2013

Medical Care Coordination Guidelines

Division of HIV and STD Programs

3/1/2013

Version 2

Table of Contents

ACKNOWLEDGEMENTS

The following people and organizations were instrumental in assisting with the development of these MCC guidelines:

Team Members

Angela Boger – Division of HIV and STD Programs
Nancy Cayasso-McIntosh, MPH – Division of HIV and STD Programs
Jason Dawson, MPH – Division of HIV and STD Programs
Wendy Garland, MPH—Division of HIV and STD Programs
Sonali Kulkarni, MD – Division of HIV and STD Programs
Heather Northover, MPH – Division of HIV and STD Programs
Jennifer Sayles, MD – Division of HIV and STD Programs
Carlos Vega-Matos, MPA – Division of HIV and STD Programs
Amy Wohl, MPH, PhD – Division of HIV and STD Programs

Vision

To improve the health outcomes of people living with HIV/AIDS in Los Angeles County and prevent new HIV infections.

INTRODUCTION/PURPOSE

Approximately 42,000 people were known to live with HIV/AIDS in Los Angeles County in 2009, while an estimated 2,000 to 2,500 new HIV infections occur every year (HIV Epidemiology Program, 2009). An additional 12,500 individuals are likely infected with HIV but unaware of their status. As the HIV epidemic continues to unfold, vulnerable populations remain disproportionately affected, including the poor and people living with co-occurring chronic illness, substance abuse and/or mental health diagnoses.

The Ryan White CARE Act was developed to build a continuum of care for underserved people living with HIV. Recent changes in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 mandated further integration of medical care with psychosocial service provision (Wilson, 2006). The Los Angeles County Commission on HIV (COH) has addressed this expectation with the development of Medical Care Coordination (MCC) services based on a synthesis of care coordination approaches utilized in the treatment of HIV and other chronic illnesses, including traditional case management, disease management and integrated treatment models. Using the standards set forth by the COH, the Division of HIV and STD Programs has developed the MCC model.

Integrated care service models, like MCC, have demonstrated success with other chronic diseases and are now being applied to HIV disease management across the country (Owens, Wollersheim, Hermens, & et al, 2005). **The purpose of MCC is to support the efforts of medical and social service providers by developing and implementing a therapeutic plan in partnership with the patient.** Coordinated care typically provides patients with a comprehensive assessment when they enter medical treatment, and then coordinates and integrates all related medical and support services (Liegal, 2006). Such coordinated care requires that interacting biological, psychological and social needs are addressed simultaneously, rather than separately and episodically. Behavioral interventions and support services are coordinated with medical care to fully respond to patients' needs, and to promote treatment adherence and health outcomes (Soto, 2004).

The integration and coordination of care is also vital to HIV treatment given the evolution of HIV as a long-term, chronic disease (Stoff, Mitnick, Kalichman, & et al, 2004). This coordinated model of care is better equipped to manage the complexity of HIV medical care treatment among populations experiencing multiple and complex needs that fluctuate in acuity throughout their lifetime. Continuity of care and care coordination are especially important as patients move across multiple service systems due to the frequent collision of medical, psychosocial and basic life needs (Klinkenberg, 2004). To provide optimal care that meets the unique needs of people living with HIV, systems must evolve to ensure continuity of care that includes:

- Consistency between primary medical care and other support services
- Seamless patient transition across levels and intensity of care
- Coordination of present and past treatment episodes (Klinkenberg, 2004)

Ultimately, the need for MCC is reflected in the poor rates of HIV care engagement among people living with HIV/AIDS in Los Angeles County. They include those who:

- Are infected but don't know their status;
- Know their status but have yet to link to HIV care; and
- Are intermittently engaged in and/or have dropped out of HIV care once linked.

In LAC, there are over 60,000 people living with HIV/AIDS (PLWHA). Unfortunately, despite efforts to expand HIV testing, it is estimated that only 79% of individuals living with HIV are aware of their infection. Surveillance data from 2009 revealed that among PLWHA in LAC who knew their HIV positive status, only 60% were in HIV care. Of the 60% of those who *were* in care, meaning they had at least one visit in 2009, 80% were retained in care (had two or more visits 3 months apart in 2009), 89% were on ART, and only 58% had an undetectable viral load at last measurement (Division of HIV and STD Programs, 2012). These data highlight the need for efforts to improve access, engagement and retention in HIV care.

Definition of Medical Care Coordination (MCC)

The Medical Care Coordination (MCC) model is a multi-disciplinary team approach that integrates medical and non-medical case management by coordinating behavioral interventions and support services with medical care to promote improved health outcomes. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction,.

The core MCC team is comprised of:

- **Medical Care Manager (MCM):** ensures the patient's biomedical needs are met and their care is coordinated. MCM also assists patients as needed through the delivery of brief interventions focused on patient education, treatment adherence, managing side effects, medical nutrition therapy, co-infections, preventative care and risk reduction. To the extent possible, it is highly recommended that the MCM acts as team lead given the intervention is imbedded within a clinic setting and seeks to affect biomedical outcomes. Must be a licensed registered nurse (RN) in the state of California.

- **Patient Care Manager (PCM):** ensures the comprehensive and thorough assessment of a patient's psychosocial needs, particularly as they relate to mental health and substance use issues. PCM also assists patients as needed through the delivery of brief interventions focused on substance misuse, mental health, risk reduction and disclosure/partner notification. Must have a Master's degree in one of these disciplines: Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or Human Services.

- **Case Worker(s) (CW)**: addresses the patient's socioeconomic needs and assists the MCM and the PCM with patient monitoring, reassessment, service linkages, plan updating, patient follow-up, and tracking outcomes. Additionally, the Case Worker acts as the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care seamlessly and in a timely fashion. Must have a Bachelor's degree in Nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or Human Services, and/or licensed vocational nurse (LVN).

See Appendix A for full MCC staff duty statements.

Aside from the core MCC team who provides direct services to patients, there are additional staff who support the program:

a) **MCC Administrative Coordinator**: The Coordinator provides administrative oversight for the MCC program. This includes ensuring contractual requirements are met. She/he is the main contact for DHSP and is responsible for, but not limited to:
   i. Submitting monthly reports
   ii. Coordinating with Finance to submit contract budgets and monthly invoices
   iii. Notifying DHSP of staffing and service delivery site changes
   iv. Responding to DHSP requests, e.g., plans of corrective actions (POCA)

b) **MCC Program Coordinator**: The MCC Program Manager/Coordinator provides programmatic oversight for the MCC program. This includes facilitating the successful integration of MCC into the clinic and maintaining fidelity to the program's process components.

c) **Clinical Supervisor for the MCM**: The role of the Clinical Supervisor for the Medical Care Manager is to increase job performance by enhancing essential knowledge and skills needed to effectively serve patients. Clinical supervision for the Case Worker is provided by core MCC team members. See page 67 for more information regarding clinical supervision guidelines.

The roles of the MCC Administrative Coordinator, Program Coordinator and/or Clinical Supervisor may be the responsibility of one staff member or filled separately, depending on staff expertise and/or agency staffing patterns.

Patient Eligibility for MCC Services

HIV medical outpatient programs should offer MCC as part of their standard suite of services and screen all eligible patients at their primary medical homes. Patients eligible for MCC include those who:

- Reside in Los Angeles County[1];
- Are age 12 years or older;
- Have a household income equal to or below 400% Federal Poverty Level (FPL); and
- Are HIV-Positive.

[1] Patients do not have to be citizens or legal residents of the United States to receive services, they must, however, be able to prove they reside in Los Angeles County.

MCC Goals and Objectives

The goals of MCC are to:

- Streamline care coordination to improve HIV+ patients'
  - Access to medical care
  - Adherence to care and treatment
  - Health outcomes
- Empower patients to self-manage care and reduce dependence on care system
- Reduce HIV transmission

The primary objectives of MCC are to:

- Support patients in adhering to medical care and antiretroviral therapy (ART)
- Promote sexual risk reduction to reduce patient acquisition of sexually transmitted infections (STIs) and transmission of HIV infection
- Facilitate access and linkage to appropriate services in the continuum of care
- Increase patient self-efficacy by reducing acuity level
- Eliminate duplication of services by integrating medical and non-medical case management for HIV-positive patients
- Increase coordination among providers

MCC Performance Measures

The following are MCC performance measures designed to evaluate the program's efficacy by determining if the program is:

- Fulfilling program goals (outcome)
- Achieving program objectives (impact); and
- Maintaining fidelity to the program model (process).

1. **Retention in HIV care**
   Percentage of **active and self-managed** medical care coordination (MCC) patients who had 2 or more medical visits at least 90 days apart within the past 12 months

   *Related Performance Measure*s:
   - Percent of HIV-infected patients CD4 T-cell counts <500 cells/mm3 who are prescribed ART in the measurement year
   - Percentage of HIV-infected patients on antiretroviral therapy (ART) with the last viral load undetectable (<200 copies/mL) in the measurement year
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year

2. **Viral load suppression less than 200 copies/mL when on antiretroviral therapy (ART)**
   Percentage of **active and self-managed** MCC patients who are prescribed ART and achieve viral suppression (< 200 copies/mL) within the past 12 months.

   *Related Performance Measure*s:
   - Percent of HIV-infected patients with CD4 T-cell counts <500 cells/mm^3 who are prescribed ART in the measurement year
   - Percentage of HIV-infected patients on antiretroviral therapy (ART) with the last viral load undetectable (<200 copies/mL) in the measurement year
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year
   - Percentage of HIV-infected patients on ART who were assessed for adherence (and counseled if suboptimal adherence) two or more times in the measurement year.

3. **Provision of antiretroviral (ART) adherence intervention to high-risk patients**
   Percentage of **active** MCC patients who are provided the ART adherence intervention in the past 12 months.

   *Related Performance Measure*s:
   - Percent of HIV-infected patients with CD4 T-cell counts <500 cells/mm^3 who are prescribed ART in the measurement year
   - Percentage of HIV-infected patients on antiretroviral therapy (ART) with the last viral load undetectable or <200 copies/mL in the measurement year
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year
   - Percentage of HIV-infected patients on ART who were assessed for adherence (and counseled if suboptimal adherence) two or more times in the measurement year

4. **Linkage to mental health programs**
   Percentage of **active** MCC patients who were successfully linked to mental health programs
   *Related Performance Measure*s:
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year
   - Percentage of patients with HIV infection who have had a mental health assessment in the measurement year

5. **Linkage to substance abuse programs**
   Percentage of **active** MCC patients who were successfully linked to substance abuse programs

   *Related Performance Measure*s*:*
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year
   - Percentage of patients with HIV infection who have been assessed for substance use (alcohol and illicit substances) in the measurement year.

6. **Linkage to housing programs**
   Percentage of **active** MCC patients who were successfully linked to housing programs

   *Related Performance Measure*s:
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year

7. **Linkage to partner services**
   Percentage of **active** MCC patients who are successfully linked to partner services in the past 12 months

   *Related Performance Measure*s:
   - Percentage of patients with HIV infection who had a test for syphilis performed within the measurement year
   - Percentage of patients with HIV infection who had a test for Chlamydia within the measurement year
   - Percentage of patients with HIV infection who had a test for Gonorrhea within the measurement year
   - Percentage of patients with HIV infection who received HIV risk counseling within the measurement year

8. **Provision of behavioral risk reduction counseling and education intervention and linkage to partner services**
   Percentage of **active** MCC patients who were provided the behavior risk reduction intervention in the past 12 months

   *Related Performance Measure*s:
   - Percentage of HIV-infected patients who had a medical visit two or more times at least 3 months apart in the measurement year
   - Percentage of patients with HIV infection who had a test for syphilis performed within the measurement year
   - Percentage of patients with HIV infection who had a test for Chlamydia within the measurement year

- Percentage of patients with HIV infection who had a test for Gonorrhea within the measurement year
- Percentage of patients with HIV infection who received HIV risk counseling within the measurement year

See Appendix B for the full Performance Measures document that outlines how each measure is defined and calculated (numerator, denominator and data elements/sources used), any applicable exclusions, and national goals/benchmarks for comparison.

THEORETICAL FOUNDATION FOR MCC SERVICE DELIVERY

The treatment of HIV has undergone dramatic changes since the beginning of the epidemic. HIV treatment is often considered to be a biomedical intervention, however, for patients who need to attend regular appointments and take medications daily or more often, treatment requires behavioral changes. Similarly, MCC is integrated into, and is a part of, a patient's clinical medical home, but the program is a ***behavioral, rather than biomedical,*** intervention. The program's goals are biomedical in nature, i.e., to improve individual health outcomes through HIV viral load suppression, but the MCC team will have to support individuals in changing behaviors related to HIV transmission and treatment adherence to achieve these goals. These behaviors may include:

- Attending regularly scheduled doctor's appointments
- Communicating honestly with healthcare providers
- Disclosing HIV status to friends, families and partners
- Reducing/eliminating recreational drug use
- Seeking mental health services when needed
- Taking HIV and other medications regularly and as prescribed
- Using condoms to reduce STI acquisition and STI and HIV transmission

Ultimately, the success of MCC relies on a patient's ability to change behaviors that will lead to the improved health outcomes. It is, therefore, important for the MCC team to apply behavior change theory to service delivery, and to enhance patient self-efficacy and motivation to adopt protective health behaviors through effective counseling styles. Below is a brief introduction to the Transtheoretical Model, a behavior change theory, and motivational interviewing, a patient-centered counseling approach, both of which will assist the MCC team in supporting behavior change throughout the process of MCC service delivery.

Transtheoretical Model (Stages of Change)

The Transtheoretical (also called the Stages of Change) model acknowledges that behavior change involves specific stages of readiness to change and that specific actions or processes are needed to move through these stages (Prochaska & DiClemente, 1982) (Prochaska, DiClemente, & Norcross, 1992). Proschaska JO & DiClemente CC, 1983; Prochaska JO, . These stages include: precontemplation, contemplation, preparation, action, maintenance, and termination. (Sometimes people add relapse as a seventh stage to the cycle of behavior change.)

Providers assess the patient's stage of change and use the transtheoretical model to guide their choice of appropriate interventions. To advance the patient's progress most effectively, interventions are carefully stage-matched. The table below outlines stages of change descriptions and corresponding process of change:

Table 1: Processes of Change for Each Stage of Change

Stage	Readiness to change	Processes of Change
Pre-contemplation	Patient does not see behavior as a problem and sees no reason to change because: - lacks knowledge about the problem, or - tried to change in the past but it did not work and has given up on change	-Increase awareness about the problem -Impact of patient's behavior on others (what others' impressions would be, or how affected by behaviors) -Pointing out discrepancies between the way the patient would like it to be and how it is
Contemplation	Patient recognizes a problem and is thinking about change but has not committed to it: -ambivalent about change -lacks confidence to change	-Explore ambivalence by discussing pros and cons of change -Pointing out discrepancies between the way the patient would like it to be and how it is -Build confidence (self-efficacy) around change
Ready for Action	Patient has decided to change within the next 30 days: -has taken some behavioral steps in this direction	-Encourage commitment to change -Support self-efficacy to change -Develop a plan that considers strengths and deficits -Identify action goals for change
Action	Patient has changed behavior more than 1 day and less than 6 months	-Positive reinforcement for new behaviors – support self-efficacy -Identify immediate positive impact of behavior change on patient
Maintenance	Patient has changed behavior for more than 6 months	-Identify social support network members who can help support behavior change -Help patients identify and avoid cues to trigger old behaviors (relapse)

Adapted from Prochaska JO et al. 1997; Coury-Doniger, et al. 2000)

See Table 3 for characteristics and recommended interventions typically associated with each stage of change.

As a general rule, research has shown that for high-risk populations, 40% are in precontemplation; 40% are in contemplation; and 20% are in preparation for behaviors not yet adopted (Prochaska & Velicer, 1997).

Key principles of the Transtheoretical Model include:

1. **Change occurs in steps over time.** It is unrealistic to expect someone to fully change a long-standing behavior after a single intervention. However, providers can assess what stage a person is at in relation to a specific behavior, and then focus on trying to move that person to the next stage using stage-specific and tailored interventions that are delivered over multiple contacts.

2. **People are in different stages for different behaviors.** People are all in the process of changing many different behaviors at the same time. The Stages of Change model is very specific; it describes a person's relationship to changing a particular behavior (not a person's relationship to change in general). For example, it is very useful to recognize that a patient who doesn't want to use condoms is pre-contemplative about their condom use. It would be inaccurate, however, to think of this person as simply pre-contemplative about all behavior change related to STI risk reduction or treatment adherence because he/she may have different beliefs about related behaviors.

3. **Different interventions work better at different stages.** One of the most powerful aspects of using this model is that different kinds of interventions tend to work better with different people, depending on what stage they are in. For example, "Contemplative" and "Preparation" usually respond best to verbal processes, focusing on insight, as well as education. Strictly behavioral interventions will be less successful at these stages compared to the "Ready for Action" and "Action" stages.

4. **The stages of change are not linear.** People tend to move fluidly back and forth between stages. The pace of movement through these stages may vary greatly. For example, some individuals may remain in the contemplative stage for months—even years while others may fluctuate between the contemplative and ready for action stages. Work with patients where they are and strategize ways to help them move forward, understanding that there may be movement between stages.

5. **Relapse (or recycling) to earlier stages is always possible**. Once a person initiates a behavior change, that person is susceptible to relapse at any time and therefore may cycle back through the stages repeatedly. Think about that famous line from Mark Twain: "It's easy to quit smoking. I've done it hundreds of times."

Relapse is an important function of the stages of change and illustrates how this model is not a linear process. People may relapse/recycle back to any stage at any time, depending on the unique context within which they find themselves. Therefore, it will be important to explore what the relapse means to them and the context within which it occurred. In many instances, relapse (or recycling) can be seen as a learning opportunity to revisit the plan and explore what did and didn't work.

6. **Once an individual leaves the precontemplative stage, he or she will never again have the same capability for denial and avoidance**. Example: people in Alcoholics Anonymous sometimes say that AA can "really ruin your drinking." Once someone attends an AA meeting, he or she will never feel the same about drinking—even if the drinking continues.

Motivational Interviewing[2]

Motivational interviewing (MI) is a more directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence (Rollnick, 1995). It is more focused and goal-directed than some other patient-centered approaches. The examination and resolution of ambivalence is its central purpose, and the provider is intentionally directive in pursuing this goal. This method is best utilized when a patient is in the contemplative stage of change and may be an effective tool to move the patient forward in their progress. However, MI techniques can be useful at every stage of change.

The basic principles of MI are similar to the Transtheoretical Model and involve:

1. Assessing the patient's readiness or willingness to change
2. Using specific techniques to move people toward change based on their present state of willingness
3. Assisting the patient in creating a favorable climate for change to occur
4. Exploring, addressing, and, to an extent, resolving ambivalence and resistance

Motivational interviewing is characterized by the following beliefs:

1. Readiness to change is not based on who a patient is but where the patient is in his/her readiness to change. Avoid seeing resistance and denial as patient traits, but as cues to modify motivational strategies.

2. Ambivalence is the largest obstacle to change. Ambivalence stems from a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in a patient-centered and respectful atmosphere.

[2] This section is taken/adapted from "What is MI?" Behavioral and Cognitive Psychotherapy 23, 325-334.

3. The patient, rather than the provider, must articulate and resolve their ambivalence. A patient needs the opportunity to explore the often confusing, contradictory and uniquely personal aspects of their conflict. The provider's task is to facilitate this cost-benefit analysis, and to guide the patient toward a resolution that triggers change.

4. Direct persuasion, aggressive confrontation, and argumentation are not effective methods for resolving ambivalence. These tactics often encourage the patient to defend the status quo, thereby increasing resistance to change.

When practicing motivational interviewing:

1. Explore both sides of the status quo or keeping things as they are. Start with good things about the status quo; then ask about the problems or potential problems.

2. Accent the positives of change. The more patients talk about changing behavior and hear their own reasons to change reflected back, the more likely they are to change.

3. Recognize when the balance tips toward positive change. Once it becomes clear that the patient wants to make a change, summarize the motivation towards change, discuss options for change, and support the patient's commitment, confidence and ability to change.

4. Roll with resistance. Resistance is defined as a patient's refusal to look at change behavior. View encountering resistance as an opportunity to reevaluate and adjust motivational strategies.
    a. Monitor the patient's degree of readiness to change, and ensure that resistance is not generated by pushing the patient too hard or fast toward change.

    b. Use active listen skills, such as parroting, paraphrasing and reflection to demonstrate the patient is being heard, such as "So you are saying/feeling that…"

    c. Use double-sided reflections to link their resistance to previous, contradictory statement that the client has made.

        Example:
        Patient: *"But I can't quit drinking. It's who I am."*
        Provider responds: *"You see drinking as a part of your identity, and at the same time you're worried about how it's changing you and your relationships."*

    d. Affirm the patient's freedom of choice and control.

MI Techniques

Specific MI techniques used to accomplish behavior change include **OARS** (open-ended listening, affirmations, reflective listening and summarizing) and "change talk." These techniques are described in detail below.

- **O**pen-ended questions are those questions which are not easily answered with a one-word response ("yes" or "no") and do not assert the provider's values or objectives.

  Example:
  Close-ended question: *"Do you know how people get HIV?"*
  Open-ended question/elicitation: *"Tell me what you know about HIV."*

- **A**ffirmations are a way of verbally validating a patient's thoughts, emotions or actions. They help build self-efficacy by highlighting past or present strengths, efforts or intentions that the patient has demonstrated but may not have recognize or acknowledge. Affirmations may also be posed as a question to encourage patients to self-identify what has been going well.

  Example:
  Patient: *I don't know why I feel so overwhelmed. My husband has a real job and works long hours—nearly 60 hours a week! I just stay at home with the kids, cook and clean.*

  Provider: "*You spend a lot of time taking care of the household. It sounds like your husband depends on you to raise the children and keep the family organized."* or "*How do you feel about what you've accomplished since the last time we met?*"

- **R**eflective listening is a way of clarifying, amplifying or guessing the meaning behind what the patient is saying. There are three levels of reflective listening: parroting, paraphrasing and reflection.

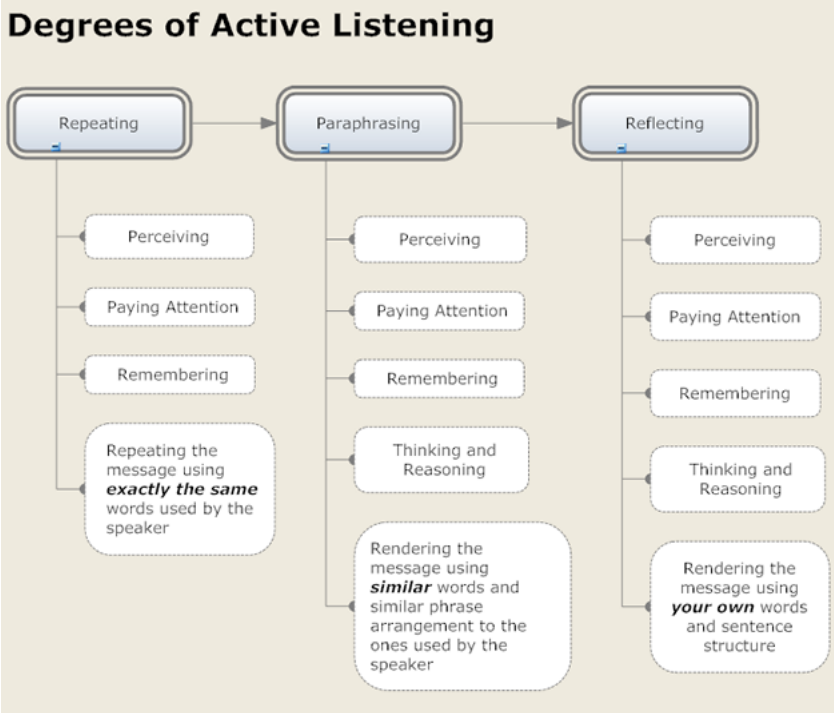
  - Repeating (or parroting): repeating the patient's words exactly. When used sparingly, this technique can help the patient feel heard.

  - Paraphrasing: repetition of the gist of patient's feelings by the provider in their own words.

  - Reflection: seeks to identify deeper feelings that are unsaid but lie beneath what is literally said. Reflecting statements are *validating* statements and, by allowing the patient to hear his/her words in another person's voice, may help to clarify patient's feelings.

Example:
Patient: *"I know I should use condoms, but honestly, I just don't feel a connection when I use them."*
Provider responds: *"You don't feel intimacy with your partner when condoms are involved."*

It is easy to confuse the purpose of "repeating," "paraphrasing" and "reflection." Below is a graph clarifying the subtle differences between the three techniques.



[3]

- **S**ummarizing highlights the most important aspects of what has been discussed. At the same time, providers are giving the "gist" of what was heard and checking for accuracy.

Example:
Patient: *"Last month I had sex with Todd and never told him my status. I felt awful. Now he wants to get together seriously and I don't know what to do."*
Provider summarizes by saying: *"Not telling Todd your status made you feel guilty because you felt you weren't being honest with him.. This has made it difficult for you to move forward with a potential relationship."*

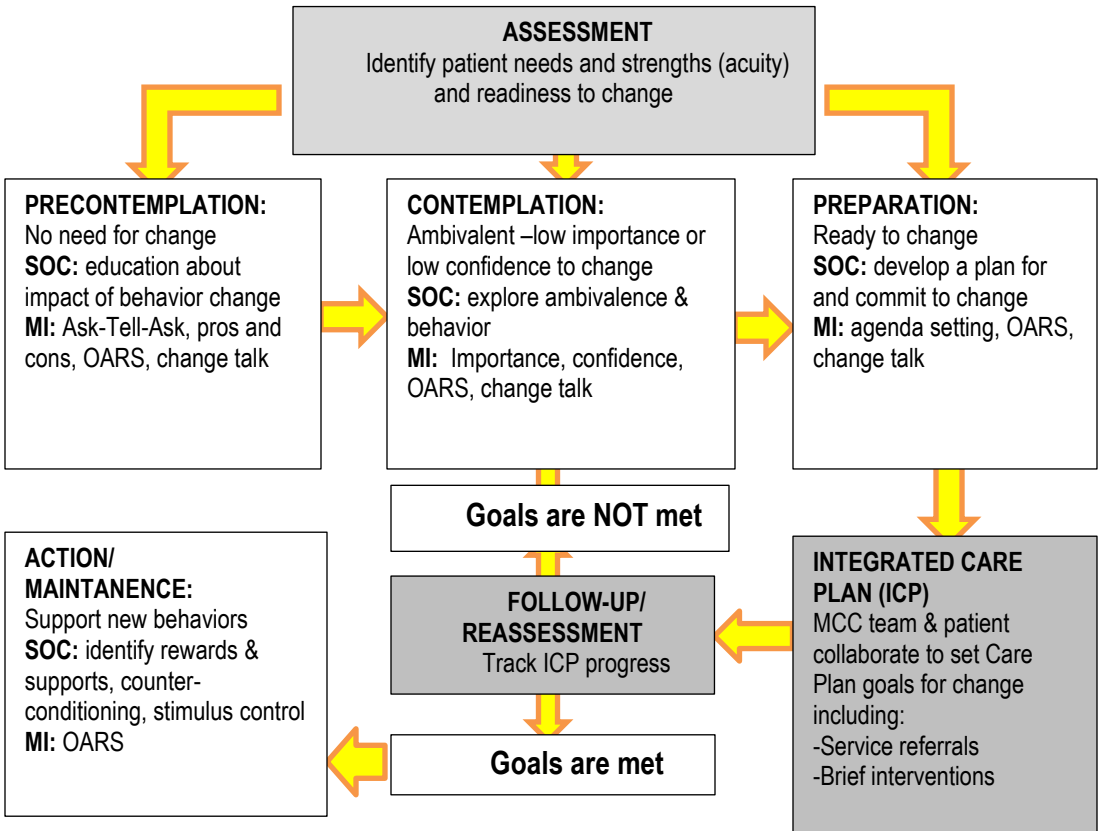
[3] Citation unknown. Last accessed on October 31, 2012 from: http://en.wikipedia.org/wiki/Active_listening.

- **Change Talk** invites the patient to make the argument for change by eliciting types of statements that indicate readiness to change. Types of change talk are categorized as follows:
  - Desire to change (I want…)
  - Ability to change (I can…)
  - Needs to change (I should…)
  - Commitment to change (I will…)
  - Reason to change (it's important because…)

  The acronym DANCR is frequently used to refer to these five categorizes of change talk.

Figure 1 below illustrates how the Transtheoretical model and MI techniques can be used effectively in the delivery of MCC towards the goal of behavior change: increased treatment adherence and HIV risk reduction.

Figure 1. Medical Care Coordination Model Components: Stages of Change (SOC) and Related Behavior Change Strategies



Adapted from (Abramowitz, Flattery, Franses, & Berry, 2010).
SOC=stages of change; MI=motivational interviewing; OARS=open-ended questions, affirmations, reflections and summaries

MCC PROCESS COMPONENTS

MCC is a departure from traditional case management due to the greater emphasis on an integrated, team approach to service delivery, but many of the basic goals and process components are similar. MCC includes the following activities:

1. **Screen** patients for MCC services. The process differentiates patients who are self-managed from those who need active MCC services. This is done on a semi-annual basis to ensure clinic patients with changing health statuses and life circumstances do not fall through the cracks. Once screened, the MCC team should contact eligible patients within **7 days** of notification;

2. **Enroll** eligible patients into active MCC services. This process involves confirming patient eligibility and introducing the service to the patient. Enrollment must be complete within **30 calendar days** of referral and/or screening;

3. **Assess** active MCC patients' needs for HIV medical and other support services. The assessment focuses on twelve (12) life areas (domains) that can potentially affect health status, treatment access and/or adherence, and risk behavior. The patient assessment must be completed within **two (2) weeks** of enrollment;

4. **Calculate** active MCC patients' acuity. A patient's acuity level is based on the assessment and determines service intensity. Acuity levels may fluctuate depending on the patient's life circumstances, and service intensity should adjust accordingly. A gradual reduction in acuity is expected for actively enrolled MCC patients with the goal of reaching a self-managed state.

   The DHSP Data Management System (DMS) calculates the patient's acuity based on assessment information entered into the system. The assessment must be entered into DHSP DMS within **seven (7) days** of completion.

5. **Develop** service goals and integrated care plan (ICP) with patients receiving active MCC service. This is a collaborative process between the Medical Care Manager, Patient Care Manager, and MCC patient. The plan identifies behaviors a patient is willing to change and steps needed to achieve their goals. The plan should be patient-centered and informed by the assessment. Frequency of plan updates is minimally determined by patient acuity. Complete ICP within **two (2) weeks** of assessment's completion;

6. **Monitor** patients' progress. This includes maintaining contact with the patient to support their efforts in meeting the action steps and goals outlined in the ICP, such as linkages to, coordination of, and retention in HIV medical care and other support services. Frequency of follow up is minimally determined by patient's acuity; and

7. **Case Conference** among multidisciplinary team to ensure coordinated patient care and follow up. Participants may include physicians, the MCC team, clinical nursing staff, mental health specialists, nutritionists, substance abuse treatment counselors, and others directly involved in the patient's care.

   The MCC team is also expected to meet more frequently as a unit to ensure greater integration of service delivery and **care coordination** for active MCC patients. Frequency of patients discussed by the team is minimally determined by patient's acuity.

8. **Deliver** brief interventions designed to promote treatment adherence and overall wellness for active MCC patients. The brief interventions are not a substitute for specialized care for patients with a high level of need; referrals to more specialized care may be warranted in those situations. For example, patients with established mental health therapy and substance use treatment needs should be referred to the appropriate specialist. MCC intervention activities primarily focus on, but are not limited to:
   a. Engagement in HIV care and patient education,
   b. Retention in care and HIV education,
   c. Antiretroviral adherence counseling,
   d. Risk reduction counseling, and
   e. Social support including disclosure assistance/ partner notification service

9. **Transition** active MCC patients with reduced acuity levels to lower-level acuities with the ultimate goal of a self-managed status or, in rare cases, close cases when patients no longer meet eligibility (e.g., move out of the County), die, or are discharged due to threatening and/or abusive behavior directed toward the clinic staff or other clinic patients.

Proper documentation to record service delivery is required for each component.

PATIENT SCREENING FOR MCC

The majority of patients eligible for MCC services will be identified through the screening process. Agency staff will screen all clinic patients for active MCC services **every 6 months** using an MCC screening tool programmed into the DHSP Data Management System (DMS)

as part of the mandatory registration screens for medical outpatient patients (see screening criteria below under "Active MCC Patients"). A copy of the clinic registration MCC screening tool in DHSP DMS is included in Appendix C.

The screening process differentiates eligible patients who are self-managed from those who need active MCC services. The frequency of screenings ensures clinic patients whose health status or life circumstances change do not fall through the cracks.

The DHSP DMS sends alerts to the MCC team to inform them that patients meeting the screening criteria for active MCC have been identified in the registration process. The MCC team is responsible for following up with these patients to explain and formally enroll them in active MCC services.

To ensure timely patient assessment and care, the MCC team should contact eligible patients within **7 days** of notification.

Active MCC Patients

Eligible patients who meet any of the following criteria are enrolled in active MCC services:

- are recently diagnosed with HIV (in the past 6 months);
- are out of HIV care (no HIV medical appointments in the past 7 months or more);
- are not on antiretroviral therapy (ART) but meet current clinical guidelines for treatment;
- are currently on ART and have detectible viral load (greater than 200 copies/mL);
- have multiple medical and/or psychosocial co-morbidities that negatively affect health status that include at least one active HIV-related complication or 2 or more poorly controlled co-morbidities; or
- were incarcerated within the last 6 months.

Self-Managed Patients

Patients who do not meet any of the above criteria for, or who opt out of, MCC services are enrolled in passive MCC services as "self-managed" patients because they require a lower level of engagement and low-intensity of service delivery or she/he declines MCC to self-manage their own care. Self-managed patients are screened semi-annually **(every 6 months)** through the clinic registration process to determine if, based on changes in their health status or life circumstances, they are eligible for active MCC services. For clients who are deemed eligible for active MCC services but who opt out to self-manage their own care, the MCC team should actively continue to engage them in MCC services.

Additional Referral Methods

In addition to MCC screening process during the registration process, patients who are eligible for active MCC services may also be identified through the following:

- Provider Referral**:** HIV clinic staff who provide patient care (e.g., physicians, clinic nurses, physician assistants) may refer patients directly to the MCC team when they feel active MCC services are warranted, such as patients who
    - Have a viral load of >200 copies/mL
    - Have not attended an HIV medical appointment in the past 7 months
        - Includes recently diagnosed <6 months
    - Are at risk for transmitting HIV
    - Contracted other STIs within the last 6 months
    - Have multiple and complex diagnoses (such as diabetes, hepatitis, liver disease, etc.) that negatively affect a patient's health status and complicate HIV management
    - Were incarcerated within the last 6 months.

  Providers can refer patients to the MCC team through the DHSP DMS, during case conference and/or direct introduction to an MCC team member.

- Clinic In-reach**:** The MCC team actively works to identify eligible patients for active MCC services by querying the clinic's electronic medical records (EMR) and/or appointment scheduling systems for those who are any of the following:
    - Recently diagnosed with HIV (in the past 6 months);
    - Currently on ART but have detectible viral loads (greater than 200 copies/mL); or
    - Out of care (no HIV medical care visits in 7 months or more).

  The MCC team should run queries at least **every three (3) months** to ensure newly diagnosed and treatment non-adherent patients are quickly identified for active MCC enrollment.

  The MCC team should also form strong partnerships with any HIV testing programs at their agency or in their area of Los Angeles. This ensures newly diagnosed patients can be quickly linked to HIV care following their diagnosis.

- Clinic Outreach**:** Outreach can be used to find and link patients to the MCC team at clinics with established outreach programs. While the MCC team itself does not conduct direct patient outreach activities, the team may collaborate with other outreach staff to engage or re-engage identified patients in care, and build referral relationships among community providers who offer ancillary and other support services to patients who are newly diagnosed or who have fallen out of care.

Particularly for the newly diagnosed, it is critical that the MCC team work with their agency's outreach programs and/or HIV testing sites to link individuals to HIV care who have just tested positive. It is recommended that the MCC team consider establishing relationships with outside HIV testing sites and other programs that encounter newly diagnosed or out-of-care patient populations as a source of external referrals.

Patient Registration/Intake

Per Health Resource Services and Administration (HRSA) reporting requirements, patients' registration and intake information **must be updated every six (6) months** and entered into the DHSP Data Management System (DMS). The Case Worker conducts patient registration/intake for all MCC patients new to HIV care. For patients already in care and/or enrolled at the clinic, MCC team members should confirm that registration is complete and/or up-to-date when enrolling patients into active MCC services. Otherwise, the program cannot report patient service delivery to DHSP.

PATIENT ENROLLMENT

Once identified as a candidate for active MCC, the MCC team enrolls patients into the program. This process involves confirming patient eligibility and introducing the service to patients. Enrollment must be complete within **30 calendar days** of referral and/or screening.

Introducing MCC

MCC services are critical to the provision of HIV care and treatment within the HIV medical home. When introducing or explaining MCC services, clinic staff should frame MCC as part of routine HIV care and treatment. Introduce the MCC team members as part of the patient's core medical team—not as part of some separate service—and explain that they will be routinely involved in the patient's medical care.

Key tips:

- Introduce MCC providers by their name and as part of the patient's core medical team. Avoid introducing them by their functional titles of "Medical Care Manager," "Patient Care Manager" and "Case Worker," or the program as "Medical Care Coordination (MCC)."

- Do explain the roles of the MCC staff members in relation to their medical and psychosocial needs.

- Frame the service in terms of how the MCC team will work with and assist the patient, rather than in terms of the program in general.

  Examples:
  "Let me introduce you to Aaron and Serra. They're a part of your medical team. They'll talk to you about your HIV care from time to time and connect you to services when needed."

  "Hi! I'm Serra. Aaron and I are part of your medical team. We're here to talk with you about your HIV care and to connect you to some services you might need."

Handling Patients Who Do Not Want Active MCC Services

The decision to participate in active MCC services is ultimately the choice of the patient. In the rare event a patient is eligible for active MCC services but is not interested in receiving them, that patient is given the opportunity to formally "opt-out". Patients who opt-out are considered to be making a choice to manage their own care will be enrolled as self-managed and the MCC team will work to engage them into active services every 6 months.

Documentation of Enrollment Status

The MCC team documents patients' MCC enrollment status into the DHSP DMS database within **seven (7) days** of enrollment. This documentation tracks patients from screening or referral for MCC to program enrollment. It "sets" the clock for active MCC patient monitoring activities including assessment, care plans, case conferencing and follow-up. It also allows for the MCC team to document those patients who met the criteria for active MCC services but chose to opt out.

A copy of the Enrollment Status screen in DHSP DMS is included in Appendix D.

MCC ASSESSMENT

The MCC Assessment is the foundation of the MCC program because it allows the MCC team to explore with the patient complex issues affecting their successful engagement in HIV care. Understanding what factors hinder patients' ability to reduce risk behaviors and adhere to treatment lays the foundation for ICP development and outlines next steps needed to promote increased retention in care, adherence to ARTs, and self-sufficiency. Based on findings on the Assessment, the MCC team will also deliver brief interventions and link patients to needed social services with the intent of reducing barriers to care and ART adherence and risk reduction identified during the Assessment.

Context

One of the most important goals over the course of conducting an assessment is to understand the *context* of a patient's behavior and the overall circumstances surrounding the situations that influence HIV treatment non-adherence and risk behaviors. Context refers to the ability to explore the physical and emotional circumstances under which a patient's life, and consequently his or her behaviors, takes place.

DEFINITION OF CONTEXT
Context refers to the broader circumstances surrounding a patient's behavior. These may include their sexual partners and behaviors, substance use, physical environment, their emotional state, peer influences, personal history, motivations for participating in the behaviors and so on. A patient's social environment can have a large complex set of cofactors that might include the communities they live in, their cultural influences, the languages they speak, and the impact of poverty and other forms of oppression on their ability to initiate and be supported in risk reduction.

A thorough exploration of context can help providers build empathy and maintain their neutral stance—and assist patients in enhancing their perception of their risk. By making an accurate assessment of a patient's risks and needs, providers will be able to provide more focused and appropriate interventions.

The MCC Assessment is conducted through face-to-face interviews between the MCC Team (MCM and PCM) and active MCC patients using a countywide standardized assessment tool programmed in DHSP DMS. The assessment determines:

a) Patient's level of need for medical and psychosocial support services;
b) Domains (or areas) in which the patient requires assistance securing services; and
c) Patient acuity level.

Patient responses to the MCC Assessment are scored to calculate acuity levels for each domain (e.g., health status, housing, mental health) and to guide the delivery of directed activities that include referrals and brief interventions.

Acuity

Acuity refers to the patient's level of functioning and determines the intensity of active MCC services needed to improve the patient's level of functioning (Washington State Department of Health, 2004). The acuity level is determined by responses on the assessment and may fluctuate over time. Service intensity is adjusted accordingly.

The four acuity levels for domain-specific and overall acuity are the following:

- Severe: patient is experiencing complex and ongoing challenges that greatly impair their ability to manage HIV medical care and treatment, such as chronic homelessness, addiction, and mental health issues. Patient is frequently or currently in crisis. Immediate and intensive intervention is necessary.

- High: patient has episodic or on-going concerns that interfere with HIV medical care and treatment. Large gaps exist in the patient's ability to cope with and manage health status.

- Moderate: patient needs assistance in resolving barriers to HIV medical services with health education, risk reduction, skills building or other brief intervention. Patient requires some assistance in accessing resources and/or social service referrals.

- Self-Managed: patient is stable, and capable of managing their HIV medical care with no or intermittent need for assistance, or chooses to opt out of active MCC services to manage their own care.

Domain-Specific Acuity levels are calculated based on the patient's responses to key questions in the corresponding domain's section of the Assessment. Higher scores reflect higher acuity levels. Domain specific acuity is useful for guiding targeted service delivery and tracking improvement for specific needs. For example, the Adherence Domain acuity level (severe or high) would guide whether patient needs adherence intervention.

Overall acuity level is calculated by adding all of the domain-specific acuity scores on the Assessment. In calculating the overall acuity score, the domains scores for health status, ART adherence and access, housing, substance use and mental health are weighted more heavily to reflect the increased staff time required to address needs in these domains. The overall acuity level determines the intensity of services a patient receives and tracks overall patient improvement.

All acuity scores are calculated by the DHSP Data Management System (DMS) once completed assessments are entered into the system. The MCC team is expected to serve and actively manage a mix of severe, high and moderate acuity patients with activities and interventions designed to promote patient autonomy and self-sufficiency in managing their

HIV care successfully. Patient acuity will also determine frequency of service delivery. See Table 2 of acuity-driven service intensity.

MCC Assessment Domains

The following are domains covered in the MCC assessment along with key notes to assist in conducting the assessment. As previously mentioned, the MCM is responsible for all clinical and treatment related domains (sections I-IV) and the PCM is responsible for the domains related to support systems and relationships, substance use and mental health (sections IX, XI-XII). The MCM or PCM may complete any of the other sections. See Appendix E for a copy of MCC assessment form and Appendix F for the companion Assessment Guidance tool.

I. Health Status**:** The MCC team must be aware of the patient's current health status and medical problems in order to help the patient access medical services and achieve optimal health outcomes. If a patient has not recently seen a doctor, refer or make a medical appointment for the patient within 2 weeks (preferably sooner).

The MCM completes this section (pages 2-7) and abstracts information from the patient's medical record prior to meeting with the patient, if possible.

If the patient has not seen a doctor (is new to care); has not seen a doctor recently (has been out-of-care); or the team is unable to access the patient's chart prior to conducting the assessment, allow the patient to answer questions to the best of their ability and verify information with the medical chart/labs when available. This verification should be done within thirty **(30) days** of the assessment.

The assessment is structured to identify the following priority health issues:

- Patients who meet ART treatment guidelines are on ART, including pregnant women (questions 2, 6, 7, 9);
- Patients who are on ART and have detectible viral load (question 3);
- Patients who have any active HIV-related complications (question 7.1); or,
- Patients who have active and poorly controlled co-morbidities (question 7.2).
- Patients who have co-morbidities that interact with HIV (e.g., hepatitis B or C) (question 8);
- Patients who have current or recent STIs (question 10);
- Patients needing a nutrition referral (questions 1-9);
- Patients needing vaccinations (question 11).

II. Quality of Life/Self-Care**:** The MCM completes this section on pages 8 and 9, which is used to evaluate patients' health-related quality of life and functional health status ((Katz, Ford, Moskowitz, & et al, 1983) (Lawton & Brody, 1969). Geriatric syndromes are assessed for patients over the age of 50 as a screening measure

(Saliba, Elliott, Rubenstein, & et al, 2001) (Rosen & Reuben, 2011). The priority issues identified are as follow:

- Patients over age 50 who have geriatric syndromes that includes cognitive impairment (question 4);
- Patients with limited capacity for self-care and daily living activities (impaired functional status, questions 3a-3p);
- Patients with fair or poor perceived health status (question 1); or,
- Patients with any current health concerns (question 2).

Key note:

For patients over the age of 50, the MCC team evaluates the geriatric functional status questions in the Assessment (questions 4-10 on page 8). For any patient who responds "yes" to 4 of the 7 questions, the MCM should evaluate their cognitive status using the Montreal Cognitive Assessment (MOCA) test (see Appendix G). The test is available in English and Spanish. The MCM should share the results of the MOCA test with the patient's physician to determine whether the patient needs formal neuropsychological evaluation or has a diagnosis of dementia and requires additional services.

III. Medical Access, Linkage and Retention**:** The MCM completes this section (pages 12-13), which addresses issues related to HIV-related medical care adherence, and motivation for and barriers to care. Access, engagement, and retention in care are evaluated. The priority issues identified are as follows:

- Patients who have not attended at least 1 HIV care visit in the past 6 months (question 1);
- Patients who do not have a doctor who they see regularly for their HIV care (question 2);
- Patients who have been hospitalized and/or in the emergency room in the past 6 months (questions 6 & 7)
- Patients who usually or always miss their HIV care appointments (question 8); and,
- Patients with identified barriers to HIV care (question 9);

IV. ART Access and Adherence**:** The questions in the section on pages 10-11 are asked only of patients who are currently receiving HIV drug treatment. The MCM completes this section, which identifies issues related to ART adherence and determines which patients are in need of support, education, and/or additional brief adherence interventions (Carey & Schroder, 2002) (Simoni, Amico, Pearson, & Malow, 2008) (Wohl, Galvan, Myers, & et al, 2011) . The priority issues identified are as follows:

- Patients who cannot explain what a viral load and CD4 count are (questions 1 & 2);

- Patients who cannot explain the how ART effects viral load and CD4 count (question 1a & 2a);
- Patients who cannot correctly name the medications their current ART regimen (question 3);
- Patients who report not taking all doses of their ART medications (questions 4, 5 & 8); and,
- Patients with identified barriers to adherence (question 9).

V. Housing Situation: This section (page 14), along with the additional housing information collected during the registration process, informs the MCC team if patients have immediate housing needs (which can negatively impact adherence to care and treatment), and guides appropriate service referral and linkage. It identifies the following priority issues:
   - Patients who are currently homeless or in temporary housing (question 1);
   - Patients who are or have been homeless in the past 6 months (question 1a, 2a, or 3a);
   - Patients who have received eviction or utilities shut off notices in the past 6 months (question 1b or 2b);
   - Patients who do not feels safe in their current housing situation (question 1c, 2c, or 3c); and,
   - Patients who want assistance to change housing situation (question 1d, 2d, or 3d).

VI. Financial Stability: An inability to secure basic necessities, such as food, can lead to risk behavior (e.g., survival sex) and interfere with the ability to successfully manage health status (e.g., missed appointments or doses of medication, poor nutrition, stress). This section (page 15), along with the financial information collected during the registration process, is used to determine any need for financial assistance (short or long-term). It identifies the following priority issues:
   - Patients without a regular monthly income (question 1);
   - Patients without a reliable source of monthly income (question 2); and,
   - Patients who are unable to meet monthly living expenses (question 3).

VII. Transportation**:** This section on page 15 helps to evaluate a patient's ability to travel for medical and social services, groceries and other essential HIV-related purposes. It is not scored as part of patient acuity but helps the MCC team to identify the following priority issues:
   - Patients with a long travel time to the clinic (question 1);
   - Patients without a reliable source of transportation (question 3); and,
   - Patients that miss HIV care appointments because they do not have transportation (question 4).

VIII. Legal Needs/End of Life Needs**:** This section (page 16) is useful to understand incarceration history and determines if patients need assistance completing legal forms. It identifies the following priority issues:

- Patients who ever or recently (past 6 months) have been incarcerated (questions 1 & 1a-1d);
- Patients who are currently on parole or probation (question 1e);
- Patients who need a power of attorney, an advanced directive, a guardianship, wills and/or end of life legal documents (questions 2 & 3); and,
- Patients without a health care proxy (question 4)

IX. Support Systems and Relationships**:** Assessing key factors related to social support will provide a more comprehensive picture of the context regarding patient's access to and maintenance of HIV specific medical and support services. The PCM completes this section (page 17-19). It assesses patients' sources of support and stress, the types of support received, past or current violence/abuse, and HIV disclosure (Wohl, Galvan, Myers, & et al, 2011) (Sherbourne & Stewart, 1991) (Ernst, Weiss, & Cham, 2004) . The priority issues identified are as follows:

- Patients who have not disclosed their HIV status to social network members (question 4);
- Patients who receive no or little social support (questions 7a-7e); and
- Patients who ever experienced or currently experience abuse or violence (question 8)

Key notes:

HIV Disclosure

It will be important to examine who, if anyone, in the patient's support system is aware of the patient's HIV status. This may determine if the patient needs assistance or support in disclosing his or her status, and identifies potential caregivers in the event the patient may become unable to care for him or herself. Also, individuals who have disclosed their status to more people in their lives are more likely to be retained in HIV care. Assist patients with HIV disclosure issues and partner notification services when necessary and appropriate.

- Discourage partner notification if there is a high likelihood that disclosure may lead to intimate partner/domestic violence or other abuse. Keep in mind that MCC providers should not initiate dual disclosure and third-party notification options if there is a potential threat to the patient, provider or field worker (e.g., Public Health Investigator).

Intimate partner violence

- Intimate partner/domestic violence (IPV/DV) is common. It is important to assess whether patients may be experiencing violence in their relationships,

including physical, verbal, psychological, sexual or financial abuse.[4] Also recognize that IPV/DV affect patients of all genders and sexual orientations. While providers typically consider IPV/DV a "women's issue," research has shown rates of IPV/DV among young men who have sex with men is comparable to heterosexual women.[5]

Because the terms "intimate partner violence" or "domestic violence" may not be familiar to many people, the following questions may elicit more illuminating responses (versus "Have you experienced intimate partner/domestic violence?"):

- ✓ **"How does your partner react when they are upset at you? How do you react when you are upset at them?"**
- ✓ **"What does fights look like between you and your partner?"**
- ✓ **"Has there ever been a time when you have been afraid of your partner for any reason?"**

- Providers are only mandated to report intimate partner/domestic violence if they are a clinician and *see physical signs of abuse during an exam* (this includes the MCM as they are RNs). An MSW (or PCM if appropriately qualified/credentialed) may also assist by conducting further evaluation and interventions depending on the patient's need and readiness. This may include assisting patients by offering supportive messages, assessing patient safety, and giving options for assistance for when the patient is ready to access services. See Appendix H for mandated reporting requirements per the penal code section 11160-11163.6. There are also documents that include specific information regarding elder abuse from the California Advocates for Nursing Home Reform (CANHR), as well as minor consent, confidentiality and child abuse reporting laws in California from the National Center for Youth Law.

X. Risk Behavior**:** The prevention, diagnosis, and treatment of STIs other than HIV are essential for the patient's overall health and reduced risk for HIV transmission. This section (pages 20-21) is useful to identify issues related to sexual behaviors, HIV knowledge and HIV disclosure (Osborn, Davis, Bailey, & Wolf, 2010). The identified priority issues are as follows:

- Patients who do not understand how HIV is transmitted (questions 1-8);
- Patients who are sexually active in the past 6 months (questions 9 & 10);
- Patients who are not using condoms with sexual partners (question 11);

[4] A potential form of abuse affecting PLWH/A, in particular, is the threat of disclosing their HIV status to others.

[5] Kubicek, K. " Discrimination and Violence in the Lives of Young Men who Have Sex with Men: Implications for Policy and Practice." Presented January 20, 2011.

- Patients who are not disclosing their HIV status to sexual partners (question 11a);
- Patients who want partner notification assistance to disclose HIV status to past sexual partners (question 15).

Key notes:

- Use gender-neutral terms when asking about patient's personal relationships until the patient has established their preference(s). For example, **"Are you going out with someone?**" versus "Do you have a girlfriend?"

- Discussing unsafe sexual practices may be particularly stigmatizing for PLWH/A, as it acknowledges that they may be putting others at risk for infection. It is important to express empathy about any challenges patients may face in having protected sex, while emphasizing the importance of using condoms and other safer sex practices for their own health and safety (e.g., risk of other STIs). When dealing with STIs, however, remind the patient that traditional HIV risk reduction methods may not be as effective at reducing other STI infection, as some infections are more easily transmitted via oral sex (e.g., gonorrhea) and skin-to-skin contact (e.g., syphilis, herpes and HPV).

XI. Alcohol/Drug Use and Addiction**:** Substance use can be a barrier to successful engagement in HIV care and to ART adherence, and contribute to poor viral suppression and survival among persons living with HIV (Chander, Himelhoch, & Moore, 2006); (Tucker, Burnham, Sherbourne, & et al, 2003); (Tobias, Cunningham, Cabral, & et al, 2007); (Braithwaite, Conigliaro, Roberts, & et al, 2007). The potential relationship between substance use and unsafe sexual behaviors also highlights the need for a comprehensive assessment of alcohol and drug use (TCU Institute of Behavioral Research, Fort Worth, Texas 2006) (refs –for SA and unsafe sex). The PCM completes this section (pages 22-23). The priority issues related to drug and/or alcohol use are as follows:

- Patients who have ever used alcohol and/or drugs (question 1);
- Patients who have used alcohol and/or drugs in the past 6 months (question 1b);
- Patients with drug or alcohol abuse problems identified with the substance use screener (questions 16-24); and
- Patients who are currently trying to reduce or stop drug and/or alcohol use (question 25);
- Patients who want help to reduce or stop their drug and/or alcohol use (question 26);
- Patients who have completed drug and/or alcohol treatment (question 27)
- Patients who are currently participating in an support group for substance use (questions 28)

Key notes:

- Patients may be uncomfortable sharing information about substance and alcohol use, particularly if they are using illicit drugs. Past experiences with providers and in some cases, law enforcement, may have taught patients that it is dangerous to share this type of information. It is important to approach the topic in a neutral way that does not make assumptions about whether patients use substances. For example, **"What has been your experience with alcohol and other drugs?"** versus "Do you use drugs or alcohol?" or "What kinds of drugs have you used?"

- Since relapse is possible among patients with a history of substance use, it is important to check in with patients around substance use behavior even when they report sobriety, particularly within the first year or when triggers may arise (e.g., increase in life stress, peer influence, romantic break up).

XII. Mental Health**:** Mental health issues can not only reduce access to and engagement in regular HIV medical care, adherence to ART regimens and viral suppression, but they can also lead to increased substance use and risk behaviors (Tucker, Burnham, Sherbourne, & et al, 2003); (Tobias, Cunningham, Cabral, & et al, 2007); (Chander, Himelhoch, & Moore, 2006); (Braithwaite, Conigliaro, Roberts, & et al, 2007). The PCM completes this section (pages 24-26). It explores patient's mental health history and screens for symptoms of depression or anxiety (Kroenke, Spitzer, & Williams, 2001) (Spitzer RL, Spritzer, Kroenke, Williams, & et al, 2006). The priority issues related to mental health are as follows:

- Patients who are diagnosed with a mental illness or problem (questions 1 & 1a);
- Patients who are currently receiving mental health counseling or therapy (2a)
- Patients who meet the screening criteria for depressive disorders (questions 4-12);
- Patients who meet the screening criteria for anxiety disorders (questions 13-19);
- Patients who are currently considering hurting themselves and/or others (question 21); and,
- Patients with mental health issues who are not ready to seek mental health services (question 22)

If patients indicate that they are a danger to self or others, contact the clinic supervisor and refer for immediate evaluation as directed.

Please Note: Although these topics are presented in a logical order, they may not necessarily be addressed in this order during a session. These sessions should be patient centered, which means the focus is on the patient's concerns and interests. The conversation should be based on the patient's needs.

Strategies for Completing the MCC Assessment

The assessment is an interactive conversation during which the patient's medical, physical, psychosocial, environmental, and financial needs are identified. Simply asking a series of questions will not give a provider the detailed information that is needed to help and support the patient. This means effective communication is essential to facilitate an MCC assessment.

Providers who offer a safe space where patients can "feel heard" will elicit more information and allow the MCC team to explore gaps in patient knowledge, healthcare, needed services and social support. However, it is important to understand that some patients may find it difficult to express their needs. Others may consciously choose not to volunteer information, especially if they feel it is irrelevant or embarrassing. Providers should not be surprised if additional information is uncovered during later sessions. Patients may not tell everything until full trust has been established, further emphasizing the importance of being non-judgmental and developing rapport from the beginning.

Keep the following in mind:

- Inform patients about any reporting obligations *before* a patient may disclose sensitive information, i.e., prior to the start of each session with every patient. MCMs, PCMs and Case Workers who are LVNs are mandated reporters. Other Case Workers may not necessarily be mandated reporters, but are still required to report child abuse, suicidal ideation, or homicidal intent. See Appendix H for more information about mandated reporting requirements.

- Do not give the assessment form to patients to complete on their own. The process of completing the assessment with the patient is critical for the MCC team to successfully and appropriately deliver MCC services.

- Avoid reading the form to patients verbatim when conducting the assessment. It is simply a tool to record notes and trigger important topics for discussion.

- Begin the conversation with topics that may seem less invasive and/or threatening. Avoid potentially stigmatizing topics until rapport with the patient is established.

- Use a strength-based approach. Acknowledge positive behaviors and attempts to change risk behaviors. Avoid focusing on deficits.

- Reinforce assets and positive relationships.

Tips for Eliciting Information

The following are techniques and statements that can assist providers in facilitating a conversation:

- **Listen carefully**
  Avoid completing sentences for the patient, or filling in a word when the person is struggling to find one, or asking another question when the person pauses for "too long." Let the person fill the spaces.

- **Ask simple questions**
  If your question is complex, the patient might not understand it, and then he or she might not answer the question you asked.

- **Encourage elaboration**
  - Once information has been elicited, ask the patient to elaborate more fully.
  - Ask for specific examples, including clarification as to why (how much, in what
  - way) each one is a concern.
  - Ask “what else” questions
    - “What else have you noticed?”
    - “What other concerns have you had?”
    - “What else have you thought about your behavior?”

- **On short or slow answers, follow up**
  When the patient gives a response that's much shorter than most other responses, or when a response contains atypically little content, it's possible that you've touched on something that the patient doesn't want to speak about. Follow up.
    - “Can you tell me more about that?”

- **Use the hypothetical**
  If the patient seems blocked by something, ask a hypothetical: "If you did know what was best, what would it look like?"

- **Seek clarification**
  Use "starters" such as "By that you mean..." or "Say more about that." Encourage the patient to go on a bit without specific guidance. Because clarifications give patients a chance to speak up, they frequently elicit more information than was originally shared.

- **Try to get corrected**
  If you have a guess about something, and open questions haven't worked, try making a statement that you know is incomplete or incorrect in some way. The patient who knows better might then correct you.

Being able to ask the right question is an art and a skill. Once mastered, it will allow a provider to pull out as much information as possible from a patient.

Making the Connection:
Stages of Change (Transtheoretical Model) - Assessment

The assessment is designed not only to identify the patient's medical, physical, psychosocial, environmental and financial needs, but it is also used to evaluate the patient's readiness to change. "Readiness to change" refers to the patient's intent and ability to engage in behaviors and/or seek needed services to support their health and well-being. Properly assessing a patient's readiness to adopt new or maintain positive behaviors is key to implementing effective strategies to motivate and sustain change.

Frequency of Assessments

The MCM and PCM perform the following steps when assessing patients:

Initial Patient Assessment

- Conduct a fully integrated assessment using the MCC Assessment tool once a patient enrolls in active MCC services. It is recommended that the assessment is performed together with the MCM or PCM taking the lead on different life areas called domains. The MCM is responsible for all clinical and treatment related domains (sections I-IV) and the PCM is responsible for the domains related to support systems and relationships, substance use and mental health (sections IX, XI-XII). The MCM or PCM may complete any of the other sections. Complete the assessment within **two (2) weeks** of enrollment.

- Ensure the assessment is entered into the DHSP Data Management System within **seven (7) days** of completion. The data system calculates the patient's acuity based on the information entered into the system which is critical for care planning.

- Maintain a copy of the completed assessment and acuity screen from the data system in the patient's chart.

- Conduct further evaluation when warranted based on the patient's needs in some domains. For example, for patients with needs related to sexual risk behavior, emotional support, substance use and mental health, the PCM should do additional evaluation (unless he/she is not appropriately qualified/credentialed, in which case, they may be referred to an MSW).

On-going Patient Assessments

The frequency of ongoing assessments is determined by a patient's acuity level on the prior Assessment. The MCC Assessment tool is also used for ongoing assessments. During each assessment, the MCC team explores challenges and/or barriers previously identified in greater depth as well as new issues that may arise. They should also evaluate domains that patients formerly reported as stable, so potential life changes aren't missed. Some patients may not disclose new challenges or barriers unless they are specifically asked or triggered to do so.

The following are **mandatory *minimal*** intervals based on acuity:

- **Severe:** every thirty (30) days
- **High:** every ninety (90) days
- **Moderate:** every six (6) months.
- **Self-Managed:** N/A; however, self-managed patients are screened every six (6) months for active MCC services using the screening tool programmed in the DHSP Data Management System as part of registration and only undergo a full integrated assessment once they meet the eligibility criteria for active MCC.

Please note, the MCC team should continuously assess patients whenever they are interacting with them (not just during formal assessments), and quickly take note of any progress or setbacks. These informal assessments allow the providers to regularly monitor and identify challenges or barriers when they arise, so service provision may be adjusted accordingly.

PATIENT ACUITY

The objective of MCC service delivery is to help active MCC patients reduce their acuity level(s) over a twelve (12)-month period with the ultimate goal of transitioning patients towards self-management. While some patients will not achieve self-sufficiency within a year of active MCC enrollment, the expectation is that most patients will substantially reduce their acuity within that time period. As mentioned above, acuity refers to the patient's level of functioning and determines the intensity of active MCC services needed for the patient. Acuity is determined by the assessment and may change over time depending on circumstances in the patient's life. Service intensity is adjusted accordingly.

Acuity Levels

Monitoring patient acuity enables the MCC team to track patients' progress. As patients' acuity levels change over time, which are tracked through on-going assessment, the intensity and frequency of MCC services are adjusted accordingly. Therefore, regular patient monitoring and reassessment is required. The MCC team documents any changes to acuity in progress notes and revises the integrated care plan (ICP) to address these changes.

The different acuity levels are:

- Severe
- High
- Moderate
- Self-Managed

See page 26 for full descriptions of each acuity level.

Acuity-Driven Service Intensity

Acuity-driven service intensity leads to a patient-centered approach and allows the MCC staff to tailor service delivery based on the patients' needs. Patients with severe acuity levels (the highest need) receive the most intensive services, while those with lower acuity levels (high and moderate) receive less intensive services based on the fact that they have fewer or less demanding needs.

The table below illustrates the minimum service delivery schedule by acuity level

Table 2: Minimum Service Delivery by Acuity Level

	MCC SERVICE ACTIVITY (MINIMUM)					
ACUITY LEVEL	**Registration/ Screening**	**Re-Assessment**	**ICP**	**Brief Interventions**	**Ongoing Follow-Up**	**Case Conference**
Severe	Every 6 months	Every 30 days	Every 30 days	Weekly	Weekly	Monthly
High	Every 6 months	Every 90 days	Every 90 days	Monthly	Monthly	Quarterly
Moderate	Every 6 months	Every 6 months	Every 6 months	Every 90 days	Monthly	Every 6 months
Self-managed	Every 6 months	n/a	n/a	Referrals as needed	As needed	n/a

INTEGRATED CARE PLAN

Developing an integrated care plan (ICP) is a collaborative process between the MCM, PCM and patient that supports the patient in meeting their needs self-identified during the comprehensive assessment. It is a clear outline of tasks that the patient and MCC team agree to accomplish within a specified period of time, in order to meet specific objectives. These objectives should relate to the goals of increasing access and/or adherence to HIV medical treatment or STD/HIV risk reduction.

Because the ICP clearly outlines tasks and documents progress, the ICP keeps the MCC team and patient moving toward the patient's goals and may be used as a motivating tool that illustrates what the patient has accomplished and what they are currently working toward. The steps involved in creating the ICP with the patient - goal setting, problem solving, and monitoring progress on goals - are also all necessary skills to promote self-management (Swedeman, Ingram, & Rotheram-Borus, 2009). The MCC team and patient should revisit and update the care plan regularly as tasks or goals are accomplished, and when new needs arise.

ICP Development

The MCM and PCM perform the following steps when developing an integrated care plan with patients:

a) Summarize patient needs identified during the assessment following its completion. Solicit feedback from the patient to ensure clarity; ask about other immediate needs that may not have been identified during the assessment.

b) Discuss with the patient which issues are most important/pressing and prioritize which issues to address first.

c) Work with the patient to establish goals and preliminary objectives that relate to the patient's prioritized needs.

d) Provide immediate referrals, as needed.

e) Before the patient leaves, schedule a follow up meeting with the patient to finalize the ICP. Schedule the meeting within the next **two (2) weeks**.

Key note:

- In order to immediately engage the patient, it may be a good idea to identify and assign one item each for the patient and MCC team to accomplish by the

next meeting. Agreeing upon tasks that are easily attainable for the patient and the MCC team to accomplish will build the patient's confidence and establish credibility for the MCC team when completed by the next session.

f) Before the next meeting with the patient, the MCM and the PCM formally develop the ICP together based on the discussion with the patient about their prioritized needs. List suggested action steps for objectives appropriate to the patient's readiness to change, and use patient acuity to guide intensity of service delivery and types of services provided.

g) At the next meeting, share any updates on the tasks assigned to the MCC team and patient during the last meeting (if applicable). Follow up on any referrals provided (if applicable).

h) Share the ICP with the patient, review the established objectives with the patient, and make any necessary changes based on the patient's feedback.

i) Divide each objective into manageable tasks needed to achieve the objective. For example, an objective to increase condom use may involve several tasks to accomplish, including learning how to use condoms correctly, identifying where to obtain condoms, practicing condom use negotiation skills with partners, and addressing any other barriers to using condoms.
   - At this time, it may be necessary to:
     1) inventory needed skills to accomplish the goal;
     2) assess the patient's current skill level; and
     3) determine how to enhance needed skills to complete the necessary tasks.

j) Identify who must complete each task or step.

k) Discuss any barriers or challenges to completing the task. Strategize ways to overcome these concerns.

l) Identify a date by when each task and objective must be completed. Allow realistic timelines.

m) Establish when the MCC team will follow up with the patient and who will meet with the patient next. Schedule the next meeting date/ time.

n) Maintain appropriate documentation in patient record. The ICP should include:
   - Name, date and signature of patient and MCC team members on the initial care plan. Subsequent revisions may be dated and initialed;
   - Patient goals;
   - Possible barriers;

- Goal objectives, including:
  - What the patient and MCC team will do to accomplish the objective (tasks);
  - Timeframe by when tasks are expected to be met; and
  - Disposition of each objective as it is met, revised, or determined as unattainable.

See Appendix I for an example of an ICP form.

S.M.A.R.T. Objectives

Follow the guidelines for **S.M.A.R.T.** objectives when developing the ICP with patients:

- **Specific**: Clearly define the objective, including the *what*, *why, and who*. *What* will be done? *Why* will it be done? *Who* will do it?

  Example:
  Victor (who) *will tell his boyfriend that he has HIV* (what), *so he can convince his boyfriend to use condoms when they have sex* (why).

- **Measurable**: Set criteria to measure progress towards the objective. How will you know if the objective is reached or accomplished? For example, an objective to reduce sexual risk behaviors may involve several tasks to accomplish, including learning how to use condoms correctly, identifying where to obtain condoms, practicing condom use negotiation skills with partners, and addressing any other barriers to using condoms.

- **Achievable/Attainable**: Ensure the objective can be reached with the proper tools. Developing different attitudes, abilities and skills may be necessary. Keep in mind that a good objective *should* challenge and stretch someone outside of their comfort zone. An objective that is too easy will not allow a person to grow, while an objective that is unrealistic will only discourage, frustrate and foster fatalism. Some objectives may be more complex than others due to higher acuity or patient readiness to change and require multiple tasks to achieve.

- **Relevant**: Ensure the objective aligns with the goals of MCC, including reducing HIV/STI risk behavior, and increasing access, adherence and linkages to medical care and treatment. It must also be an objective the person is willing and able to prioritize and work towards.

- **Timely**: Develop a realistic timeframe or target date to achieve the objective. Too short and the person risks automatic failure. Too long and you invite procrastination.

Strategies for Completing the ICP

- Remain patient-centered and develop goals and objectives in partnership with the patient. Focus on goals and objectives the patient wants to achieve.

- Use motivational interviewing skills to encourage patients to address challenges to STD/HIV risk reduction, and access or adherence to HIV treatment if not immediately identified by the patient as issues to address.

  Key note:

  a. If the MCC team identifies issues that the patient is not yet willing to discuss or address on their care plan, particularly issues with some sensitivity (e.g., substance use, HIV disclosure), it is recommended that the MCC team makes note of:
     1) the issue(s) in the progress notes;
     2) the patient's (lack of) readiness to address them; and
     3) subsequent attempts to address them with the patient.

- Limit the number of objectives to address at one time. It may be difficult for a patient to focus on, much less accomplish, several goals at once, causing patients to feel overwhelmed or discouraged if unable to achieve immediate success.

Frequency of Care Plan Updates

The ICP is a working document and will evolve as patients progress toward their goals. Depending on the acuity of the patient, MCC team should develop, revise and revisit the care plan at regular intervals.

- **Severe Acuity Patients**: Develop care plan following the initial comprehensive assessment; revisit and revise as necessary (based on subsequent assessments) every 30 days.

- **High Acuity Need Patients**: Develop care plan following the initial comprehensive assessment; revisit and revise as necessary (based on subsequent assessments) every 90 days

- **Moderate Acuity Patients**: Develop care plan following the initial comprehensive assessment; revisit and revise as necessary (based on subsequent assessments) every 6 months

- **Self-Managed Patients**: Developing a care plan is not required for self-managed patients.

FOLLOW UP & MONITORING

Integrated Care Plan (ICP) implementation and evaluation require ongoing follow up with (or on behalf of) the patient to monitor the patient's progress towards meeting their goals. The MCC team also collaborates with colleagues to ensure a fully integrated patient-centered medical home approach to care coordination through multidisciplinary case conferences and MCC team meetings.

Patient Follow Up and Monitoring

The MCM, PCM, or the CW conduct follow-up with the patient depending on the goals or action steps involved. Through ongoing contact, the MCC team does the following:

- Ensures that patients are attending scheduled medical appointments
- Monitors changes in the patient's condition, circumstances or acuity, update/revise the ICP as needed, and provide appropriate interventions and referrals
- Confirms linkage to support service referrals
- Assists patients in resolving barriers to completing referrals and accessing, maintaining, and adhering to services
- Actively follows up with patients on ICP and evaluates patient progress in accomplishing tasks and achieving goals
- Provides ongoing encouragement and support for behavior change, and positively reinforces newly adopted behaviors
- Document any changes in contact information

Patient follow-up consists of face-to-face meetings with the patient or a telephone conversation. The MCC team must meet face-to-face with each active MCC patient at least **once (1) every 90 days**- this can be done in coordination with medical appointments or separately, based on the preference of the patient. Telephone follow-up must involve a conversation with the patient; leaving a voicemail or message with someone else is not considered follow-up. Multiple attempts to reach a patient may be necessary. Use the emergency contact if attempts to reach the patient using their contact information remain in vain.

The MCC team may also use email or text messaging as follow-up strategies only if the agency has an established, HIPAA-compliant protocol in place to maintain patient confidentiality.

Strategies for Effective Follow Up

Regular patient attendance at scheduled face-to-face MCC meetings is essential to meet the goals in the ICP successfully. Not only can a missed appointment be a sign of decreased motivation on the part of the patient, but it can also represent a missed opportunity for the patient and the MCC team to discuss adherence, engagement in HIV care, risk reduction and other issues. Therefore, it is important to minimize the number of missed appointments and any opportunities to lose patients to MCC and HIV care.

Strategies for minimizing missed appointments include:

- **Be flexible.** Patients may have difficulty keeping appointments at certain times or on certain days. If possible, make a wide variety of appointment times available that include drop-ins, evenings and weekends. **Try to coordinate with their scheduled medical appointments as much as possible.**

- **Remind patients.** Reminder phone calls or note card sent a few days before the appointment can reduce chances of patients missing their appointments. At every patient encounter, verify patient contact information to make sure that it is correct and reliable.

  Key note:

  As patients decrease their acuity and become more engaged in care, strategize ways in which patients can become self-reliant in remembering their appointments and reduce their reliance on reminders from the MCC team.

- **Patient Input** – Discuss with patients ways to improve their appointment keeping. Solicit suggestions that imply shared responsibility. This can lead to opportunities for building patient capacity for self-sufficiency.

- **Follow-up on Missed Appointments** – Follow-up with patients that miss MCC appointments within **twenty-four (24)** hours of the missed appointment. Determine why patients miss appointments and help identify strategies to prevent missed appointments in the future. If follow-up cannot be conducted within the twenty-four (24) hour time period, the MCC staff member must document reason(s) for delayed follow-up. Document all missed appointment follow-up in the MCC progress notes in the patient's medical record.

Frequency of Follow Up

The MCC team meets and follows up with patients on a regular basis to ensure continued engagement and increased (or continuing) stability. Frequency of patient follow depends on the patient's acuity and ICP. The following are the mandatory *minimal* intervals based on acuity:

- **Severe Acuity Patients**: weekly
- **High Acuity Patients**: at least once per month
- **Moderate Acuity Patients**: at least once per month
- **Self Managed Patients**: Follow on service coordination and referrals, as needed

Additional contact with the patient may be necessary based on ICP objectives and as necessary for effective care coordination. This includes follow up designed to ensure patient follow through on referral linkages and tasks outlined in the ICP when their "due dates" fall in between regularly scheduled follow up meetings.

Documentation

The MCC team documents all contact with or on behalf of the patient. Progress notes detailing activities related to monitoring and follow up must be maintained and kept on file in the patient chart. Required documentation includes:

- Description of all patient contacts, attempted contacts and actions taken on behalf of the patient
- Date and type of contact (telephone, face-to-face or other) with patient or other providers
- Time spent with, or working on behalf of, the patient;
- Description of what occurred during the contact
- Changes in the patient's condition or circumstances
- Progress made towards achieving goals identified in the ICP
- Barriers identified in goal process and actions taken to resolve them
- Linked referrals and interventions provided
- Barriers identified to referral linkage or completion of brief intervention deliver and actions taken to resolve them
- MCC team member's signature and professional title

See Appendix J for an example of a progress note form.

Case Conference

Case conferences are multi-disciplinary meetings where health professionals collaborate on a coordinated plan to meet the health and service needs of patients at the HIV medical

home. These are especially essential to provide seamless care for patients with complex multidisciplinary care needs.

The purpose of case conferencing is to provide coordinated and integrated patient services across providers, and to reduce duplication. The MCC team use case conferencing to:

- Identify or clarify issues regarding a patient's status, needs, and goals
- Review activities including progress and barriers towards goals
- Map roles and responsibilities
- Resolve conflicts or strategize solutions
- Adjust current service plans

Case conferencing sessions are attended by a variety of professionals, who present their cases for discussion in order to receive consultation from other professionals involved in the patient's care. Participants may include primary care or HIV physicians, mid-level providers (e.g., nurse practitioners and physician assistants), mental health counselors and specialists, patient care coordinators, nurses, social workers, case managers, nutritionists, dentists, substance abuse treatment counselors, prevention counselors, and others directly involved in the care of the patient. The MCC team should take part in these established meetings as members of patients' core medical team.

In the event that case conferencing is not already established, it is the responsibility of the MCM to initiate, schedule and coordinate formal case conferencing meetings on a monthly basis at the HIV medical home.

Key note:

Case conferencing remains an expectation for MCC teams who serve patients seeking care outside of the HIV medical home.

Frequency of Case Conference

The MCM and/or the PCM present selected active MCC patient cases at case conferences. The frequency that MCC patient cases should be presented at case conference meetings is based on acuity:

- **Severe Acuity Patients**: monthly
- **High Acuity Patients**: quarterly
- **Moderate Acuity Patients**: every six (6) months
- **Self-Managed Patients**: N/A

Case conferencing is also recommended to take place on a more informal basis, i.e., outside of regularly scheduled case conference meetings as needed, between the MCC team and other providers to facilitate service coordination. This is strongly encouraged and should be

documented in progress notes when it occurs and include the elements for documentation below.

Documentation

The MCC team member who presents the patient case during case conference is responsible for documenting it on case conference forms in the patient's medical chart. Required documentation includes:

- Date of case conference and patient name or identification number
- Name, title, and signature of case conference participants
- Medical and psychosocial issues and concerns identified
- Description of guidance provided and/or interventions to be implemented
- Action plan for interventions or next steps to be implemented and responsible parties
- Results of implementing previous interventions/guidance

See Appendix K for an example of a Case Conference form.

Care Coordination

Care coordination involves ongoing contact and coordination of patient care among the MCC team, in order to ensure greater integration of service delivery for active MCC patients. Such activities are in addition to traditional multidisciplinary case conferencing. Care coordination includes communication, information sharing and collaboration, and occurs regularly between the MCM, PCM, and CW. Coordination activities may include:

- directly arranging access or reducing barriers to obtaining services;
- attending medical appointments with patients to reinforce care plan;
- identifying alternative strategies for working with non-compliant patients or patients with high, unchanging acuity levels
- establishing linkages; and
- other activities recorded in progress notes.

Frequency of Care Coordination

Frequency of each patient discussed among the MCC team shall be determined by patient's acuity.

- **Severe Acuity Patients:** weekly
- **High Acuity Patients:** monthly
- **Moderate Acuity Patients:** every ninety (90) days

Documentation

Required documentation for care coordination is less formal than case conference and is documented in the patient's medical chart. Information should include:

- Date of care coordination encounter
- Medical and psychosocial issues and concerns identified
- Action plan for interventions or next steps to be implemented and responsible parties

BRIEF INTERVENTIONS AND REFERRAL

Brief interventions are service delivery activities that help move active MCC patients toward behavior changes that enhance HIV treatment adherence and risk reduction. They focus on specific needs identified in the patient's Assessment, and assist the MCC team in successfully addressing those needs.

Elements of a Brief Intervention

A brief intervention consists of five basic steps, regardless of the behavior being addressed. They are as follows:

1. **Introduce the issue in the context of the patients' health:** Seek to build rapport with the patient, define the purpose of the session, gain permission from the patient to proceed, and help the patient understand the reason for the intervention within the context of their health.

   Key note:

   Help the patient understand the focus of the intervention. State the target topic clearly and stress confidentiality; be nonjudgmental and avoid labels.

2. **Screen, evaluate, and assess the issue:** Use the information collected in the most current Assessment and explore the issue further with the patient. Ongoing monitoring of the issue during the intervention delivery may also be necessary. Use open-ended questions and other MI techniques to elicit a greater understanding of any context in which current behaviors occur.

   Key note*:*

Determine how much additional information you may need to effectively address the issue. Some issues will be more sensitive than others; Watch for defensiveness or other resistance; avoid pushing too hard.

3. **Provide feedback**: Highlight certain aspects of the patient's behavior using information gathered in the previous step. This involves an interactive dialog between the patient and the MCC team. Give feedback in small amounts. Use reflective listening skills and other MI techniques to explore any ambivalence; listen for DANCR—desire, ability, need, commitment and reasons for behavior change. Provide affirmations when appropriate.

   Key note:

   Be aware of cultural, language, and literacy issues; remain nonjudgmental.

4. **Talk about change and set goals to move patients along the behavior change continuum:** Discuss the possibility of changing behavior and develop a plan of action when the patient is ready to act. Always be mindful of the patient's readiness to change and frame the discussion using stage-appropriate cues. Suggest a course of action and then negotiate with the patient to determine exactly what he/she is willing to do.

   Key note*:*

   Avoid "giving advice." This often leads to defensive behavior. Instead, elicit from the patient their own problem-solving skills and let them take the lead in developing next steps whenever possible.

5. **Summarize and reach closure:** Review the session and emphasize any progress the patient has made during the session and what steps they have agreed to moving forward. Schedule a follow-up visit to review the patient's progress. The follow-up could be another face-to-face meeting or a telephone call. Close the session with the goal of leaving the patient feeling successful and confident in their ability to follow through with next steps

   Key note:

   Tailor your closure to the patient and the particular circumstance of the brief intervention. Interpret any patient resistance in a positive light leading to progress. For example, if a patient has been unwilling to commit to change, thank him for his willingness to consider the issues and express the hope that he will continue to consider committing to change.

Making the Connection:
Stages of Change (Transtheoretical Model) - Interventions

As mentioned, the Stages of Change is a model many providers use to guide their choice of appropriate interventions once the patient's stage of change is properly assessed. To most effectively advance the patient's progress from their current stage to the next, interventions should be carefully stage-matched. Below is a table associating each stage of change with common patient characteristics and intervention strategies (UCSF AIDS Health Project & Office of AIDS, 2008).

Table 3: Processes of Change for Each Stage of Change

Stage	Characteristics	Interventions
PRECONTEMPLATIVE	Unaware Defensiveness Resistance	Engagement Trust Building Get a reaction, either cognitive or Emotional
CONTEMPLATIVE	Ambivalence, unsure Problem awareness Openness to information	Help explore ambivalence Explore barriers Pass information
READY FOR ACTION (PREPARATION)	Ready to do Experimentation	Encourage, empower, support Emphasize options Coaching; teaching skills Focus on developing a step
ACTION	Practice new behaviors Avoiding old behaviors	Support, praise, recognition Focus on rewards Follow-up, reach out Problem-solving
MAINTENANCE	Sustaining behavior	Reinforcement Support, praise, recognition Find other supports Become a role model to others

*Chart taken from UCSF AIDS Health Project and Office of AIDS, California Department of Public Health. *Building Quality HIV Prevention Counseling Skills: The Basic I Training for Counselor II Staff Working in HIV Counseling and Testing—Participant's Manual.* San Francisco: UCSF AIDS Health Project, 2008.

See Table 1 for additional stages of change descriptions and corresponding process of change.

Types of Brief Interventions

The brief interventions fall into the following areas of emphasis:

- Improving health status
- Promoting antiretroviral therapy (ART) adherence
- Promoting safer sex and HIV risk reduction
- Engagement in HIV care and HIV education
- Building social support and disclosure assistance/partner services

Improving Health Status

One of the primary goals of MCC is to improve patient health outcomes through the reduction of morbidity and mortality related to HIV infection and its complications. The main objectives for improving health status and quality of life are to ensure:

1. All patients meeting criteria for ART are receiving and tolerating an adequate regimen;
2. All patients on ART achieve and maintain viral load suppression;
3. Patients with history of STDs receive more frequent STD testing;
4. Patients receive care consistent with HIV standards of care, specifically DHSP's HIV care performance measures (e.g., TB screening, vaccinations);
5. Patients receive care consistent with standard health care maintenance (e.g., dental referrals, colon cancer screening);
6. Patients with need for medical subspecialty care receive timely referrals and linkage to those services;
7. Patients with impairments that limit independent living are identified and brought to the attention of the medical providers; and,
8. Patients' quality of life and self-perceived health status is optimized

As the MCC team works with patients, sharing improvements in their health status is a source of positive feedback for patients' efforts (Swedeman, Ingram, & Rotheram-Borus, 2009). Both CD4 and viral load counts are good indicators of their health status and can be used to demonstrate improvements over time since they are collected regularly. Sharing improvements can also give patients a greater sense of control and responsibility for their health.

See Appendix L for a list of recommended intervention activities and frequency of follow-up by acuity.

Supporting Antiretroviral Therapy (ART) Adherence

Antiretroviral therapy (ART) is crucial for the successful treatment of HIV to suppressing HIV virus levels and maintaining optimal health among patients, and may reduce the likelihood of HIV transmission to partners (Sethi, Celentano, Gange, & et al, 2003) (Bangsberg, Hecht, Charlesbois, & et al, 2000) (Metsch, Pereyra, Messinger, & et al, 2008) (Cohen MS, et al., 2011) (Walensky, Paltiel, Losina, & et al, 2006). High levels of adherence to ARTs is needed for patients to fully benefit from treatment ((Paterson, Swindells, Mohr, & et al, 2000). An ART adherence intervention can assist patients in successfully managing their HIV treatment and reducing non-adherence. Each contact between MCC staff and the patient is an opportunity to discuss, review and support ART adherence. The main objectives for supporting ART adherence, based on the DHHS guidelines, are to:

1. Establish readiness to start ART;

2. Ensure that ART is prescribed for all patients meeting clinical HIV treatment guidelines (DHHS, 2012);
3. Identify potential barriers to adherence prior to starting or changing an ART regimen;
4. Assess adherence at least every 6 months; and
5. Deliver the ART Adherence Enhancement Program (AEP) to **patients with severe or high acuity** in the Antiretroviral Access and Adherence domain.

See Appendix L for a list of recommended intervention activities and frequency of follow-up by acuity to support adherence to ART.

Strategies to Improve ART Adherence

The MCM and PCM employ different strategies (Health Resources and Services Administration, 2011) to help patients take their ARTs regularly and encourage readiness for treatment.

1. The PCM identifies and addresses potential barriers to successful adherence by reviewing the patient's Assessment for current mental and physical health, substance use, support system, or other psychosocial issues. They may also provide brief interventions and /or referrals to resolve or improve barriers.

2. The MCM and PCM gauge patient readiness to adhere to ARTs to determine best starting point to work with patient. A "readiness to adhere to ART" tool is available in Appendix M and is useful to track patient progress along the behavior change continuum.

3. The MCM explains to patients the goals of ART treatment, the importance of adherence, and highlights the immediate benefits of adherence while also discussing the possible consequences of non-adherence.

4. The MCM works with the provider to involve the patient in ARV regimen selection to best tailor it to the patient's needs, including simplifying regimens.

5. The MCM educates the patient about how the ART drugs work, what potential side effects to anticipate, and how to manage potential side effects. This builds trust and will help the patient proactively identify issues that could be potential barriers.

6. The MCM provides reliable sources of information about treatment and coping with side effects - cautions people against using the Internet indiscriminately as many websites contain inaccurate, and in some cases harmful, information.

7. The MCM uses educational aids including pictures of ART medications, pillboxes, and calendars to improve patient medication adherence.

8. The MCM or PCM may deliver the Adherence Enhancement Program to **patients with high or severe acuity levels on the Adherence domain section.**

Adherence Enhancement Program (AEP)

The Adherence Enhancement Program (AEP) provides in-depth education around ART and the importance of adherence, addresses barriers to ART adherence, and promotes self-efficacy around ART adherence. It should be delivered to patients with high or severe acuity levels on the Adherence section of the Assessment, but may also be used for other patients with less severe adherence issues.

The AEP uses a patient-centered approach, delivered by a nurse to help patients improve their adherence to ARTs. It is adapted from a cognitive-behavioral intervention to support adherence to ART (Wagner, Kanouse, Golinelli, & et al, 2006).

The program uses motivational interviewing techniques to understand patients' experience with HIV and ARTs, including their motivation and commitment to take their ARTs, management of side effects, and trouble-shooting barriers to adherence. The MCC team should tailor the program to differentiate between the needs of patients *who are starting* ARTs for the first time and those *who are on ART but are in need of an adherence support* "boosters".

- For those patients starting ART, the program is a minimum of 5 sessions, two of which include a practice vitamin/candy adherence trial.

- For those patients who have been on an ART regimen in the past and may have different challenges to adherence, the program is a minimum of 4 sessions. Both modules have maintenance sessions with patients when they return for regular clinical care visit to check-in with patients and help to trouble-shoot any adherence difficulties.

All members of the MCC team will be trained by DHPS on how to deliver the AEP. A copy of the intervention manual is included in Appendix N.

Key note:

Patients with housing, mental health or substance use issues identified in the Assessment are at increased risk for adherence problems. **Barriers to ART adherence should be reviewed with any patients with severe or high acuity**

scores in these domains even if their acuity score for the Access, Engagement and Retention in Care domain is low.

Promoting Safer Sex and Risk Reduction

Patients remain at risk for HIV/STI re-infection and infection, as well as transmitting the virus to others. Approximately one-third of HIV-positive patients continue to engage in risky sexual and drug-use behaviors following their HIV diagnosis (McGowan, Shaw, Ganea, & et al, 2004) (Metsch, Pereyra, Messinger, & et al, 2008) (Fisher, Fisher, Cornman, & et al, 2006) (Kalichman, Cherry, White, & et al, 2011). **Addressing unprotected sex among HIV positive individuals is a high priority for the MCC program.**

Risk reduction counseling builds on HIV/STI knowledge to motivate and empower patients with strategies to reduce their risk of HIV/STI transmission and acquisition. It goes beyond mere delivery of information; it is a dynamic interaction between the MCC team and patient designed to motivate and support patients in changing behaviors. The following are main objectives for this intervention:

1. The MCM provides more frequent STD testing for patients with history of STDs;
2. The MCM screens for STDs according to DHSP's HIV care performance measures;
3. The MCM, PCM or Case Worker may educate patients on how to use condoms to reduce their risk of transmitting HIV and STDs or contracting STDs;
4. The Case Worker facilitate partner notification and support HIV disclosure;
5. The Case Worker links patients to substance use treatment and support;
6. The PCM addresses psychological issues that facilitate risk behavior.
7. The MCM or PCM delivers the Options/Opciones risk reduction program to patients with **severe or high acuity** in the Risk Behavior domain.

See Appendix L for a list of recommended intervention activities and frequency of follow-up by acuity to promote risk reduction.

Strategies to Improve Risk Reduction

The MCC team counsel patients to develop mutually agreed upon and achievable risk-reduction objectives that enable patients to initiate and sustain behaviors that reduce their risk of contracting or transmitting HIV/STIs through sex and substance-using behaviors. In addition to counseling, the MCC staff addresses sexual and substance-using behaviors by providing accurate health information and education to patients regarding HIV prevention, transmission and risk behavior management. The HIV education and skills patients need to include the following:

1. How HIV and STIs are transmitted
2. Basic information on how to reduce risk for HIV/STIs

3. Skills necessary to reduce risk (e.g., using both male and female condoms, cleaning needles and works, obtaining new needles and works)
4. Negotiation strategies for safer sex (e.g. discussing condom use with partners)

It is important to remember that risk reduction related to HIV transmission involving people living with HIV primarily means techniques that reduce the likelihood of transmitting the virus to their partner(s) versus techniques to protect themselves against HIV infection. For example, this may entail advising patients to act as the receptive partner versus insertive partner when having sex with an HIV-negative person. However, this would make the patient more vulnerable to STI acquisition.

Key note:

Patients with housing, mental health or substance use issues identified in the Assessment are more like to engage in high risk sexual behaviors. **Current risk behaviors should be reviewed for any patients with severe or high acuity scores in these domains even if their acuity score for the Risk Behaviors domain is low.**

Options/Opciones program

It is recommended that the MCM or PCM use the **Options/Opciones Risk Reduction Strategy** Manual as a resource for providing the education and developing the skills listed above. **This is required for individuals with high or severe acuity but may be used for patients with less severe risk histories.** The Options/Opciones program is a clinic-based HIV risk reduction intervention for HIV-positive patients designed to be delivered by providers during routine visits (Fisher, Fisher, Cornman, & et al, 2006). The objectives of the Options/Opciones intervention are to:

1. Prevent the transmission of HIV to uninfected partners;
2. Protect HIV-positive patients from co-infection with STIs or hepatitis B and C; and
3. Reduce risk of re-infection of HIV-positive patients with drug-resistance strains of HIV.

To reduce HIV risk behaviors, the Options/Opciones intervention uses motivational interviewing techniques to address patients' lack of HIV prevention information, motivation and behavioral skills that is consistent with patients' readiness to change. The MCM or PCM can deliver the intervention during scheduled MCC meetings. The first meeting takes approximately 5-10 minutes, and the MCM or PCM uses MI techniques to talk to the patient about his/her risk behavior and the patterns of his/her risk behavior (where or when), and to develop patient-centered goals to move him/her towards safer behaviors. During subsequent MCC contacts, the MCM or PCM checks in briefly with the patient (5-10

minutes) to review previously identified issues and progress on established risk reduction goals.

MCC staff will be trained to deliver the Options/Opciones intervention by DHSP. A copy of the manual is included in Appendix O.

Condom Use – Hands On Skills Building

Correct and consistent condom use is an effective strategy to reduce HIV and STI transmission and acquisition. Teaching patients the skills necessary to correctly use condoms is critical to reduce HIV and STI transmission and acquisition and to build their self –efficacy around condom use (Campbell, Tross, Hu, & et al, 2011) . It is recommended that the MCC team support correct and consistent condom use by:

1. Showing patients how to correctly use both male and female condoms with anatomical models;
2. Having patients demonstrate correct condom use with the anatomical models; and
3. Offering patients both male and female condoms to encourage regular use.

Engagement in HIV Care and Patient Education

Poor engagement and retention in HIV care can severely impact patient health outcomes. These poor health outcomes include decreased access to and use of ART, higher rates of ART treatment failure (viral loads are not suppressed), increased risk behaviors that can transmit HIV, higher rates of hospitalizations, and shorter survival time or life span (Coleman, Rajabun, Cabral, & et al, 2009) (Mugavero, Lin, Allison, & et al, 2005) (Mugavero, Lin, Willig, & et al, 2009) (Fleishman, Moore, Conviser, & et al, 2008) (Lucas, Chaisson, & Moore, 1999) (Giordano, 2011) (Berg, Safren, Mimiaga, & et al, 2005) (Ulett, Willig, Lin, & et al, 2009). Reasons patients may have difficulty engaging—or maintaining engagement—in HIV care (i.e., regularly attending to HIV care appointments) may include the following:

1. Unmet psychological needs (such as substance use and mental health issues), which the PCM will address brief interventions and/or linkages to more intensive services;
2. Unmet socioeconomic needs (such as housing, transportation, food, financial security), which the Case Worker will work to resolve through linkages to needed services;
3. Unmet HIV care needs (such as multiple co-morbidities, low HIV care and treatment knowledge), which the MCM will address with the clinical care team; and/or
4. Ongoing competing needs (such as having to work, childcare) (Giordano, 2011), which the PCM and Case Worker will work to resolve with the patient through care coordination.

A primary objective of MCC is to assist patients in accessing HIV treatment so they are more likely to stay engaged and retained in HIV medical care. The MCC team may accomplish this by the following:

- Identifying newly diagnosed individuals and patients who have not had adequate follow-up appointments with their HIV provider;
- Addressing and reducing patient or system barriers to HIV care;
- Assessing and increasing patient motivation (readiness) to engage in HIV care;
- Improving patient self-care capacity to navigate the healthcare system.

Patients will vary in their motivation or readiness to stay engaged in HIV care. Understanding where patients are along the behavior change continuum (pre-contemplation, contemplation or preparation) helps the MCC team to determine the types of strategies needed to improve attendance to and engagement in HIV care. The "Readiness to Change – Engagement in HIV Care" tool (see Appendix P) can help the MCC team tailor intervention delivery.

The table below lists the stage of change and the related process of change or action to move patient towards successful engagement and retention in care:

Table 4: Stages of Change and Actions/Interventions Applied to Engagement in HIV Care Goals

Stage	Process of Change
Pre-contemplation : Patient is not aware of/does not see importance of receiving consistent medical care	▪ Raise patient's awareness around the consequences of not seeking care and the benefits of improved health status (pros and cons)
Contemplation: Patient knows that regular HIV care is important but is ambivalent or is not sure about ability to do it.	▪ Educate and counsel about how consistent medical care leads to improved health outcomes; ▪ Highlight that benefits of consistent care outweigh the costs

Ready for action: Patient is ready to engage in consistent HIV care	▪ Through education and referrals, work with patient to reduce/address potential barriers to care;
	▪ Describe to patient what to expect:
	  ▪ frequency of appointments
	  ▪ what routine appointments involve
	  ▪ how to talk to provider
	  ▪ Make reminder phone calls?

Action: Patient has been consistently attending appointments for ≤6 months	▪ Build self-efficacy regarding attendance and provide concrete positive feedback such as improved clinical outcomes
Maintenance : Patient has been consistently attending appointments for >6 months	▪ Support sustained attendance through self-efficacy building and positive feedback; ▪ Work with patient to improve sources of social support to minimize relapse

The MCC team can provide positive feedback and reinforcement to patients regarding their efforts to attend their HIV care appointments and follow treatment recommendations. Both viral load and CD4 count data can be used to see how their clinical care attendance can affect their health (Swedeman, Ingram, & Rotheram-Borus, 2009). Information from the Assessment can be used to show patients improvement in their HIV knowledge (page 9, questions 1-3) and reductions in their acuity in Section III. Providing opportunities for positive feedback can strengthen and support behavior change.

Best Practices to Improve Engagement and Retention in Care

While not all strategies will work for all patients, the strategies listed below are evidence-based and/or expert recommendations that can be tailored to meet the individual needs of patients. The MCC team may implement the following:

- **Explain to patients what to expect as they start or re-engage in HIV care**. Let patients know that when they are starting care or returning to care, they may need to attend more frequent appointments. However, the frequency of appointments and blood draws will likely decrease significantly once their disease is under control, particularly if they remain adherent to treatment.

- **Educate patients so they understand their HIV care and treatment.** Explain to patients how ART works to suppress the amount of HIV virus in their bodies and how they can monitor their HIV by understanding their CD4 and viral load measures. Explain that even if they are not experiencing any symptoms related to HIV, the virus is still affecting their body negatively. Explain that if individuals are on regular treatment and the virus is suppressed, their life expectancy will be near normal.

- **Give a tour of the clinic** (Macharia, Leon, Rowe, & et al, 1992). After the first or second meeting with the patient, offer to show him/her around the clinic pointing out where:
    - sub-specialty services are provided;
    - benefits specialty staff are housed;
    - the restrooms are located;
    - MCC staff are based; and,
    - any other relevant services are located.

  Also, introduce the patient to the front desk and scheduling staff, and any other key staff.

- **Discuss how to schedule appointments at the clinic**. Since the process of scheduling appointments may differ by clinic, let patient know:
    1. if appointment reminders are used (telephone calls or letters);
    2. if walk-in patients are seen or if same-day appointments are available; or
    3. if patients can schedule an appointment at a time that is convenient for them or are they assigned the next available appointment;

Key notes:

1. If appointment reminders will not be performed by other clinic staff, the MCC team should contact active MCC patients 1-2 days in advance to remind them of their upcoming appointment. Work with the scheduling staff to schedule an appointment that is convenient for the patient.

2. Work with the clinic to develop "fast-track" and/or same day appointments for newly diagnosed HIV patients to ensure immediate linkage from testing sites.

- **Clearly inform patients how to contact the MCC team and their physician**. This includes when to expect a reply, how to get an urgent same day appointment, when to go to ER, etc.

- **Monitor the appointment schedule and contact patients with missed appointments** (Giordano, 2011). The appointment schedule should be reviewed daily to identify any MCC patients coming in clinic that day. MCC staff should contact any active MCC patients (and self-managed, if time permits) who do not attend their appointments within 24 hours to address any issues or barriers and work to resolve them. Document all contacts and missed appointments in the MCC section of the patient medical chart.

- **Help patients learn how to communicate with their providers** (Giordano, 2011). Suggest that patients write down a list of concerns or questions they want to discuss with their doctor a few days before their appointment since it is easy to forget things at the last minute. Explain to patients that they should bring this list to their appointment and either describe or show it to their doctor. Explain that the doctor will appreciate knowing what the patients concerns are at, particularly at the beginning of the visit. This strategy empowers patients to take responsibility for their own care.

Patient Education

Information alone rarely changes behavior but is the foundation on which further interventions must be based. Without a fundamental understanding of HIV and other sexually transmitted infections (STIs), transmission and treatment, patients will be unable to protect themselves and others from infection and re-infection, or make informed decisions about their treatment. HIV education and skills may also be needed to prevent further HIV transmission and patient acquisition of additional STIs work in concert to promote HIV/STI risk reduction. Patients should know:

1. The difference between HIV and AIDS
2. How HIV is transmitted
3. Basic information on how to reduce risk for HIV/STIs
4. Skills necessary to reduce risk (e.g., using condoms, cleaning needles and works, obtaining new needles and works)
5. How HIV treatment works
6. Whether they are ready to begin ART treatment successfully

The MCC team should be equipped to provide accurate health information and education to patients, regarding HIV prevention, transmission, risk behavior management and treatment. They may also need to offer prevention, education and counseling services to family, partners and social affiliates. The main objectives for this intervention are to:

1. Increase patient knowledge about HIV care and what is required for successful disease management;
2. Improve health literacy; and
3. Improve patient self-care capacity to navigate the healthcare system.

Key notes:

- It is important to deliver all information as simply and straightforward as possible. Use simple, non-technical words (e.g., minimize acronyms), and keep your statements as brief as possible.
- Ensure written material is easy to read. Choose materials with clean formatting and simple, plain language with a 7th grade literacy level or (preferably) less. For more tips on plain language, see Appendix Q.
- When you don't know the answer, say "I don't know" and find the correct information by the next time you meet with the patient.

Social Support and HIV Disclosure

Social support systems are critical in assisting patients to change behavior and maintain healthy habits. Family, friends and partners all play a role in helping—or hindering—the patient's success. The MCC team encourages patients to identify positive influences, strengthen existing support, and foster new supportive relationships. This may require helping patients with HIV disclose their status to members of their social support system - family, friends or partners- and engaging these social support system members in HIV/AIDS and/or risk reduction strategies. It is also an opportunity to explore the patient's comfort with existing or potential support systems, including disease-, identity-, or hobby-specific (support) groups and faith-based communities.

The main objectives for Social Support and HIV Disclosure intervention are as follows:

- The PCM and Case Worker assesses and evaluates patients' existing support network and sources of social support;
- The PCM and Case Worker increases the number of supportive people in the patient's life that can encourage and support their efforts to adhere to HIV care and ARTs;
- The PCM and Case Worker connects patients new to ARTs and/or HIV care with peers who may be able to empathize and offer support and information;
- The MCC team offers HIV disclosure assistance through Partner Services activities.

HIV Disclosure and Partner Services

The topic of patients disclosing their HIV status is typically framed with regard to needle sharing and sex partners as a strategy to promote risk reduction. However, it is equally important to encourage disclosure to family, friends and future sex and needle-sharing partners when the need arises. Patients who are able to disclose their HIV status typically benefit through greater acceptance of and comfort with HIV status; a reduction in stress related to disclosure issues; and increased social support from partners, family and friends, which can improve HIV treatment plan adherence and overall wellness. Patients who disclose their HIV status to friends and family are more likely to be retained in HIV care (Wohl, Galvan, Myers, & et al, 2011). Consider disclosure assistance as a tool to enhance social support and treatment adherence.

Partner Services (PS) also remains an essential prevention strategy designed to assist patients in disclosing their HIV status to past and current sex and needle-sharing partners with the goals of reducing HIV risk behavior and promoting HIV testing among those exposed to HIV (Mathews, Coetzee, Zwarenstein, & et al, 2002). This intervention ensures that partners are notified of exposure to HIV and that all notified partners are offered appropriate testing opportunities and linkages to other needed services if HIV positive. Three options for partner notification exist: self, dual, and anonymous third-party.[6]

- **Self disclosure**: patient tells their partner(s) with support from the provider in developing a plan.

- **Dual disclosure**: patient tells their partner(s) in the presence of and with the support of the provider.

- **Anonymous third-party**: patient wants to remain anonymous while a trained professional notifies partner(s).

[6] As mentioned earlier, discourage partner notification if it might lead to intimate partner/domestic violence or other abuse. Keep in mind that Youth Case Managers should not initiate dual disclosure and third-party notification options if there is a potential threat to the patient, provider or field worker (e.g., Public Health Investigator).

See Appendix L for a list of recommended intervention activities and frequency of follow-up by acuity.

Best Practices to Enhance Social Support

Social support needs are unique for each patient depending on his/her HIV disclosure experience, perceived stigma related to his/her HIV status and life experiences. While not all strategies will work for all patients, the strategies listed below are evidence-based and/or expert recommendations that can be tailored to meet the individual needs of patients:

1. **Talk to patients about feeling stigma related to their HIV status**. Increased feelings of stigma can affect successful ART adherence and retention in HIV care (Variable, Carey, Blair, & Littlewood, 2006). Education around HIV care and management can help patients better understand and cope with their diagnosis, as well as to better educate those around them.

2. **Identify strategies to help patients cope with stress**. Patients may feel stress from dealing with their HIV status as well as stress from family and friends. Work with patients to identify positive coping strategies to manage stressful situations such as reframing, giving positive affirmations, exercising, mediating, getting enough rest and seeking mental health support as needed.

3. **Provide opportunities for patients to strengthen sources of support.** Work with patients to identify family and friends who can encourage and support their efforts to adhere to HIV care and ARTs. Connect patients new to ARTs and/or HIV care with peers who may be able to empathize and offer support and information. Acknowledge the role of patients' spiritual and/or religious sources of support. Increase the scope of patients' support networks by connecting them to support groups related to their interests/needs.

All MCC team members are trained by DHSP to provide the Partner Services training developed by the State of California.

Linkage to Support Services

When MCC patients need services beyond the scope of MCC service delivery, the MCC team links patients to other programs or agencies that provide the needed support services. These linkages to support services can reduce barriers to HIV care and adherence to ARTs (Sherer, Stieglitz, Narra, & et al, 2002); (Aidala, Lee, Abramson, Messeri, & Siegler, 2007). The most commonly needed support services are mental health, substance abuse

treatment, financial assistance, housing assistance, legal services, and transportation. The PCM facilitates linkages to mental health and substance abuse treatment with the Case Worker's support, while the Case Worker is primarily responsible for linkages to socioeconomic services (e.g., financial assistance, housing assistance, legal services, and transportation). The MCC team is responsible for linking patients to needed services when indicated by the Assessment **within fourteen (14 days)**; patients should be successfully linked **within thirty (30) days** after referral.

Substance Abuse Treatment Referrals

The MCC team should refer any severe or high acuity patients to substance abuse treatment services for further evaluation. It is also recommended that the MCC team deliver Options/Opciones to patients with identified drug addictive behaviors. (see **Promoting Safer Sex and Risk Reduction)**.

For moderate acuity patients, the MCC team should follow up monthly, in order to monitor changes in drug and/or alcohol use or to determine if treatment is needed. Patients may vary in their readiness to seek treatment, so the MCC staff may need to use MI techniques to educate and motivate patients to enter into substance treatment programs and services.

Mental Health Treatment Referrals

For patients with severe or high mental health acuity, or who screen positive for depression or anxiety on the Assessment, the **MCC staff should inform the patient's medical provider**. Together the medical provider and the MCC team can decide on an action plan and whether a mental health referral is needed. (It is not needed in all cases, as many HIV providers can treat uncomplicated depression or anxiety without a MH provider being involved).

While some patients may need to be linked immediately to mental health services for further assessment, other patients with existing mental health issues may require support to return to or to stay engaged in mental health services. Use MI techniques to encourage patients and educate them about the importance of MH services. For patients with existing mental health issues who do not want to return to mental health services, the MCC staff should:

- discuss this issue with the patient's medical provider; and
- present the patient at case conferencing to strategize with other providers to get the patient back into care.

If patients indicate that they are a danger to self or others, contact the clinic supervisor and refer for immediate evaluation as directed.

Key note:

Because drug and/or alcohol use often co-occurs with mental illness (Chander, Himelhoch, & Moore, 2006), the MCC team should review the Mental Health section of the Assessment for severe and high acuity patients to assess if there are co-morbid mental health issues that may complicate addressing any substance treatment efforts.

Documenting support services referrals

The MCC staff document all referrals provided in the MCC progress notes in the medical record and in DHSP DMS. All documentation includes the following elements:

1. Date of the referral
2. Type of referral
3. Reason for referral
4. Date of referral linkage
5. Name of MCC team member providing the referral

Strategies for successful service linkage

To ensure successful linkage of support service referrals:

1. Consider limiting the number of referrals made at a given time so patients are not overwhelmed. Prioritize based on need with the patient and document immediate referrals on care plan.

2. Ensure referral services are appropriate to a patient's culture, language, gender, sexual orientation, age, and development levels. Check in with patient to assess their comfort level with the possible referral options.

3. Call ahead to confirm the referral site can accommodate the patient. Services may be limited to the type of population(s) served and availability.

4. When possible, call the agency or initiate the first appointment while with the patient. Otherwise, provide a specific contact person with relevant contact information. Contact information includes agency name, address/location, telephone number, types of services, hours, eligibility requirements, costs, time frame to get a 'usual' appointment, and process for making an appointment/securing services. Write down the information and/or encourage

patient to program the number (and information, if possible) into their cell phone or offer to send information via text message or e-mail.[7]

5. Provide maps and transportation information (e.g., http://maps.google.com/ or www.metro.net).

6. Review what patient should expect, including length of time they should expect to wait for and at an appointment, and what they will be required to provide during the appointment, if applicable.

7. Assess and address any other barriers to accessing the referral. Identify strategies to overcome these barriers with the patient.

8. Arrange to call the patient (or have the patient call you) to follow up on referral to ensure linkage and elicit feedback on services received.

TRANSITION & CASE CLOSURE

MCC services assist patients in successfully managing their HIV care with the goal of fostering patient autonomy and self-sufficiency. It is anticipated that patients will transition out of active MCC services once they are deemed self-managed, and able to access and navigate the care and social service system network effectively.

Patient Transition

Patients may transition from active MCC services when they:

1. achieve a self-managed state
2. decline/opt out of active MCC services
3. seek services elsewhere or at another HIV PCMH

Patient Achieves Self-Managed Acuity

All eligible patients are enrolled in MCC, and the screening process differentiates eligible patients who are self-managed from those who need active MCC services. The clinic will continue to screen patients who are considered self-managed on a semi-annual basis for any changes to their health status and life circumstances that may warrant active MCC

[7] It is inappropriate to provide a written referral for domestic/intimate partner violence, since it may compromise patient safety if found by perpetrator. Encourage patient to memorize resources, like the National Domestic Violence Hotline: 1-800-799-SAFE (7233)

services. For patients in need of active MCC services, the MCC team works with them to reduce patient acuity over a twelve (12) month period with the ultimate goal of transitioning these patients to a self-managed state. This process may take longer than 12 months for patients with severe or high acuity due to complex life situations. **Active MCC services may be delivered until acuity is reduced to self-managed.**

- Active MCC patient will be considered self-managed once their overall acuity score is 12-25 based on the assessment.

- Continue to screen patient every six (6) months for active MCC services.

Patient Opts-Out or Declines Active MCC Services

There may be some instances when patients need active MCC services based on their acuity but may decline the service or voluntarily terminate services after initiation and opt-out of MCC services to manage their own care. In these cases, the MCC team should transition these individuals from active to self-managed services with the hope that they can successfully engage the patient in active MCC services at a later time. In these cases, the MCC team should:

1. Present patient at case conference and/or clinical supervision to receive guidance on possible ways to engage patient.

2. Screen patient every six (6) months for active MCC services and attempt to re-engage patient.

Patient Transitions to Another Provider

The MCC team transitions patients to other MCC service delivery site in Los Angeles County when the patient:

1) chooses to seek MCC services elsewhere in Los Angeles County
2) becomes incarcerated long-term (6 months or more)

- Work with patient to identify another MCC provider in Los Angeles County. If patient is in custody, link patient to Transitional Case Management (TCM) program.

- Obtain written consent from patient to share records.

- Ask permission to, and if granted, contact patient or provider to follow up and confirm successful patient transition.

- Complete the Case Transition/Closure form and update all case notes.

Case Closure

Case closure only occurs when the patient no longer qualifies for MCC services (e.g., relocates outside of Los Angeles County), dies or is discharged due to threatening and/or abusive behavior directed toward the clinic staff or other clinic patients. In these cases, the MCC team completes a Case Transition/Closure form and updates all case notes within one month of the qualifying date.

If the patient has died, the MCC staff should also complete the case closure form in DHSP DMS. Be aware that case closure in the data system will automatically close the case for all providers offering services in the network of HIV care throughout Los Angeles County.

Documentation

The Case Transition/Closure form should include the following information:

- Date and signature of MCC team and Clinical Supervisor
- Date of case transition/closure
- Status of the ICP (unnecessary in case of patient death)
- Status of primary health care and support service utilization (unnecessary in case of patient death)
- Reason(s) for transition and criteria for re-entry into active services, if applicable

See Appendix R for sample Case Transition/Closure Form.

DHSP ADMINISTRATIVE REQUIREMENTS

For agencies contracted by the Division of HIV and STD Programs (DHSP) to deliver MCC services, there are additional administrative requirements outlined in the Medical Care Coordination (MCC) service agreements. Review the administrative requirements that are in addition to the expectations for direct service delivery outlined above.

Clinical Supervision

Clinical supervision is a type of mentorship between a supervisor and their staff, and enhances knowledge, skills, and attitudes that are important in working with patients. The goal is to increase job performance by enhancing skills and decreasing job related stress that interferes with peak work performance. Clinical supervision ensures that professional guidance and high quality of services are provided by assisting MCC team members in problem-solving issues related to a patient's progress towards meeting their goals. Clinical

supervision may be conducted in individual or group multidisciplinary team case conference formats.

The Nursing Executive, Nursing Supervisor or Nursing Director, in collaboration with the medical team and Medical Director/HIV Specialist, is responsible for clinically supervising the medical care manager (MCM). The MCM is responsible for clinically supervising any case workers with a Bachelor's degree in Nursing or who are Licensed Vocational Nurses (LVNs). The patient care manager (PCM) shall clinically supervise case workers with a Bachelor's degree in Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or other related human services.

The MCC team will maintain documentation of clinical supervision in the patient record. Required documentation includes:

1. Date of clinical supervision and name or identification number of patient;
2. Name, title, and initials of clinical supervision participants;
3. Psychosocial issues and concerns identified;
4. Description of clinical guidance provided;
5. Verification that the previous clinical guidance provided and suggested interventions have been implemented; and
6. Clinical supervisor's name, professional title and signature.

See Appendix S for sample Clinical Supervision form.

Staff Development

Continuing education is critical for the professional growth of the MCC team. All DHSP-funded MCC staff are required to participate in the following trainings <u>in addition</u> to on-going agency staff training and support:

- **DHSP Data Management System Training**: The training is offered by Automated Case Management System (ACMS) and is designed to familiarize staff with data entry and tracking service delivery in the electronic data collection system called Casewatch. Call ACMS at (323) 460-7700 to schedule a training once staff is authorized by the DHSP Program Manager.

- **MCC Training Series**: This training series provides an opportunity to further develop staff capacity to delivery MCC services. It does <u>not</u> offer formal certification. The trainings will cover:
  - MCC process components and guidelines for service delivery
  - Motivational interviewing
  - Adherence Enhancement Program implementation

  Contact the DHSP Program Manager for upcoming training dates.

- **Partner Services Training**: Formerly known as Partner Counseling / Risk Reduction Services (PCRS), the training offers an overview of disclosure assistance services and enhances skills needed to support patients in making an informed decision about HIV disclosure. Training is available on how to support patients and deliver partner services. For more information about training opportunities offered by DHSP, visit their website at www.ph.lacounty.gov/aids. A provider training calendar with dates and course descriptions is located at http://www.ph.lacounty.gov/aids/trainings.htm . The California STD/HIV Training Center also offers training courses on Partner Services. Visit their website at: http://www.stdhivtraining.org

- **Sixteen (16) hours of continuing education per year**.[8] This may be in-person or web-based trainings. Staff development and enhancement activities should include, but not be limited to:
  - HIV/AIDS medical and treatment updates;
  - Risk behavior and prevention interventions;
  - Substance use and treatment;
  - Mental health and HIV/AIDS;
  - Family dynamics and developmental issues;
  - Youth development and cultural competency; and
  - Marginalized populations (e.g., homeless or formerly incarcerated individuals).

Documentation on file verifying staff attendance is required, such as a certificate of completion or letter verifying training completion. It should include:

1. Participant's name
2. Name of training
3. Sponsoring agency
4. Date of training
5. Length of training (or number of continuing education credits)

Resources on in-person and/or online training opportunities for MCC team may include, but are not limited to:

1. Charles Drew University Pacific AIDS Education and Training Center (www.HIVtrainingCDU.org)
2. HIV Drug and Alcohol Taskforce (http://hivdatf.org)
3. Hollywood Homeless Youth Partnership (http://hhyp.org)
4. Shared Action (www.sharedaction.org)
5. STD/HIV Prevention Training Center (www.stdhivtraining.org)

[8] The Case Manager Training and/or Partner Services Training fulfill the 16 hours of continuing education requirement during the contract year it is attended.

6. The Center for Strengthening Youth Prevention Paradigms (SYPP): www.chla.org/site/c.ipINKTOAJsG/b.6092439/k.E43F/Center_for_Strengthening_Youth_Prevention_Paradigms.htm#)
7. The New York/New Jersey AIDS Education and Training Center (AETC) (www.nynjaetc.org)

Monthly Reports

Agencies must enter, track and report patient service delivery data to DHSP via monthly reports using Casewatch, the current data collection system mandated by DHSP. The monthly report tracks:

1. Number of unduplicated patients served
2. Number of direct patient service hours: time spent with or on behalf of patient
3. Number of unduplicated patients discussed during case conference
4. Number of unduplicated patients discussed during clinical supervision
5. Number of patients and hours devoted to intervention and follow-up activities, including:
   - Implementation, Monitoring, and Follow-Up
   - Engagement in HIV Care and Patient Education
   - Risk Reduction Counseling
   - Antiretroviral Adherence Counseling
   - Partner Services/Disclosure Assistance
   - Other Interventions
6. Number of referrals made and linked, including
   - Housing Services
   - Mental Health Services
   - Substance Abuse Treatment
   - Partner Services
   - Other Services

See Appendix T for an example of a daily tracking log to assist providers in recording their time spent with patients.

The monthly report must also include a narrative that describes:

1. Agency's performance in meeting program goals/objectives;
2. Strategies (planned and implemented) to resolve barriers in meeting goals/objectives and results of these strategies;
3. Agency progress in collecting outcomes data; and
4. Implementing plan of corrective action (if applicable). (see Appendix U for monthly narrative template)

The complete monthly report must be submitted no later than **thirty (30) days after the end of the reporting month**. For example, April's monthly report is due no later than May 30th. The report is only complete once it contains all report sections. The sections include:

1. Section I: Cover Summary Page
2. Section II: Patient Demographics
3. Section III: Task Summary Report
4. Section IV: Monthly Narrative

Section I through III are generated automatically by Casewatch when running the monthly report. Section IV is completed separately and submitted concurrently.

In order to submit the monthly report:

1. Ensure all service delivery data for the reporting month is entered.

2. Generate the monthly report using Casewatch.

3. Review the monthly report for accuracy before the agency's designee signs the document**. Signature confirms approval and accuracy of reported information**. If the report is incorrect, follow up with staff or ACMS to correct any errors.

4. Complete and include the monthly report narrative.

5. Scan a copy of the signed monthly report to Finance Services at DHSP and e-mail a copy to the DHSP Program Manager.

6. It is recommended to keep an electronic copy or make a paper copy for your records (optional). There are instances when reports may be lost.

7. Mail or deliver the original signed copy of the monthly report to:
   Dave Young, Finance Director
   Financial Services Division
   Division of HIV and STD Programs
   600 South Commonwealth Avenue, 10th Floor
   Los Angeles, California 90005

Monthly reports are frequently sent with contract invoices (two copies), since invoices are not processed without receipt of the monthly report. However, some agencies send the monthly report and invoices separately if their programmatic and administrative arms are separate.

Patient Charts

All MCC services delivered must be documented **in the patient's primary medical chart**. This encourages full integration of MCC into the clinic setting and allows all clinic service providers to access MCC-related information.

File organization

The MCC team should:

1. Create a separate MCC file tab used only for MCC documentation in each active MCC patient's medical chart at enrollment. This includes all MCC-related patient interactions, documentation and required reports.

2. Neatly maintain and organize the files.

3. Update patient information in the MCC file in a timely manner (within 24 hours of contact). Memory recall is unreliable after days to weeks have elapsed since the date a contact was made.

4. Keep all progress notes current and maintain a copy in the patient's MCC file. These notes may be reviewed by other members of the medical team and may be important for future service activities.

At a minimum, the patient's MCC file must contain the following MCC documents, preferably in the following order:

1. Registration/Intake Documentation
2. Enrollment Status
3. MCC Assessments in reverse chronological order (the most current assessment on top)
4. ICP (initial and revisions)
5. Patient monitoring
6. Documentation and Progress Notes
7. MCC Patient Termination or Discharge

File storage and retention

All MCC files are stored as part of the patient medical chart. These charts are stored according to agency protocol but should be consistent with HIPAA policies. At a minimum, the storage system should be a locked file cabinet in a secured room or facility that only MCC and agency staff can access. MCC and agency staff must maintain the confidentiality

of all data and records included in the MCC patient files and shall comply with state and federal laws, including, but not limited to clinic procedures and standards, and the DHSP data security and confidentiality requirements.

Contracted agencies must keep the MCC files for at least seven (7) years after the case has been closed. All closed case files will be destroyed after seven years or following agency protocol.

Maintaining Patient Confidentiality

It is important to ensure that patients' rights to privacy and confidentiality are maintained in the event that patient information is released to other providers or agencies for additional services. The MCC team should respect patients' right to privacy and only collect information that is essential to providing quality care services. All information about a patient and his/her significant others or family members should be held in the strictest confidence.

Information may be released to other professionals and agencies ***only with the written permission of the patient or his/her guardian***. The *Consent to Release Information or Records* details what information can be disclosed, to whom it may be disclosed, and for what purpose it will be disclosed. This consent will be reviewed, signed and dated by both the MCC staff member (MCM or PCM) and the patient upon enrollment in MCC and every six (6) months thereafter. The patient has the right to revoke this release by written request at any time. See Appendix V for a sample of the Consent to Release Medical Information and the Casewatch consent forms in English and Spanish.

The MCC team members must avoid discussing confidential information in any setting where privacy cannot be ensured, including public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants. The MCC team members should also protect the confidentiality of patients' written and electronic records, and other sensitive information, and must take reasonable steps to ensure that patients' records are stored in a secure location and are unavailable to others who are unauthorized to access them. The MCC team members shall take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information shall be avoided whenever possible.

Any person who willfully or negligently discloses a patient's HIV status, as defined in Section 120775 of the Public Health and Safety Code, to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in

Section 1603.1 or 1603.3 or any other statute that expressly provides an exemption to this section, that results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year or a fine of not to exceed ten thousand dollars ($10,000) or both.

While all efforts are taken to maintain patient confidentiality, there are certain exceptions. The *Notice of Privacy Practices* describes these exceptions and states that neither MCC staff nor the MCC site clinic shall disclose the patient's Protected Health Information (PHI) without the patient's permission, except in situations such as: 1) a patient harming himself/herself or others; or 2) suspected abuse or neglect of a child or a dependent adult. Inform all MCC patients of these exceptions during enrollment by providing them with a copy of the form and reviewing it with them. See Appendix W for a copy of this form.

Electronic patient data

The use of electronic files to gather and collect patient information requires specific precautions to avoid a breach of confidentiality and protect the patient's right to privacy. Electronic mail is never used to transmit unencrypted confidential information. Other electronic transmissions of confidential information must be safeguarded following current DHSP data security and confidentiality policies and protocols. As with hard copies, procedures should be in place to limit public access to electronic information that includes:

a) Placing computer monitors to prevent unauthorized viewing;
b) All computers including laptops that access or store confidential information must be password protected and the data must be encrypted in accordance with DHSP policies, protocols and procedures;
c) Laptops containing confidential patient information must never be taken from the clinic site and must be returned to the secured area at the end of the working day;
d) HIV/AIDS information cannot be faxed except in the case of a medical emergency, or with the written informed consent of the patient (see Appendix S-Consent to Release Information or Records)

People Living with HIV/AIDS Bill of Rights & Responsibilities

This statement outlines the rights and responsibilities of the patient to receive timely services delivered by courteous staff and the patient's role in working with the MCC team to develop the ICP and achieve the goals established therein. See Appendix X for the document.

Quality Assurance

It is highly recommended that MCC programs conduct regular internal audits to ensure program fidelity and compliance with DHSP requirements. See Appendix Y for a sample checklist.

Medical Care Coordination Performance Measures

Below are listed the DHSP performance measures for MCC. These are used to track how well the program is being delivered and patient outcomes.

Table 5: DHSP performance measures for MCC

Performance Measure	Indicator
1.1: Retention in HIV care	Percentage of **active and self-managed** MCC patients who had 2 or more medical visits at least 90 days apart within the past 12 months
1.2: Viral load suppression less than 200 copies/mL when on antiretroviral therapy (ART)	Percentage of **active and self-managed** MCC patients who are prescribed ART and achieve viral suppression (< 200 copies/mL) within the past 12 months
2.1: Provision of antiretroviral (ART) adherence intervention to high-risk MCC patients	Percentage of **active** MCC patients who are provided the ART adherence intervention in the past 12 months
2.2: Linkage to mental health programs	Percentage of **active** MCC patients who were successfully linked to mental health programs
2.3: Linkage to substance abuse programs	Percentage of **active** MCC patients who were successfully linked to substance abuse programs
2.4: Linkage to housing programs	Percentage of **active** MCC patients who were successfully linked to housing programs
2.5: Linkage to partner services	Percentage of **active** MCC patients who are successfully linked to partner services in the past 12 months
2.6: Provision of behavioral risk reduction counseling and education intervention	Percentage of **active** MCC patients who were provided the behavior risk reduction intervention in the past 12 months

Grievance Procedures

The MCC staff informs all new MCC patients about the grievance policies and procedures during the enrollment process. Patients will be reminded of the grievance policy if a problem is identified that may result in a grievance such as services being reduced, suspended, denied or terminated, or if a patient is dissatisfied with the way services were provided.

The Grievance Policy includes information about DHSP Grievance Line and additional methods of communication:

Phone: 1-800-260-8787
Email: oappgrievance@ph.lacounty.gov
Web: www.publichealth.lacounty.gov/aids/aidsresrc/grievance.htm
Address: Attention: QM Grievance Coordinator
600 S. Commonwealth Ave., 10th Floor
Los Angeles, CA 90005

See Appendix Z for a sample Grievance Procedures notification form.

Works Cited

Abramowitz, S. A., Flattery, D., Franses, K., & Berry, L. (2010). Linking a Motivational Interviewing Curriculum to the Chronic Care Model. *Society for General Internal Medicine, 25*(Suppl 4), 620-6.

Aidala, A. A., Lee, G., Abramson, D. M., Messeri, P., & Siegler, A. (2007). Housing Need, Housing Assistance, and Connection to HIV Medical Care. *AIDS and Behavior, 11*, 101-105.

Bangsberg, D. R., Hecht, F. M., Charlesbois, E. D., & et al. (2000). Adherence to protease inhibitors, HIV-1 viral load, and development of drug resistance in an indigent population. *AIDS, 14*, 357-366.

Berg, M. B., Safren, S. A., Mimiaga, M. J., & et al. (2005). Nonadherence to medical appointments is associated with increased HIV RNA and decreased CD4 cell counts in a community-based HIV primary care clinic. *AIDS Care*, 902-907.

Braithwaite, R. S., Conigliaro, J., Roberts, M. S., & et al. (2007). Estimating impact of alcohol consumption on survival for HIV+ individuals. *AIDS Care, 19*, 459-466.

Campbell, N. C., Tross, S., Hu, M., & et al. (2011). Female Condom Skill and Attitude: Results from a NIDA Clinical Trials Network Gender-specific HIV Risk Reduction Study. *AIDS Education and Prevention, 23*(4), 329-340.

Carey, M. P., & Schroder, K. E. (2002). Development and Psychometric Evaluation of the Brief HIV Knowledge Questionnaire. *AIDS Education and Prevention, 14*(2), 172-182.

Chander, G., Himelhoch, S., & Moore, R. D. (2006). Substance Abuse and Psychiatric Disorders in HIV-Positive Patients: Epidemiology and Impact on Antiretroviral Therapy. *Drugs., 66*, 769-789.

Cohen MS, C. Y., Cohen, M. S., Chen, Y. Q., McCauley, M., Gamble, T., & et al. (2011). Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine, 365*, 493-505.

Coleman, S. M., Rajabun, S., Cabral, H. J., & et al. (2009). Sexual risk behavior and behavior change among persons newly diagnosed with HIV: the impact of targeted outreach interventions among hard-to-reach populations. *AIDS Patient Care STDs, 23*, 639-.

Coury-Doniger, P. A., Levenkron, J. C., McGrath, P. L., & et al. (2000). From theory to practice: Use of stage of change to develop an STD/HIV behavioral intervention. *Cognitive and Behavioral Practice, 7*, 395-406.

DHHS. (2012). *Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents.* Retrieved September 26, 2012, from http://aidsinfo.nih.gov/guidelines/: http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf

Division of HIV and STD Programs. (2012). *Policy Brief: HIV Prevention Through Care and Treatment.* Los Angeles: Los Angeles County Department of Public Health. Retrieved from http://publichealth.lacounty.gov/aids/reports/TLCBrief4-12.pdf

Ernst, A. A., Weiss, S. J., & Cham, E. (2004). Detecting Ongoing Intimate Partner Violence in the Emergency Department Using a Simple 4-Question Screen: The OVAT. *Violence and Victims, 19*(3), 375-384.

Fisher, J. D., Fisher, W. D., Cornman, D. H., & et al. (2006). Clinician-Delivered Intervention During Routine Clinical Care Reduces Unprotected Sexual Behavior Among HIV-Infected Patients. *Journal of Acquired Immunodeficiency Syndrome, 41*(1), 44-52.

Fleishman, J. A., Moore, R. D., Conviser, R., & et al. (2008). Associations between outpatient and inpatient service use among personal with HIV infection: a positive or negative relationship? *Health Serv Res, 43*, 76-95.

Giordano, T. P. (2011). Retention in HIV care: what the clinician needs to know. *Topics in Antiviral Medicine, 19*(1), 12-16.

Health Resources and Services Administration. (2011). *Guide for HIV/AIDS Clinical Care.* Retrieved from http://hab.hrsa.gov/deliverhivaidscare/clinicalguide11/: http://hab.hrsa.gov/deliverhivaidscare/clinicalguidelines.html

HIV Epidemiology Program, L. A. (2009). *An Epidemiologic Profile of HIV and AIDS in Los Angeles County.*

Kalichman, S. C., Cherry, C., White, D., & et al. (2011). Sexual HIV Transmission and Antiretroviral Therapy: A Prospective Cohort Study of Behavioral Risk Factors Among Men and Women Living with HIV/AIDS. *Annals of Behavioral Medicine, 41*(1), 111-119.

Katz, S., Ford, A. B., Moskowitz, R. W., & et al. (1983). Studies of illness in the aged. The index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association, 185*, 914-919.

Klinkenberg, W. a. (2004). Mental disorders and drug abuse in persons living with HIV/AIDS. *AIDS Care, 16 (Supplement 1)*, S22-S42.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606-613.

Lawton, M. P., & Brody, E. (1969). Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist, 9*, 179-186.

Liegal, B. (2006). How to make the care management model work. A case study. *The Case Manager, 5(2)*, 51-54.

Lucas, G. M., Chaisson, R. E., & Moore, R. D. (1999). Highly active antiretroviral therapy in a large urban clinic: risk factors for virologic failure and adverse drug reactions. *Ann Intern Med, 131*, 81-87.

Macharia, W. M., Leon, G., Rowe, B. H., & et al. (1992). An overview of interventions to improve compliance with appointment keeping for medical services. *JAMA, 267*(10), 1813-17.

Mathews, C., Coetzee, N., Zwarenstein, M., & et al. (2002). A systematic review of strategies for partner notification for sexually transmitted diseases, including HIV/AIDS. *International Journal of STD & AIDS, 13*, 285-300.

McGowan, J. P., Shaw, S. S., Ganea, C. E., & et al. (2004). Risk Behavior for Transmission of Human Immunodcficiency Virus (HIV) among HIV-Seropositive Individuals in an Urban Setting. *Clinical Infectious Diseases, 38*, 122-27.

Metsch, L., Pereyra, M., Messinger, S., & et al. (2008). HIV Transmission Risk Behaviors among HIV-Infected Persons Who Are Successfully Linked to Care. *Clinical Infectious Diseases, 47*, 577-84.

Mugavero, M. J., Lin, H. Y., Allison, J. J., & et al. (2005). Racial disparities in HIV virologic failure: do missed appointments matter? *JAIDS, 19*, 423-431.

Mugavero, M. J., Lin, H. Y., Willig, J. H., & et al. (2009). Missed visits and mortality among patients establishing initial outpatient HIV treatment. *Clinical Infectious Diseases, 48*, 248-256.

Osborn, C. Y., Davis, T. C., Bailey, S. C., & Wolf, M. S. (2010). Health Literacy in the Context of HIV Treatment: Introducing the Brief Estimate of Health Knowledge and Action (BEKHA)-HIV Version. *AIDS and Behavior, 14*, 181-188.

Owens, M., Wollersheim, H., Hermens, R., & et al. (2005). Integrated care programmes for chronically ill patients: A literature review. *International Journal for Quality in Health Care, 17*(2), 141-149.

Paterson, D. L., Swindells, S., Mohr, J., & et al. (2000). Paterson DL, Swindells S, Mohr J, Brester M, Vergis EN, Squier C et al. Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Annals of Internal Medicine, 133*, 21-30.

Prochaska, J. O., & DiClemente, C. C. (1982). Stages and Process of Self-Change of Smoking: Towards an Integrative Model of Change. *Journal of Consulting and Clinical Psychology, 51*, 390-395.

Prochaska, J. O., & Velicer, W. F. (1997). Misinterpretations and misapplications of the transtheortical model. *American Journal of Health Promotion, 12*, 11-12.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*(47), 1102-14.

Prochaska, J. O., Redding, C. A., & Evers, K. E. (1997). The Transtheoretical Model and Stages of Change. In L. F. Glanz K (Ed.), *Health Behavior and Health Education: Theory, Research and Practice* (2nd ed., pp. 66-84). San Francisco, CA: Jossey-Bass Inc.

Rollnick, S. &. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*, 325-334.

Rosen, S. L., & Reuben, D. B. (2011). Geriatric Assessment Tools. *Mt Sinai J Med, 78*(4), 489-97.

Saliba, S., Elliott, M., Rubenstein, L., & et al. (2001). The Vulnerable Elders Survey (VES-13): A Tool for Identifying Vulnerable Elders in the Community. *Journal of the American Geriatric Society, 49*, 1694-1699.

Sethi, A. K., Celentano, D. D., Gange, S. J., & et al. (2003). Association between Adherence to Antiretroviral Therapy and Human Immunodeficiency Virus Drug Resistance. *Clinical Infectious Diseases, 37*, 1112-8.

Sherbourne, C. D., & Stewart, A. L. (1991). The MOS Social Support Survey. *Soc Sci. Med., 32*(6), 705-714.

Sherer, R., Stieglitz, K., Narra, J., & et al. (2002). HIV multidisciplinary teams work: support services to improve access to and retention in HIV care. *AIDS Care*, S31-44.

Simoni, J. M., Amico, K. R., Pearson, C. R., & Malow, R. (2008). Strategies for Promoting Adherence to Antiretroviral Therapy: A Review of the Literature. *Current Infectious Disease Reports, 10*, 515-521.

Soto, T. B. (2004). Literature on integrated HIV care: a review. *AIDS Care, 16 (Supplement 1)*, S43-S55.

Spitzer RL, K. K., Spritzer, R. L., Kroenke, K., Williams, J. B., & et al. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine, 166*, 1092-1097.

Stoff, D. M., Mitnick, L., Kalichman, S., & et al. (2004). Research issues in the multiple diagnoses of HIV/AIDS, mental health illness and substance abuse. *AIDS Care, 16* (Supplement 1), S1-S5.

Swedeman, D., Ingram, B., & Rotheram-Borus, M. J. (2009). Common elements in self-management of HIV and other chronic illnesses: an integrative framework. *AIDS Care, 21*(10), 1321-1334.

Tobias, C. R., Cunningham, W., Cabral, H. D., & et al. (2007). Living with HIV but without medical care: barriers to engagement. *AIDS Patient Care and STDs, 21*, 426-34.

Tucker, J. S., Burnham, M. A., Sherbourne, C. D., & et al. (2003). Substance Use and Mental Health Correlates of Nonadherence to Antiretroviral Mediations in a Sample of Patients with Human Immunodeficiency Virus. *American Journal of Medicine, 114*, 573-580.

UCSF AIDS Health Project, & Office of AIDS. (2008). Building Quality HIV Prevention Counseling Skills: The Basic I Training for Counselors II Staff Working in HIV Counseling and Testing - Participant's Manual. San Francisco: UCSF AIDS Health Project.

Ulett, K. B., Willig, J. H., Lin, H., & et al. (2009). The therapeutic implications of timely linkage and early retention in HIV care. *AIDS Patient Care and STDs, 23*(1), 41-49.

Variable, P. A., Carey, M. P., Blair, D. C., & Littlewood, R. A. (2006). Impact of HIV-Related Stigma on Health Behaviors and Psychological Adjustment Among HIV-Positive Men and Women. *AIDS and Behavior, 10*(5), 473-482.

Wagner, G., Kanouse, D. E., Golinelli, D., & et al. (2006). Cognitive-behavioral intervention to enhance adherence to antiretroviral therapy: a randomized controlled trial (CCTG 578). *AIDS, 20*, 1295-1302.

Walensky, R. P., Paltiel, A. D., Losina, E., & et al. (2006). The survival benefits of AIDS treatment in the United States. *Journal of Infectious Diseases, 194*(1), 11-19.

Washington State Department of Health. (2004). *System Acuity Measurement for HIV Care Case Management.* Olympia: Washington State Department of Health.

Wilson, P. (2006). Medical case management: A look at the Ryan White HIV/AIDS Treatment Modernization Act of 2006. *The 19th Annual National Conference on Social Work and HIV/AIDS.* Albuquerque, New Mexico.

Wohl, A. R., Galvan, F. H., Myers, H. F., & et al. (2011). Do Social Support, Stress, Disclosure and Stigma Influence Retention in HIV Care for Latino and African American Men Who Have Sex with Men and Women? *AIDS and Behavior, 15*, 1098-1110.

List of Appendices

All appendices are available and can be accessed on the DHSP website at http://www.ph.lacounty.gov/aids/Contractors.htm.