as the center of that support (Chernesky & Grube, 2000). A recent Canadian study demonstrated that case management services have reduced client isolation and improved health-related quality of life (Crook, et al., 2005).

Case management services are important in promoting adherence to treatment (Office of HIV Planning, 2002). Case managers help patients overcome fears about medical treatment, adhere to medication regimens, and advocate for themselves with physicians (Katz, et al., 2001). Gasirowicz and colleagues (2005) found that case management

with a prevention focus significantly decreased reported risk transmission behaviors, including unprotected vaginal intercourse, insertive anal intercourse, and needle sharing.

Case management is integral to medical care. Messeri and colleagues (2002) found that case managers strengthen connections to care by informing clients of the availability of appropriate medical resources, educating them about their benefits and serving as advocates in coordinating medical services and accessing insurance to cover their costs (Messeri et al., 2002). This same New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in a significantly increased likelihood of a client's entering and maintaining medical care (Messeri et al., 2002). The Wisconsin study demonstrated that pregnant women receiving prenatal care that included medical case management by a specialized nurse were significantly more likely to receive appropriate treatment and deliver infants with a lower rate of HIV infection than women whose care did not include services provided by nurse case managers (Havens, 1997).

Integrated Care. Integrated treatment actively combines interventions in order to treat presenting disorders, related problems and the needs of the whole person more effectively (Klinkenberg & Sacks, 2004). The most common components of integrated care programs include: patient education, case management, self-management support and multidisciplinary patient care (Owens, et al., 2005). Integration of services can be achieved in any of several different ways (Klinkenberg & Sacks, 2004):

- Communicating among providers and agencies
- Cross-training staff from different disciplines
- Consulting with professionals of other disciplines
- Coordinating treatment planning (staff of different agencies meeting to discuss needs of particular clients and developing a consistent treatment plan)
- Co-locating of services (all services located at the same sight)
- Integrating treatment teams (members of different disciplines provide coordinated direct service to the same client)

A recent literature review of integrated care programs for chronically ill patients found that integrated care programs generally had positive effects on the quality of patient care (Owens, et al., 2005).

Disease Management. A shift toward a model of disease management, emphasizing coordination of care, evidence-based interventions and outcome evaluation is a relatively new phenomenon in the care of people living with chronic diseases (Krumholz et al., 2006). Key disease management strategies include an integrated approach to assessment and care planning that addresses medical, psychosocial, environmental, prevention and disease management needs while coordinating care across providers, settings and services (Fisher & Raphael, 2003). Disease management requires that practitioners not only identify physical risks, but also psycho-logical and social risks that may affect medical, cost and quality of life outcomes (Claiborne & Vandenberg, 2001).

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Along with physicians, nurses and social workers serve case coordination functions in the disease management model (Krumholz, et al., 2006).

Basic principles of disease management include (Krumholz, et al., 2006):

- Improvement of quality of care and outcomes
- Scientifically derived guidelines
- Focus on treatment adherence
- Clinical outcomes

All of these factors should be present in an integrated and comprehensive system of care in which the provider/patient relationship is central (Krumholz et al., 2006). Several studies have documented significant benefit from positive treatment relationships to outcomes; such relationships can contribute to a client's interest and pursuit of further treatment (Sells, Davidson, Jewell, Falzer, & Rowe, 2006).

Effective disease management requires a shift from the traditional practice of single providers treating specific episodes of illness to an interdisciplinary team coordinating all services for patients throughout the course of their illnesses (Claiborne & Vandenburg, 2001). Providers that approach this multi-disciplinary collaboration from a biopsychosocial conceptual base and prioritize services based on patients' expressed needs may experience improved engagement and retention in primary care (Soto, Bell & Pillen, 2004). Disease-specific management programs have also demonstrated significantly improved outcomes and fewer readmissions (Krumholz et al., 2006).

Social workers can provide important contributions to disease management programs because of their awareness of the psychosocial and mental health issues that affect their clients (Claiborne & Vandenburg, 2001). Under managed care-dictated time-frames, physicians often must restrict their focus to physiological functioning and may not have time to fully explore the mental health, psychosocial and environmental needs of their patients. Social workers can help make the link-age between unmet patient needs and medical care (Claiborne & Vandenburg, 2001).

Chronic Care. Chronic disease is managed inadequately in the United States (Dorr, et al., 2006; Berenson, 2006). Chronically ill patients are often left to initiate and coordinate their own care. Although autonomy and fragmentation of the care delivery system may thwart it, regular communication with healthcare teams, including patients, nurses, physicians, social workers and others, is crucial to successful care management (Dorr, et al., 2006). To make matters more complicated, nearly one half of patients with chronic diseases seen in outpatient care settings have multiple chronic conditions (Dorr, et al., 2006).

In order to positively affect quality-of-life outcomes for people living with chronic conditions, medical and supportive services must be systematically interwoven (Leutiz, Greenlick & Nonnenkamp, 2003). Chronic care models that access home and community-based services shift from acute episode-based service delivery to an

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increasingly holistic approach that includes bio-logical, psychological, social and environmental needs commonly beyond the reach of traditional medicine (Alkema, Reyes, & Wilber, 2006).

Systems accustomed to treating patients with acute illnesses struggle to provide consistent, quality care throughout the continuum of a chronic disease. Such care requires continuity of providers, attention to outcomes, observation of emerging patterns and intense support of patient self-management knowledge and skills. Global Nursing Exchange members have assembled a list of principles upon which chronic care management programs should be based (Bower, 2004). Among them are:

- Teaching patients and their caregivers how to manage their health is a cornerstone of effective care management programs
- Coaching, educating and mentoring clients are critical skills to possess as programs shift from acute care models to chronic care management
- Understanding adherence as a complex interplay between knowledge, economics, social support, culture, values, emotional health, etc.
- Developing knowledge of community resources is key; creativity and persistence are often required to develop new resources for patients with chronic care conditions

In its report on chronic care, the California HealthCare Foundation (Berenson, 2006) notes:

“The fully implemented Chronic Care Model encompasses multidisciplinary teams of professionals who collaboratively educate, counsel, and empower patients with self-care techniques to manage their chronic conditions (utilizing) individually tailored evidence-based treatment plans.” (p. 14).

The report further emphasized the importance of patient/provider relationships. Engaging a patient’s primary physician is crucial to the success of chronic care management programs. Comprehensive assessment and the careful distinguishing among patients based on their clinical conditions and specific needs were also noted as key to successful chronic disease management (Berenson, 2006).

Care Coordination. Coordinated care integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan. Traditionally, coordinated care efforts have been in an attempt to reduce inappropriate use of resources (Krumholz, et al., 2006).

Coordinated care models typically provide patients with a comprehensive assessment as they enter medical treatment and coordinate and integrate all related medical and support services (Liegel, 2006). Such coordinated care requires that interacting biological, psychological and social needs should be addressed simultaneously, rather than separately and episodically. Behavioral interventions and support services must be coordinated with medical care to be fully responsive to clients’ needs and to promote

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treatment adherence and health outcomes (Soto, Bell, & Pillen, 2004).

Continuity of care and care coordination are especially important as clients move across multiple service systems over time (Klinkenberg & Sacks, 2004). Any system attempting to provide care to the complex populations of people living with HIV must develop systems that ensure continuity of care and that include:

- Consistency between primary medical care and other support services
- Seamlessness as clients move across levels and intensity of care
- Coordination of present and past treatment episodes (Klinkenberg & Sacks, 2004)

Programs instituting care coordination services have demonstrated improved clinical assessments, provider communication and care planning (Liegel, 2006). A 2006 study which evaluated the effectiveness of systematically integrating biopsychosocial interventions with coordinated delivery of care for outpatients recovering from stroke found that mental quality of life was significantly improved for those receiving care coordination services from the social workers and posits that care coordination may also be an important intervention for enhancing the quality of life for individuals with disabilities from causes other than stroke (Claiborne, 2006).

The interface between care coordination and flexible, comprehensive data systems used to track assessments, services and referrals was noted by several studies as key to successful coordination efforts (Liegel, 2006).

Benefits Specialty. Linking clients to resources can be a demanding a mix of advocacy and mediation (Chernesky & Grube, 2000). A 2002 New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in a significantly increased likelihood of a client's entering and maintaining medical care (Messerli et al., 2002).

Other studies have shown that the receipt of ancillary services (including Client Advocacy) has been significantly associated increased use of primary medical care (Ashman, Conviser & Pounds, 2002). This finding may suggest that helping clients to solve problems not directly related to primary care may empower them to seek and obtain it. (Ashman, Conviser & Pounds, 2002).

Assessment. While not a specific approach to care management, all of the above-referenced approaches stressed the importance of detailed, comprehensive, biopsychosocial assessment. Because of the consistency of this finding, notes on assessment have been included here.

An accurate assessment completed by a medical or social work professional ensures that services are warranted and appropriate—"good treatment follows from good assessment". A complete assessment also ensures efficiency of service provision, allowing the service intensity (or amount) to vary based upon individualized need.

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Accurate assessment also ensures that needs can be realistically met and determines the provider skill level necessary for each service. Assessment can also successfully screen for emotional distress and mental health problems.

Social work assessment must be flexible enough to identify all the problems that a client may be encountering, not only those that have been validated by standardized research protocols. An accurate assessment of chronically ill patients is challenging because of the many domains of interest and the frequently changing circumstances of a given client (Vourlekis, Ell & Padgett, 2005).

SERVICE COMPONENTS

Medical care coordination services are patient-centered activities which focus on access, utilization, retention and adherence to primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV.

Medical care coordination services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by care coordination staff and other professionals to whom they are referred. Such patient-practitioner discussions are relationship building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. Medical care coordination staff are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.

All medical care coordination services will be patient-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. All medical care coordination services will be culturally and linguistically appropriate to the target population (see PROGRAM REQUIREMENTS AND GUIDELINES).

The overall emphasis of ongoing medical care coordination services should be on facilitating the coordination, sequencing and integration of primary health care and all other services in the continuum of care to achieve optimal health outcomes.

Medical care coordination services in Los Angeles County shall include (at minimum):

- Outreach
- Intake
- Comprehensive assessment/reassessment
- Patient acuity assessment
- Comprehensive treatment plan
- Implementation and evaluation of comprehensive treatment plan
- Referral, coordination of care and linkages
- Case conferences
- Benefits specialty services
- HIV prevention, education and counseling
- Patient retention services

GENERAL SERVICE CONSIDERATIONS

All patients receiving Ryan White-funded services will also be enrolled in medical care coordination services. All medical outpatient facilities providing Ryan White-funded care must have a medical care coordination program, either as part of or attached to their services. Each medical care coordination program will be a single, unified program, even if it involves multiple providers.

Physical co-location of the medical outpatient clinics and medical care coordination programs may not always be necessary, and will be determined based on the needs of the program, the patient population and the providers delivering the service. Whether co-located or located on its own premises, medical care coordination programs must operate from a central location which serves as an administrative hub and primary program venue. Rather than being thought of as a location where care is provided, medical care coordination is an integrated approach to care.

Medical care coordination programs must be co-managed by both a medical care manager (RN license) and patient care manager (possessing a master's degree in Social Work or related field (Psychology, Human Services, Counseling). The care management team will be responsible for assigning patients to care workers (based on patient need) and for supervising and monitoring all aspects of patient-related care. Depending on the size of the program and volume of patients, the program may employ additional case workers who are directly supervised by one or both of the care managers. In the case of a smaller program, the medical and patient care managers both work directly with all patients on an ongoing basis. Caseloads should range from a minimum of 30 (when all patients present with the highest acuity needs) to a maximum of 300 (when all patients present with low acuity and require only periodic contact) for each care manager and/or case worker

The medical care manager is responsible for the patient's clinical needs and is expected to directly track and address all medical components of the comprehensive treatment plan both within the Ryan White system of care and outside of it. The patient care manager is responsible for the patient's psychosocial needs and will track, address and/or supervise these components of the comprehensive treatment plan.

In order to ensure appropriate care coordination services, each program will maintain at least a half-time equivalent medical care manager and a half-time equivalent patient care manager. All programs will be required to be open at least 40 hours per week (with normal business hours to be determined, based in part, on patient population needs). In addition, programs must develop contingencies for 24-hour on-call services.

Because of the central role that public and private benefits play in the care of people living with HIV, programs providing medical care coordination services will ensure that benefits specialty services are made available for all patients. Indeed, a significant

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portion of a caseworker’s time may be spent in assisting patients to apply for benefits both inside and outside the Ryan White Care Act system. Benefits specialty services provide intensive attention and follow-up to help patients access benefits outside the Ryan White funded system of care. Care coordination programs will provide these services directly with their own staff or will contract these services through another agency or program that specializes in benefits services.

Care coordination programs may choose to engage additional providers for specific services (e.g., mental health, substance abuse) or will be expected to establish comprehensive service agreements with such providers that will facilitate the program’s access to those additional services.

Patients may enter the continuum of care from any Ryan White-funded service and will be linked to medical care coordination services at that time.

Following are descriptions of specific program components required of medical care coordination programs. These components may be provided in any sequence; their ordering below should not necessarily dictate the progression of services.

OUTREACH

Programs providing medical care coordination services will develop and implement an outreach plan that guides the program’s efforts to engage:

- Self-managed patients
- Patients who have fallen out of care
- Patients who are aware of their HIV status, but not in care (‘unmet need’)

Please refer to the “PATIENT RETENTION” section of this standard for guidance in communication and follow-up with patients.

In addition to these activities targeted to individuals, programs will also conduct outreach activities to educate HIV services providers and other supportive service organizations about the availability and benefits of medical care coordination services for people living with HIV within Los Angeles County. Programs will work in collaboration with HIV primary health care and support services providers, as well as HIV testing sites.

Service Provider Networks (SPNs) are expected to help facilitate outreach activities on behalf of medical care coordination programs in each of the County’s Service Planning Areas (SPAs).

STANDARD	MEASURE
Medical care coordination programs	Outreach plan on file at provider

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<p>will outreach to potential providers and patients who are:</p> <ul style="list-style-type: none"> • Are self-managed • Have fallen out of care • Are aware of their status, but not yet in care 	<p>agency. Programs will monitor current outreach/return to care rates and demonstrate efforts to improve them. Program monitoring to confirm activities</p>
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INTAKE

Patient intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, patient intake will be completed in the first contact with the potential patient. Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

The complete Intake process, including registration and eligibility, is required for every patient at his/her point of entry into the service system. In the event that an agency or other funded entity has the required information and documentation on file in the agency record for that patient or in the county-wide data management system, further Intake is not required.

In the intake process and throughout medical care coordination, patient confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information. (Specification should indicate the type of information that can be released).

Patient intake will include the following information to be kept on file in the patient record (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residence
- Verification of financial eligibility for services
- Date of intake
- Patient name, home address, mailing address and telephone number
- Emergency and/or next of kin contact name, home address and telephone number

In addition, programs must have the following forms on file in accordance with state and local guidelines. Completed forms are required for each patient and will be kept on file in the patient chart:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information. (Specification should be made about what type of information can be released.)
- Limits of Confidentiality
- Consent to Receive Services (See Exhibit 1 in LINKAGES AND TOOLS for a sample Consent form.)
- Patient Rights and Responsibilities
- Patient Grievance Procedures (See Exhibit 2 in LINKAGES AND TOOLS for a sample Grievance Procedures form.)
- Notice of Privacy Practices (HIPPA)

STANDARD	MEASURE
Intake process is begun during first contact with patient (unless already on file in agency)	Intake tool is completed and in patient file to include (at minimum): <ul style="list-style-type: none"> • Documentation of HIV status • Proof of LA County residence • Verification of financial eligibility • Date of intake • Patient name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality policy and Release of Information is discussed and completed	Release of Information signed and dated by patient on file and updated annually
Consent for Services completed	Signed and dated Consent in patient record
Patient is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in patient record
Patient is informed of privacy rights (HIPPA)	Signed and dated form in patient record

PATIENT ASSESSMENT/REASSESSMENT

Assessment is the systematic and continuous collection of data and information about the patient and his/her need for medical care coordination services. Assessment identifies and evaluates a patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources. The patient assessment, reassessments and comprehensive treatment plans must be performed by the medical care manager and

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patient care manager team, or by staff with equivalent licensure and education (RN/M.S.W. or related). The medical information and medical assessment portions of the assessment and reassessment must be completed by the medical care manager (or R.N.).

Comprehensive assessment is conducted to determine the:

- Patient's needs for treatment and support services
- Medical treatment plan (if one exists)
- Patient's current capacity to meet those needs
- Ability of the patient's social support network to help meet patient need
- Extent to which other agencies are involved in patient's care
- Areas in which the patient requires assistance in securing services.

Assessment includes a complete health history as well as other pertinent information for other health and social service professionals. The assessment organizes and synthesizes patient information from many sources.

Assessment is completed in a cooperative, interactive, face-to-face interview process. The assessment must be completed as soon as possible and will document the patient's needs, along with mutual decisions made regarding needs and services. While every effort will be made to complete the assessment within 30 days, referrals to needed services can begin before the assessment has been completed. In the event an assessment cannot be completed in 30 days, the reasons for non-completion will be documented in the patient record. Comprehensive assessments and reassessments will be updated on a continuous basis and completed when there are significant changes in a patient's status, when the patient has left and re-entered medical care coordination services, or (at minimum) once per year. Information gathered in the comprehensive assessment or reassessment will be used to develop or update the patient's Comprehensive Treatment Plan (CTP).

Comprehensive assessment/reassessments will include (at minimum):

- Date of assessment or reassessment
- Signature and title of staff person completing the assessment or reassessment
- Comprehensive medical information, including:
 - Patient's medical status, including a health systems review to gather history of HIV disease and other related illnesses, relevant medical and psychosocial information
 - Medical treatment plan (if one exists)
 - Description of current physiological and psychosocial status
 - Current medical care, including names of medical providers, eligibility and participation in other HIV related services

- Medical diagnoses and likely complications
 - Tests, treatment regimens and possible pharmacological complications
 - Medication review, profile assessment and pharmacy needs
 - Assessment of success and problems with adhering to medication regimens and medical appointments
 - Patient's and his/her social affiliates' risks for HIV transmission, need for health education, risk reduction education and support
 - Assessment of the patient's providers' level of expertise related to the needs of the patient
- Patient's level of understanding and educational needs related to diagnosis, treatment options, prognosis, financial resources
 - Assessment of psychological adjustment and coping mechanisms
 - Consultation with patient's health care and social service providers to gather additional data necessary for assessment
 - Reassessment of prior problems to assess current status of prior issues (in the case of reassessment)
 - Patient strengths, needs and available resources in the following areas:
 - Mental health
 - Substance use, history and treatment
 - Nutrition/food
 - Medication adherence and accessibility
 - Life management skills/Activities of Daily Living (ADL)
 - Housing and living situation
 - Family and dependent care issues
 - Transportation
 - Language/literacy skills
 - Cultural factors
 - Religious/spiritual support
 - Social support system
 - Relationship history
 - Domestic violence
 - Abuse history and risk assessment
 - Financial resources
 - Employment
 - Education
 - Legal issues
 - Incarceration history
 - Comprehensive assessment of risk behaviors
 - Comprehensive assessment of HIV prevention issues
 - Environmental factors
 - Benefits assessment which determines a patient's need for public benefits and entitlements; educates a patient about available benefits and entitlements;

identifies appropriate benefits and entitlements with the patient; preliminarily assesses a patient's eligibility for benefits and entitlements; and provides necessary forms and instructions, as indicated. Benefits assessments may include:

- Completed benefits assessment/information form
 - Notation of functional barriers
 - Brief notation of relevant benefits and entitlements and record of forms provided
- Identified resources and referrals to assist patient in areas and need
 - Patient's acuity level and date of acuity assessment

In addition, when indicated, a patient's primary support person should be assessed for his/her HIV knowledge base, health status, expectation and ability to serve as patient's primary care taker and support the patient in prevention and risk reduction behaviors.

In cases of emergencies or medical and/or psychosocial crisis, quick coordination decisions may need to be made in order to mitigate the acute presenting issues before completing the entire intake/assessment. A brief, initial abbreviated assessment provides an opportunity to determine if the patient is in crisis and to begin the intervention process before formal assessment is completed.

STANDARD	MEASURE
<p>Assessments will be completed within 30 days following intake. Updates to the assessment will be done on a continuous basis, but no less than once every year</p>	<p>Assessment or update on file in patient record:</p> <ul style="list-style-type: none"> ● Date ● Signature and title of staff person ● Comprehensive medical information (detailed above) ● Patient's educational needs related to treatment ● Assessment of psychological adjustment and coping ● Consultation with health care and social service providers ● Reassessment of prior problems to assess current status of prior issues (in the case of reassessment) ● Patient's strengths, needs and resources (detailed above) ● Benefits assessment

	A patient's primary support person should also be assessed for ability to serve as patient's primary care taker (when indicated)
Assessment, reassessments and comprehensive treatment plans must be performed by the medical care manager and patient care manager team, or equivalents. Medical assessment must be completed by the medical care manager (or R.N.).	Program review and monitoring to confirm

PATIENT ACUITY ASSESSMENT

Patient acuity levels will be assessed using the components of the intake and comprehensive assessment and based upon a patient's level of functioning and/or current need. Acuity measurements include aspects of both the medical and psychosocial arenas. Acuity assessments will be completed by the medical/patient care management team using a county-wide standardized acuity assessment tool that equally includes both medical and psychosocial concerns. Based on all information gathered, patients will be sorted into the following categories:

- Self-Managed --for patients that present with no direct care coordination needs or feel they do not require care coordination services
- Low Acuity – for patients presenting with some need, but whose needs are relatively easily addressed
- Medium Acuity – for patients who present with more complicated needs requiring a greater level of intervention to mitigate
- High Acuity – for patients who present with the most complex and challenging needs
- Crisis Acuity – for patients presenting in crisis who require immediate, high frequency and/or prolonged contact

If, in the course of intake and comprehensive assessment, it is determined that the extent of a patient's medical and/or psychosocial needs prevent him/her from participating actively in medical care coordination services, that patient will be linked to home-based case management services, skilled nursing or hospice care.

Acuity levels will be updated on an ongoing basis, dependent upon patient need, but not less than once per year. Acuity level assessment/reassessment is a ongoing component in the course of the standard contact/visit.

After careful review of all intake, assessment and acuity materials, the RN and social

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work care management team will assign a primary contact to each patient that best matches the patient's presenting problem and/or primary concern to the worker's expertise.

STANDARD	MEASURE
Acuity levels will be assigned for all patients by care management team utilizing standardized, county-wide acuity assessment tool	Completed acuity tool on file in patient record. Patients will be assigned to one of the following categories: <ul style="list-style-type: none"> • Self-managed • Low acuity • Medium acuity • High acuity • Crisis acuity
Patients unable to actively participate in medical care coordination services will be referred to home-based case management, skilled nursing or hospice care	Documentation of linked referral on file in patient record.
Patients acuity will be updated on an ongoing basis, dependent upon a patient need, but not less than once per year	Program monitoring and chart review to confirm
RN and social work care management team will assign a primary contact to each patient	Program monitoring and chart review to confirm

COMPREHENSIVE TREATMENT PLAN (CTP)

A comprehensive treatment plan is an individualized multi-disciplinary service plan to be completed within 30 days of finalizing the comprehensive assessment. The comprehensive treatment plan is based on the following (at minimum):

- Medical diagnosis
- Nursing diagnosis
- Age
- Medical history
- Mental health history and current diagnosis
- Substance abuse history and current diagnosis
- Support systems
- Geographic location
- Sources of funding and financial support
- Community HIV resources

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- Legislative requirements
- Assessment of strengths, needs and resources

For those patients with benefits needs, a benefits plan will be included in the CTP which is developed with the patient to determine the benefits and entitlements for which the patient will apply. Care coordination staff or benefits specialists acting as advocates are responsible for providing advice, referrals and other assistance necessary to carry out the benefits portion of the CTP. Through office visits, home visits and/or phone calls, the advocate will work with the patient to obtain the services or information necessary to complete the benefit/entitlement process. Patients with insignificant or no apparent functional barriers will be provided with necessary forms and instructions. Staff will follow-up within two weeks to check patient's progress in completing and applying for benefits and entitlements. Patients with significant functional barriers -- will be assisted in completing and applying for benefits and entitlements at that time

The patient will be an active participant in developing the comprehensive treatment plan. All interested parties should agree to the plan before beginning implementation. Comprehensive treatment plans will include:

- Name of patient and care manager/case worker
- Date and signature of care manager/case worker and care management team
- Date and signature of the patient on the initial and subsequent CTPs
- Description of flexible short- and long-term patient goals, desired outcomes and dates of goal establishment
- Steps to be taken by patient, care manager/case worker and others to accomplish goals
- Timeframe by which goals are expected to be met
- Number and type of patient contacts based on acuity level (at minimum):
 - Self-Managed – annual contact (face to face or by telephone) for updates and reassessment of needs
 - Low Acuity – quarterly contact (face to face or by telephone)
 - Medium Acuity – monthly contact (face to face or by telephone)
 - High Acuity – monthly face to face contact
 - Crisis Acuity – at least weekly contact, preferably face to face
- Concrete recommendations on how to implement comprehensive treatment plan
- Contingencies for anticipated problems or complications
- Disposition of each goal as it is met, changed or determined to be unattainable
- Notation of benefits and entitlements to which the patient will apply
- Notation of functional barriers status and requisite next steps
- Disposition of the application for each benefit or entitlement as it is completed, changed or determined to be unattainable

In certain rare cases, due to the type of treatment, immediacy of services and/or their confidential nature (e.g., mental health, legal services), the CTP may be limited to referencing, rather than detailing, a specific treatment plan and/or the patient's agreement to seek and access those specific services.

STANDARD	MEASURE
Multi-disciplinary CTPs will be developed in conjunction with the patient within 30 days of completing the comprehensive assessment	CTP on file in patient record includes (at minimum): <ul style="list-style-type: none"> • Name of patient and care manager/case worker • Date/signature of case worker and care management team • Date/signature of the patient • Patient goals, outcomes and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of patient contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications • Disposition of goals • Benefits plan (as indicated)

IMPLEMENTATION AND EVALUATION OF COMPREHENSIVE TREATMENT PLAN

Comprehensive treatment plan implementation and evaluation involve ongoing contact and interventions with (or on behalf of) the patient to ensure goals are addressed that work towards improving a patient's health and resolving psychosocial needs.

In the implementation and evaluation phase, medical care coordination staff are responsible for (at minimum):

- Providing linked referrals, patient advocacy and appropriate interventions based on the intake, assessment and CTP
- Monitoring changes in the patient's condition or circumstances, updating/revising the CTP and providing appropriate interventions and linked referrals
- Monitoring lab values and adherence
- Ensuring that care is coordinated among the patient, caregivers and service providers

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- Conducting ongoing monitoring and follow-up with patients and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to services
- Advocating on behalf of patients with other service providers
- Empowering patients to develop and utilize independent living skills and strategies
- Assisting patients in resolving any barriers to completing referrals and accessing or adhering to services
- Actively following-up on established goals in the CTP plan to evaluate patient progress and determine appropriateness of services
- Maintaining ongoing patient contact as outlined in CTP
- Actively following-up within the next business day after discharge from the hospital (when the medical team is aware of hospitalization). In the event that follow-up activities are not appropriate or can not be conducted within the prescribed time period, care coordination staff will document reason(s) for the delay
- Actively following-up within one business day with patients who have missed a medical care coordination appointment. In the event that follow-up activities are not appropriate or can not be conducted within the prescribed time period, care coordination staff will document reason(s) for the delay
- Collaborating with the patient's other service providers for coordination and follow-up

Current dated and signed progress notes, detailing activities related to implementing and evaluating, will be kept on file in the patient record. The following documentation is required (at minimum):

- Description of all patient contacts, attempted contacts and actions taken on behalf of the patient
- Date and type of contact
- Description of what occurred during the contact
- Changes in the patient's condition or circumstances
- Progress made towards achieving goals identified in the CTP
- Barriers identified in goal process and actions taken to resolve them
- Linked referrals and interventions provided
- Current status and results of linked referrals and interventions
- Barriers identified in completing linked referrals and actions taken to resolve them
- Time spent with, or on behalf of, the patient
- Care coordination staff's signature and professional title

STANDARD	MEASURE
Care coordination staff will: <ul style="list-style-type: none"> • Provide referrals, advocacy and 	Signed, dated progress notes on file that detail (at minimum):

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<p>interventions based on the intake, assessment and comprehensive treatment plan</p> <ul style="list-style-type: none"> • Monitor changes in the patient's condition • Monitoring lab values/adherence • Update/revise the CTP • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of patients • Empower patients to utilize independent living strategies • Assist patients in resolving barriers • Follow-up on plan goals • Maintain ongoing contact based on need • Follow-up after discharge from the hospital • Follow-up missed appointments by the end of the next business day • Collaborate with the patient's other service providers for coordination and follow-up 	<ul style="list-style-type: none"> • Description of patient contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the patient's condition or circumstances • Progress made toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent • Care coordination staff's signature and title
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PATIENT SELF-EFFICACY AND CARE

Medical care coordination programs will teach patients and their caregivers effective HIV disease self-efficacy skills with the goal to improve self-sufficiency health outcomes. Staff will coach, educate and mentor clients on the skills necessary to interact effectively with all levels of service providers and to become increasingly informed and independent consumers. As appropriate, staff will encourage patients to actively participate in facilitating the multi-disciplinary communication between all of their providers in order to ensure continuity of treatment objectives and care.

STANDARD	MEASURE
Medical care coordination staff will teach patients and their caregivers effective HIV disease self-efficacy skills	Documentation of self-efficacy education on file in patient record

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REFERRAL AND COORDINATION OF CARE

Programs providing medical care coordination services will demonstrate active collaboration other agencies to provide referral to the full spectrum of HIV-related services.

Because resource referral and coordination is such a vital component of medical care coordination services, programs must maintain a comprehensive list of target providers (both internal and external), including, but not limited to HIV LA, for the full spectrum of HIV-related and other services. Program staff will maintain knowledge of local, state and federal services available for people living with HIV.

Programs providing medical care coordination services will be required to establish linkages with Ryan White-funded and other non Ryan White-funded services in order to strengthen their programmatic responsiveness (e.g., mental health, substance abuse referrals). Programs will participate in network agreements within the program's service area (e.g., supportive services agencies). Programs will also participate in system agreements with other funded medical care coordination programs which will detail the steps necessary to facilitate transfer of patients between programs, when indicated. These system agreements will also accommodate patients' needs when they access other Ryan White-funded services beyond the capacity of a specific medical care coordination program.

Programs will develop written procedures and protocols for referring patients to other providers, networks and/or systems. Referral systems must include a process for tracking and monitoring referrals and their results; special attention will be given to those referrals for which the patient did not follow through.

In cases in which a patient is receiving services from providers in differing care coordination programs, the patient's medical case worker/care manager will be considered the primary contact and responsible for coordination activities.

Patients who receive care outside of the Ryan White funded system are still eligible for medical care coordination services. While working with non-contracted providers may prove challenging, every effort must be made on the part of the case worker/care manager to engage these 'private' providers and help to coordinate all aspects of a patient's care. Such efforts to contact and include providers will be documented in the patient record. If difficulties are encountered in coordinating care with other providers, the care management team and/or program administration will be notified for additional follow-up and/or possible resolution.

STANDARD	MEASURE
Medical care coordination programs will maintain a comprehensive list of	Referral list on file at provider agency

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providers for full spectrum HIV-related and other service referrals	
Care coordination programs will collaborate with other agencies, providers, networks and systems to provide effective, appropriate referrals	Memoranda of Understanding detailing collaborations on file at provider agency
Medical care coordination programs will develop procedures and protocols for referrals	Written procedures and protocols on file at provider agency that includes process for tracking and monitoring referrals
Case workers/care managers in medical care coordination programs will actively coordinate all care-related services for their patients	Record of care coordination activities on file in patient record
Difficulties in coordinating care with other providers will be reported to the care management team or program administration for further follow-up	Notation of report to care management/administration on file in patient record

CASE CONFERENCES

Multi-disciplinary case conferences are a critical component of medical care coordination services. Case conferences convene a patient's physician and other care providers to assess progress in meeting the needs identified in the patient's CTP and to strategize further responses.

Case conferencing is an opportunity to address major life transitions for the patient and should be conducted when possible under those circumstances. Due to logistical complications, there are no required frequencies for convening case conferences. Rather, programs are expected to convene case conferences based on patient need and acuity level.

Documentation of case conferences shall be maintained within each patient record and include:

- Date of case conference
- Names and titles of participants
- Medical and psychosocial issues and concerns identified
- Description of guidance and/or follow-up plan
- Results of implementing guidance/follow-up

STANDARD	MEASURE
Programs will convene case	Documentation on file in patient record

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conferences that include the patient's physician and other care providers when feasible and appropriate	to include: <ul style="list-style-type: none"> • Date of case conference • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow-up
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APPEALS COUNSELING AND FACILITATION

Patients who have been denied a benefit or entitlement will be offered individual appeals counseling and facilitation services. Care coordination staff/specialists will educate and advise patients on methods to address appeals, and, when indicated, accompany them to the appeal in a facilitative role (not as a legal representative).

In cases in which a staff/specialist deems that further legal assistance is required to successfully negotiate an appeal, patients will be referred to CARE Act-funded or other legal service providers.

Documentation for appeals counseling and facilitation services will be kept in the form of a progress note in the patient chart and should include (at minimum):

- Date
- Brief description of counseling provided
- Time spent with, or on behalf of, the patient
- Legal referrals (as indicated)
- Staff/specialist's signature and title

In the event that a patient does not attend a scheduled appeals counseling appointment, staff/specialists will attempt to follow-up within one business day.

STANDARD	MEASURE
As necessary, staff/specialists will assist patients with appeals counseling and facilitation. Cases that require further legal assistance will be referred to CARE Act-funded or other legal service provider	Signed, dated progress notes on file in patient record that detail (at minimum): <ul style="list-style-type: none"> • Brief description of counseling provided • Time spent with, or on behalf of, the patient • Legal referrals (as indicated)
Staff/specialists will attempt to follow-up missed appointments within one	Progress note on file in patient chart detailing follow-up attempt

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business day	
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HIV PREVENTION, EDUCATION AND COUNSELING

Medical care coordination staff will provide health information and education to patients, regarding HIV prevention, transmission and risk behavior management. Prevention, education and counseling services will also be offered to family, partners and social affiliates.

Medical care coordination staff will:

- Screen patients for risk behaviors
- Communicate prevention messages to patients
- Discuss sexual practices and drug-use with patients
- Positively reinforce changes to safer behavior
- Refer patients for substance abuse treatment
- Facilitate partner notification, counseling and testing
- Educate patients about other sexually transmitted and communicable diseases

Education and counseling will be provided within the guidelines and recommendations described in “*Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*,” MMWR, July 18, 2003/Vol.52/No.RR-12). Striving for seamless service delivery, incorporating specialized prevention staff or linking patients to specialized prevention programs (CRCS) may be necessary in some cases.

STANDARD	MEASURE
Medical care coordination staff will provide prevention and risk management education and counseling to all patients. Partners and social affiliates will be offered these services as appropriate	Record of services on file in patient record
Medical care coordination staff will: <ul style="list-style-type: none"> • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug-use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling and testing 	Record of prevention services on file in patient medical record

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<ul style="list-style-type: none"> Identify and treat sexually transmitted diseases 	
When indicated, patients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling	Record of linked referral on file in patient record

PATIENT RETENTION

Programs shall strive to retain patients in medical care coordination services. A broken appointment policy and procedure to ensure continuity of service and retention of patients is required. Follow-up strives to maintain a patient's participation in care and can include telephone calls, written correspondence and/or direct contact. Programs will demonstrate due diligence through multiple efforts to contact patients by phone or by mail. Such efforts shall be documented in the progress notes within the patient record.

In addition, programs will develop and implement a contact policy and procedure to ensure that patients who are homeless or report no contact information are not lost to follow-up.

STANDARD	MEASURE
Programs shall develop a broken appointment policy to ensure continuity of service and retention of patients	Written policy on file at provider agency
Programs shall provide regular follow-up procedures to encourage and help maintain a patient in medical care coordination services	Documentation of attempts to contact in signed, dated progress notes. Follow up may include: <ul style="list-style-type: none"> Telephone calls Written correspondence Direct contact
Programs will develop and implement patient contact policy for homeless patients and those with no contact information to ensure they are not lost to follow-up	Contact policy on file at provider agency. Program review and monitoring to confirm

CASE CLOSURE

Case closure is a systematic process for disenrolling patients from medical care coordination services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record.

All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for case closure. Cases may be closed for the following reasons:

- Patient relocation outside of the service area
- Long-term patient incarceration
- Unacceptable patient behavior
- Patient death

When appropriate, case closure summaries will include a plan for patient’s continued success and ongoing resources to be utilized. At minimum, case closure summaries will include:

- Date and signature of both the medical and patient care managers
- Date of case closure
- Status of the comprehensive treatment plan
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for re-entry into services

STANDARD	MEASURE
Patients will be formally notified of pending case closure	Contact attempts and notification about case closure on file in patient record
Medical care coordination cases may be closed for the following reasons: <ul style="list-style-type: none"> • Patient relocation • Long-term patient incarceration • Unacceptable patient behavior • Patient death 	Case closure summary on file in patient chart to include: <ul style="list-style-type: none"> • Date and signature of care coordination staff • Date of case closure • CTP status • Status of primary health care and service utilization • Referrals provided • Reason for closure • Criteria for re-entry into services

OUTCOMES AND MEASURABLE INDICATORS

To be determined by expert panels

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all care medical care coordination staff will possess the ability to provide linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Medical care coordination staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding patient confidentiality and HIPAA regulations.

In order to ensure appropriate care coordination services, each program will maintain at least a half-time equivalent medical care manager and a half-time equivalent patient care manager.

Care Managers -- Medical

Medical care managers will be Registered Nurses in good standing and licensed by the California Board of Registered Nursing. A Registered Nurse providing care coordination services must be a graduate of an accredited nursing program with a bachelor's (BSN) or two year nursing associate's degree. The Registered Nurse must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).

Medical care managers will practice in accordance with applicable state and federal regulations. Care managers will uphold the Code of Ethics for Nurses with Interpretive Statements (2001: ANA Board of Directors and Congress of Nursing Practice and Economics). Additionally, medical care managers will comply with special Codes of Ethics or HIV/AIDS Policies from their national professional associations (see www.nursingworld.org for ANA Position Statements and www.anacnet.org for Policy Position Statements and Resolutions.)

Care Managers – Social Work

Patient care managers providing medical care coordination services will possess a Master's in Social Work (MSW) degree or related master's degree (e.g., Psychology, Human Services, Counseling) from an accredited program. Patient care managers workers will practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (<http://www.naswdc.org/pubs/code/default.asp>) and comply with the Staff Development and Education requirements noted below.

Case Workers

Case workers will possess one of the following (at minimum):

- a bachelor's degree in an area of human services;
- a high school diploma (or GED equivalent) and at least one year experience providing direct patient care in a related health services field

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Case workers with medical specialty will be an LVN or Certified Medical Assistant with at least one year experience working in HIV care or an LVN license and have at least three years experience providing direct patient care within a related health services field.

Further, all case workers will possess:

- Knowledge of HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Ability to appropriately interact and collaborate with others
- Effective written/verbal communication skills
- Ability to work independently
- Effective problem-solving skills
- Ability to respond appropriately in crisis situations
- Effective organizational skills

All medical care coordination care managers and case workers will successfully complete an OAPP-approved Case Worker Training within three months of being hired and all requisite required trainings (as appropriate). In addition, medical care coordination care managers and case workers are required to attend an annual one-hour training/briefing on available public/private benefits and available benefits specialty services. RNs are encouraged to pursue registration as an AIDS Certified Registered Nurse offered by the Association of Nurses in AIDS Care and the HIV/AIDS Nursing Certification Board (see www.anacnet.org).

All care managers and case workers providing benefits specialty services will successfully complete a county-wide benefits specialty training within three months of being hired. In addition, care managers and case workers providing benefits specialty services will successfully complete certification in CARE/HIPP and ADAP within six months of being hired, as well as any requisite required trainings (as appropriate).

An exemption process shall be developed by OAPP that allows programs to consider candidates whose qualifications do not meet all the above-referenced requirements, but whose particular skills and experiences might make him/her an appropriate staff member. Such exemptions will be cleared through OAPP before hiring is initiated.

Staff Development and Education

Medical care coordination staff must maintain their licenses by fulfilling the financial and continuing education requirements established by their respective professional state and national boards. Care managers and case workers must complete a minimum of 8 hours of continuing education in HIV care-related topics per year.

In selecting other continuing education courses to fulfill licensing requirements, care

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managers are encouraged to select a majority of courses related to their respective Scopes of Practice and courses related to services within the HIV/AIDS Continuum's Primary Health Care Core.

Patient-Care Related Supervision

Supervision is required of all medical case workers in order to provide guidance and support. Patient-care related supervision will be provided for all case workers at a minimum of four hours per month. Such patient-care related supervision may be conducted in individual or group/multidisciplinary team case conference formats. Supervision will be provided by the RN care manager and social work care manager who co-direct the program.

Patient-care related supervision will address patients' medical and psychosocial issues and concerns, provide general clinical guidance and help to develop follow up plans for case workers. Supervision will assist in problem-solving related to patients' progress towards goals detailed in the comprehensive treatment plan and to ensure that high quality medical care coordination services are being provided.

Programs will ensure that each active patient is discussed as is feasible and appropriate. For each patient discussed, the supervisor will address the identified medical and psychosocial issues and concerns, provide appropriate guidance and follow-up plan, and verify that guidance provided and follow-up plan has been implemented.

Patient-care related supervision will include the following required documentation to be kept on file in the patient record:

- Date of patient-care related supervision
- Supervision format (i.e., individual, group, case conference or multidisciplinary team case conference)
- Name and title of participants
- Medical and psychosocial issues and concerns identified
- Description of guidance provided and care coordination follow-up plan
- Verification that guidance provided and follow-up plan have been implemented
- Supervisor's name, title and signature

STANDARD	MEASURE
Registered Nurses providing medical care coordination services must: <ul style="list-style-type: none"> • Hold a license in good standing from the California State Board of Registered Nursing 	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm

<ul style="list-style-type: none"> • Be a graduate from an accredited nursing program with a bachelor's (BSN) or two year nursing associate's degree • Practice within the scope defined in the California Business & Professional Code, Section 2725 	
<p>Patient care managers providing medical care coordination services will:</p> <ul style="list-style-type: none"> • Possess an MSW degree or related degree (Psychology, Human Services, Counseling) • Practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) • Comply with the Staff Development and Education requirements noted below. 	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm
Case workers will possess BA in human services; a HS diploma or GED and at least one year providing direct patient care in a related health services field	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm
Medical specialty case workers be an LVN or Certified Medical Assistant with at least one year HIV experience; or an LVN license and have at least three years within a related health services field.	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm
Care managers and case workers will complete an agency orientation upon being hired and an OAPP-approved case management training within three months of being hired and other trainings as required	Documentation of orientation and certifications in employee files
Care managers and case workers will attend an annual one hour training/briefing on public/private benefits	Documentation of attendance in employee files
Care managers/case workers providing benefits specialty services will complete a county-wide benefits specialty training within three months of being hired and certification in CARE/HIPP and ADAP within six months of being hired	Documentation of training and certifications on file in employee record
Care managers and case workers must maintain licenses by completing continuing	Record of continuing education in employee files at provider

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education requirements of their respective professional boards	agency
Case managers and case workers must complete a minimum of 8 hours of continuing education in HIV care-related topics per year.	Record of continuing education in employee files at provider agency
Case workers will receive a minimum of four hours of patient-care related supervision per month from the RN care manager and social work care manager who direct the program	<p>All patient-care related supervision will be documented as follows (at minimum):</p> <ul style="list-style-type: none"> • Date of patient-care supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Supervisors name, title and signature
Patient-care related supervision will provide general guidance and follow up plans for care coordination staff and be completed as feasible and appropriate given patients	Documentation of patient-care supervision for individual patients will be maintained in the patient's record

SERVICE UNITS

Unit of Service: Units of service defined as reimbursement for medical care coordination services are based on services provided to eligible patients.

Medical Care Coordination Units – Calculated in number of patient contacts

Number of Patients: Patient numbers are documented using the figures for unduplicated patients within a given contract period.

QUALITY MANAGEMENT

All programs will implement a Quality Management (QM) program that assesses the extent to which care and services provided are consistent with federal (e.g. Public Health Service and CDC Guidelines), State and local standards of HIV/AIDS care and services. The QM program will (at minimum):

- Identify the leadership and accountability of the medical director or executive director of the program
- Use measurable outcomes and data collected to determine progress toward established benchmarks and goals
- Focus on linkages to care and support services
- Track client perception of their health and effectiveness of services
- Serve as a continuous quality improvement (CQI) process reported annually to senior leadership

QUALITY MANAGEMENT PLAN

Programs will develop **one** agency-wide QM plan that encompasses all HIV/AIDS care and prevention services if possible. This plan will be reviewed and updated as needed by the agency's QM committee and signed by the medical director or executive director. The written QM plan shall include the following components (at minimum):

Objectives: The QM plan should delineate specific goals and objectives that reflect the program's mission, vision and values

Quality Management Committee: The QM plan will describe the purpose of the Quality Management Committee, its composition, meeting frequency (quarterly, at minimum) and required documentation (e.g., minutes, agenda, sign-in sheets, etc.). Programs that already have an established advisory committee need not create a separate Quality Management Committee, so long as the already existing advisory committee's composition and activities conform to QM program objectives.

Selection of the QM Approach: The QM plan will detail an elected QM approach, such as Plan-Do-Study-Act (PDSA), Chronic Care Model, or Joint Commission on Accreditation of Healthcare Organization (JCAHO) 10-Step model, etc.

Quality Management Program Content: The QM plan will detail program content to include (at minimum):

- **Measurement of Outcome Indicators** – collection and analysis of data measured from specific OAPP selected indicators (at minimum). In addition, agency can measure other aspects of care and services as needed
- **Development of Data Collection Method** -- to include sampling strategy (e.g., frequency, percentage of sample sized), collection method (e.g., chart abstraction, interviews, surveys, etc.) and creation of a data collection tool.
- **Collection and Analysis of Data** – results will be reviewed and discussed by the QM committee. The findings of the data analysis will be communicated with all involved program staff.
- **Identification of Improvement Strategies** – QM committee will be responsible for identifying improvement strategies, tracking progress and sustaining achieved improvement.

Client Feedback Process: The QM plan will describe the mechanism for obtaining ongoing feedback from clients regarding the accessibility and appropriateness of service and care. Feedback will also include the degree to which the service meets client need and satisfaction. Client input will be discussed in the agency’s QM committee on a regular basis for the enhancement of service delivery. Aggregate data is to be reported to the QM committee annually for continuous program improvement.

Client Grievance Process: The QM plan will detail the program’s policy and procedure for addressing and resolving client’s grievance at the level closest to the source within agency. Grievance data will be tracked, trended and reported to the QM committee for improvements in care and services. (See also PROGRAM REQUIREMENTS AND GUIDELINES.)

Random Internal Chart Audits: The QM plan will detail a plan for random chart audits for Medical Outpatient, Medical Nutrition Therapy, Case Management, Mental Health, Psychiatry and Oral Health services. Sampling criteria will be based on important aspects of care and will be, at minimum, 10% or 30 charts, whichever is less. Results of the chart audits will be reported and discussed quarterly in the QM committee.

STANDARD	MEASURE
Programs will develop a Quality Management Plan	Quality Management Plan on file at provider agency which details (at

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	<p>minimum):</p> <ul style="list-style-type: none"> • Objectives • Quality Management Committee • Quality Management Approach • Quality Management Program <p>Content including (at minimum)</p> <ul style="list-style-type: none"> ○ Measurement of outcome indicators ○ Development of data collection method ○ Collection and analysis of data ○ Identification of improvement strategies <ul style="list-style-type: none"> • Client Feedback Process • Client Grievance Process • Random Internal Chart Audits (when appropriate)
<p>Quality management plan will be reviewed and updated as needed by the agency's QM committee and signed by the medical director or executive director</p>	<p>Record of review on file at provider agency. Updated QM plans on file at provider agency</p>

PROGRAM REQUIREMENTS AND GUIDLELINES

Agencies providing care coordination services must have written policies that address confidentiality, release of information, client rights and responsibilities, universal precautions, eligibility and client grievances.

Confidentiality protects information about a clients HIV status, risk factors and use of services. A **Release of Information Form** describes the situations under which a client's information can be released and includes the name of the agency with whom information will be shared, the specific information to be shared, duration of the release consent, and the client's signature. A release of information can be rescinded verbally or in writing at any time. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the Release of Information must be a HIPAA-compliant disclosure authorization.

Funded providers are expected to post and provide to each consumer the **Patient's Bill of Rights** developed by the Los Angeles Commission on HIV which outlines a client's/patient's right to:

- respectful treatment
- competent, high quality care
- be part of the decision making process
- confidentiality and privacy
- billing information and assistance.

In addition, the Patient's Bill of Rights outlines the client/patient responsibilities as a service consumer. Programs are welcome to develop their own Bill of Rights as long as the Commission's Bill is used as a minimum standard. A copy of the Commission on HIV Patient's Bill of Rights is found as Exhibit 3 in LINKAGES AND TOOLS.

A **grievance procedure** details a procedure for clients to voice their concerns about unfair treatment or the quality of services they are receiving. Grievance procedures should detail the steps a client can follow to file a grievance and how the grievance will be handled within the agency. Included in the procedure should be steps for client appeal.

STANDARD	MEASURE
Programs will develop and enforce client confidentiality policy	Written policy on file
Programs will develop and enforce client grievance policy	Written policy on file and posted in a visible location

Programs shall post and provide each client with a Patient's Bill of Rights	Copy of Commission on HIV Patient's Bill of Rights (or program's specific Bill) on file and posted in a visible location. Each client file to note that Bill of Rights has been provided.
Agency develops and enforces written eligibility requirements for services	Written policy on file
Agency develops and enforces policy for obtaining client consent	Client consent form on file
Client records are stored in secure and confidential location	Records stored in locked file, cabinet, or room with limited access
Agency has written policies which address the following: <ul style="list-style-type: none"> • Physical plant safety • Medical/health care • Infection control and transmission risk management • Crisis management • Personnel • Risk assessment and response • Service planning • Documentation • Client/Guardian rights and responsibilities • Client discharge and transition 	Written policies on file

LINKAGES

In certain cases, clients will require additional services a given agency is unable to provide. It is incumbent upon provider agencies to develop mechanisms and referral sources to make available the full range of additional services to meet the needs of their clients. Also vital is the coordination of client care with primary care medical clinics. Developing mechanisms that ensure contact with a client's primary care clinic will ensure integration of services and better client care.

STANDARD	MEASURE
Provider agencies develop and provide referrals for full range of services	Memoranda of Understanding with additional providers on file
Special effort will be made to develop feedback mechanisms with primary care medical clinics to ensure	Memoranda of Understanding with primary medical clinics on file

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integration of service and better client care	
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PROGRAM SAFETY

Services must be provided in settings that meet federal, state and local requirements. Such requirements ensure the well-being and safety of clients and staff. Facilities should be easily accessible by all, clean, comfortable and free of hazards.

STANDARD	MEASURE
Program promotes and practices Universal Precautions	Written policy on file
Program is Americans with Disabilities Act (ADA) compliant for physical accessibility	Signed confirmation on file
Program has developed and enforces policy for health and safety related incidents.	Written policy, reviewed by all staff, on file
Agency complies with all required federal, state and local safety regulations (includes OSHA)	Signed confirmation, as needed, on file

CULTURAL AND LINGUISTIC COMPETENCE

All providers must participate in a process of training and education that increases cultural and linguistic competence and improves their ability to provide culturally and linguistically appropriate services to all people living with HIV. Culturally and linguistically appropriate services:

- Respect, relate and respond to a client’s culture in a non-judgmental, respectful manner
- Match the needs and reflect the culture and language of the clients being served
- Recognize the significant power differential between provider and client, member of the dominant culture vs. minority, and work toward developing a more collaborative interaction
- Consider each client as an individual, not making assumptions based on perceived membership in any group or class

Important in the development of cultural and linguistic competence is the ability to acknowledge one’s personal limits in cultural and linguistic competence, and the willingness to treat one’s client as the expert on their culture and relation to it.

STANDARD	MEASURE
Programs will recruit a diverse staff that reflects the cultural and linguistic diversity of the community served	Programs have a written strategy on file
All staff (including administrative staff) will receive ongoing training to build cultural and linguistic competence	All staff required to attend one training per year, verified in personnel file
Programs will maintain a physical environment that is welcoming to the populations served	Site visit will ensure
All programs will ensure access to services for clients with limited English	Programs will ensure through: <ul style="list-style-type: none"> • Bilingual staff • Face to face interpretation provided by qualified staff or volunteers • Telephone interpretation services for emergency needs • Referral to bilingual/bicultural programs
Clients' family and friends will not be considered as ongoing interpreters because of confidentiality and medical terminology limitations. If a client chooses to use family or friend as their interpreter, the provider must obtain consent. It is preferred that children under 18 not serve as interpreters.	If used, family/friend interpretation consent form signed by client will be kept on file.
Interpreters, bilingual staff and volunteers must demonstrate bilingual proficiency and be trained in the skills and ethics of interpreting. Training on terms relevant to HIV services must be provided. It is preferred that children under 18 not serve as interpreters.	Resume and documentation of training; certification (when applicable) on file
Clients shall have access to linguistically appropriate educational materials and signage	Programs must provide educational materials and required documentation (consents, grievance procedures, etc.) in the native language of the populations served
Programs will conduct ongoing assessments of cultural and linguistic competence of staff and program	Cultural competence measures developed and maintained into program and staff assessments and evaluations

GENDER AND SEXUAL IDENTITY COMPETENCE

All providers should be involved in a process of training and education that ensures their ability to deliver appropriate services regarding diverse gender and sexual identity issues relevant to people living with HIV, including Lesbian, Gay, Transgender, Bisexual, Intersexed or Queer-identified individuals. Competency in gender and sexual identity issues should include:

- Respect for and the ability to relate and respond to a client's sexual identity, sexual orientation, and gender identity in an informed and non-judgmental manner.
- Understanding the specific needs of underserved sexual and gender minority groups.
- Understanding the specific needs of women.
- Recognizing and being sensitive to the dominant culture's historic oppression of sexual and gender minorities, and working toward developing a collaborative interaction.
- Considering each client as an individual, not making assumptions based on perceived membership in any gender or sexual identity group.
- Deferring to the client's self-identification and not imposing normative culture values onto client.

STANDARD	MEASURE
Programs will recruit a diverse staff that reflects the gender and sexual diversity of the community served	Programs have a written strategy on file
All staff (including administrative staff) will receive ongoing training to build gender and sexual diversity competence	All staff required to attend one training per year, verified in personnel file
Programs will maintain a physical environment that is welcoming to the populations served	Site visit will ensure
Program documents and materials will utilize inclusive language	Documents on file for verification

ACCESSIBILITY OF SERVICES

Providers must demonstrate the capacity to ensure that services are accessible and relevant to all people living with HIV, including linguistic and cultural minorities and people with disabilities.

STANDARD	MEASURE
Agency complies with ADA criteria	Completed form/certification on file
Services are accessible to target population	Site visit to review hours of operation, location, accessibility with public transportation
Services are offered to any person meeting eligibility requirements within funding capacity	Written eligibility requirements and grievance procedures on file
Programs incorporate consumer input in design, delivery and evaluation of services	Documentation of consumer advisory board meetings, focus groups and other consumer input mechanisms on file.

MEDICAL CARE COORDINATION-SPECIFIC PROGRAM REQUIREMENTS

TUBERCULOSIS SCREENING

All care coordination program staff, other program employees, volunteers, and consultants who have routine, direct contact with patients living with HIV must be screened for tuberculosis. Programs are directed to the TB Control Program at 2615 S. Grand Avenue in Los Angeles 90007 (Phone 213-744-6151) for more information.

STANDARD	MEASURE
All care coordination staff, volunteers and consultants with routine, direct patient contact must be screened for TB	Record of TB screening for staff, volunteers and consultants on file at provider agency

PATIENT/STAFF/COLLEAGUE COMMUNICATION

Agencies must develop written policies and procedures to address communication between care coordination staff, patients and other professionals to include a protocol for colleagues, social service professionals, patients, partners, family members or other supportive persons to contact staff for emergencies, holidays and weekends.

STANDARD	MEASURE
Care coordination programs must develop policies and procedures to address communication between staff, patients, family members and other professionals, including emergency contact provisions	Communication policies and procedures on file at provider agency

TRANSLATION/LANGUAGE INTERPRETERS

Federal and state language access laws (Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency (LEP) patients at no cost, in order to ensure equal and meaningful access to health care services. Care coordination staff must develop procedures for the provision of such services, including the hiring of staff able to provide services in the native language of LEP patients.

STANDARD	MEASURE
Care coordination programs must	Interpretation policies and procedures
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develop policies and procedures to address the provision of competent interpretation services to LEP patients at no cost	on file at provider agency
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OTHER RESOURCES

AIDS Action

<http://www.aidsaction.org/>

(The) AIDS Channel (information of all kinds for people living with HIV)

<http://www.theaidschannel.com/>

AIDS Clinical Trials Group

www.actis.org

AIDS Clinical Trials Info Hotline (800-874-2572)

AIDS Clinical Trials Information Service

http://aidsinfo.nih.gov/clinical_trials

AIDS Education and Training Center

www.aids-ed.org

AIDSHotline.org (reviews of the best HIV/AIDS websites)

<http://www.aidshotline.org/crm/asp/refer/links/default.asp>

AIDS Institute

<http://www.health.state.ny.us/diseases/aids/about/casemgmt.htm>

AIDS Services Directory

<http://www.asodirectory.com/>

Association of Nurses in AIDS Care

www.anacnet.org

(The) Body (HIV resources and information)

<http://www.thebody.com/index.shtml>

California Board of Registered Nursing

<http://www.rn.ca.gov/>

Department of Health and Human Services AIDS Guidelines

www.aidsinfo.nih.gov

HIV/AIDS Bureau

www.hab.hrsa.gov

HIV/AIDS Treatment Info Service

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www.hivatis.org

HIV InSite

www.hivinsite.ucsf.edu

HIV LA

<http://www.hivla.org/>

InSpotLA (Local resources and websites)

<http://www.inspotla.org/resources/>

Infoline – Los Angeles

<http://www.infoline-la.org/>

Johns Hopkins AIDS Service

www.hopkins-aids.edu

Los Angeles County Test Sites

<http://www.lapublichealth.org/aids/hivtestsites/Sites0503.pdf>

Medline Plus – AIDS

www.nlm.nih.gov/medlineplus/aids.html

National Association of People with AIDS

<http://www.napwa.org/>

National Network of STD/HIV Prevention Training Centers

<http://depts.washington.edu/nnptc>

New Mexico AIDS InfoNet

<http://AIDSinfonet.org>

New York Department of Health AIDS Institute

www.hivguidelines.org

NIH National Center for Complimentary and Alternative Medicine

<http://nccam.nih.gov>

Nursing World (includes ANA Position Statements)

www.nursingworld.org

Project Inform

www.projectinform.org

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STAFF/COMMITTEE REPORT

COMMITTEE ACTION:

- **Issue raised post-Public Comment period:** The Committee received comment that there was no pharmacy component or intervention listed in the Medical Care Coordination standard. The Committee agreed that the pharmacist's role is an integral part in the patient's care plan, but agreed that it pertains to the medical outpatient standard. The Committee recommended that both the medical outpatient and AIDS Drug Assistance Program Enrollment (ADAP) standards should be reviewed to ensure that pharmacy-related needs are addressed when doing intake, assessment and the treatment plan. However, under the **Patient Assessment/Reassessment section** addressing patient strengths, the Committee agreed to add ". . . and accessibility" to the medication adherence bullet.
- **Issue raised post-Public Comment period:** In reference to outreach, although the Committee concurred that handling a the case management needs of lower acuity clients by a centralized telephone service is one option, it is not the same thing as a client line proposed to handle outreach. The standard specifically calls upon programs to design their own outreach plans and remained committed to a broader, more flexible requirement in the standard in order to accommodate a variety of approaches. It was also noted the Commission has a separate outreach standard. Moreover, a "Client Line" to address either function is an implementation issue, and should be referred to the administrative agency to consider, as appropriate, when services are contracted. There was no change to the Standard recommended.
- **Issue raised post-Public Comment period:** The Committee agreed that the suggestion that the Standard require the administrative agency to design and implement a county-wide data management system was out of the scope of the standard. However, the SOC Committee has made recommendations to the Office of AIDS Programs and Policy (OAPP) regarding data management needs of medical care coordination, and the need for uniform data management will also be discussed in the Commission's Comprehensive Care Plan.
- **Issue raised post-Public Comment period:** The Committee felt that the contact with a patient deemed to be at the "crisis" acuity level was adequately addressed in the standard ("at least weekly, preferably face-to-face"). As a result, the Committee added a second sentence to the third paragraph under **Patient Acuity Assessment** stating that, "An acuity level assessment/re-assessment is an ongoing component in the course of the standard contact/visit" to address

any confusion reflected by the recommendation that crisis acuity be re-certified every 30 days. In addition, under **Case Conferences**, “. . . and acuity level” was added to the last sentence of the second paragraph to reflect that case conferences should be based on patient need and their acuity level.

- **Issue raised post-Public Comment period:** Regarding the recommendation that increased benefits counseling training be included as part of the comprehensive treatment plan, the Commission only addresses the need/requirement for training(s) in the standard, but does not prescribe how those trainings are managed in the standards because trainings are not services, and are, as a result, program support and implementation issues.
- **Issue raised post-Public Comment period:** Acknowledging that it requires both care managers to agree to a client’s treatment plan, the Committee agreed it should take both care managers to agree to close a client’s case. As a result, that the first bullet under **Case Closure**, detailing what case closure summaries should minimally include, should read “Date and signature of both the medical and patient care managers.”
- **Issue raised post-Public Comment period:** Concerns about the transition from current case management care to medical care coordination are issues of implementation and outside the scope of the standard. The Commission and OAPP have agreed to an implementation plan and next steps to facilitate and enable the migrate to medical care coordination services.

LINKAGES AND TOOLS

Exhibit 1 – Sample Consent to Receive Services

Exhibit 2 – Sample Grievance Procedure Form

Exhibit 3 -- Commission on HIV Patient's Bill of Rights