LOS ANGELES COUNTY
COMMISSION ON HIV

MEDICAL CARE COORDINATION STANDARDS OF CARE

DRAFT 8/13/18

PUBLIC COMMENT PERIOD: 8/13/18 - 8/31/18

Email comments to: hivcomm@lachiv.org

INTRODUCTION

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards are to ensure that all Ryan White service providers offer the same fundamental components of the given service category. The standards establish the minimal level of care that a Ryan White funded agency or provider may offer in Los Angeles County.

The Los Angeles County Commission on HIV developed the Medical Care Coordination Services Standards of Care to ensure people living with HIV (PLWH) receive coordinated medical and non-medical care regardless of where services are received in the County. The development of the Standards included review of and alignment with the *Guidelines for the Provision of HIV/AIDS Medical Care Coordination Services in Los Angeles County* and *Medical Care Coordination Services for Persons Living with HIV in Los Angeles County* (September 2017) from the Los Angeles County Department of Public Health - Division of HIV and STD Programs, as well as feedback from the Los Angeles County Commission on HIV – Standards & Best Practices Committee and content experts in HIV treatment and care.

MEDICAL CARE COORDINATION SERVICES OVERVIEW

The Medical Care Coordination (MCC) model is an integrated service model that addresses patients' unmet medical and non-medical support needs (i.e. mental health, substance abuse, and housing) through coordinated case management activities to support continuous engagement in care and adherence to antiretroviral therapy. Services are delivered by multidisciplinary teams (nurse, social worker, caseworker, retention outreach specialists) co-located in clinics across Los Angeles County. Medical Care Coordination services are supervised and overseen by a team consisting of a Medical Care Manager (MCM), Patient Care Manager (PCM), Retention Outreach Specialist (ROS), and Case Worker(s) (CW). Individuals on the Medical Care Coordination team must be in good standing and hold all required licenses and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs.

Medical Care Coordination services will include:

- Outreach
- Intake
- Comprehensive assessment/reassessment
- Integrated Care Plan
- Implementation and evaluation of Integrated Care Plan
- Brief interventions
- Referral and coordination of care
- Case conferences
- Patient retention services

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

The goals of medical case coordination include:

- Increase retention in HIV care
- Improve adherence to antiretroviral therapy (ART)
- Link patients with identified need to mental health, substance abuse and housing support services
- Reduce HIV transmission through sexual risk reduction counseling and education, including Undetectable = Untransmittable (U=U)
- Educate clients on the etiology of HIV
- Educate clients on associated chronic illnesses

Recurring themes in this standard include:

- Medical Care Coordination will respect the dignity and self-determination of patients.
- Services will be delivered to support and enhance a patient's self-sufficiency and retention in care.
- All services will be based on a comprehensive assessment, around which an Integrated Care Plan and implementation activities are developed.
- Ongoing monitoring of progress is integral to care coordination services.
- Medical Care Coordination staff require specialized training and ongoing patient care-related supervision to deliver culturally-competent and timely services.

MEDICAL CARE COORDINATION EVALUATION

In 2017, the first comprehensive report on the implementation and evaluation of Medical Care Coordination services was released by the Los Angeles County Department of Public Health – Division of HIV & STD Programs. The evaluation of 1,204 patients enrolled in MCC in 2013 demonstrated the success of the integrated service model and has been utilized in the development of these Standards. Key findings indicated that MCC was able to reach and serve vulnerable populations impacted by HIV, increase retention in HIV care and adherence to antiretroviral therapy, and increase viral suppression for patients. Given that there is minimal to no risk of transmitting HIV for patients that are able to achieve and maintain an undetectable viral load, the key findings align with LA County HIV/AIDS Strategy goals of increasing viral suppression to 90% and reducing annual infections to 500 by 2022.

In Los Angeles County there were an estimated 60,946 persons living with HIV/AIDS with 1,881 newly diagnosed HIV cases in 2016. Of the 1,881 HIV cases that were newly diagnosed; 84% were men who have sex with men (MSM). HIV incidence is highest among MSM of color, young MSM (YMSM) ages 18-29, and transgender persons. Patients enrolled in MCC showed improvements in all health outcomes across all patient demographics and social determinants of health, particularly in those aged 16-24 years, transgender, uninsured and high/severe acuity. The evaluation results for MCC services demonstrates its effectiveness as an integrated medical and non-medical care program in improving health outcomes for people living with HIV.

SERVICE COMPONENTS

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

Medical Care Coordination services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by care coordination staff and other professionals to whom they are referred. Such patient-practitioner discussions are relationship-building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen.

Medical Care Coordination staff are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www. thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.

All Medical Care Coordination services will be patient-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. All Medical Care Coordination services will be culturally and linguistically appropriate to the target population. (See Program Requirements and Guidelines in the Standards of Care Introduction.)

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

Medical Care Coordination services in Los Angeles County will include (at minimum):

- Outreach
- Intake
- Comprehensive assessment/reassessment
- Integrated Care Plan
- Implementation and evaluation of Integrated Care Plan
- Brief interventions
- Referral, coordination of care and linkages
- Case conferences
- Patient retention services

GENERAL SERVICE CONSIDERATIONS

All patients receiving medical care in Ryan White-funded clinics are routinely screened for MCC need based on clinical and psychosocial criteria. Those patients who need MCC or who are directly referred by their medical provider are then enrolled into more intensive services. Each Medical Care Coordination program will be a single, unified program, even if it involves multiple providers.

Physical co-location of the medical outpatient clinics and Medical Care Coordination programs is necessary, and will be determined based on the needs of the program, the patient population and the providers delivering the service. Whether co-located or located on its own premises, Medical Care Coordination programs must operate from a central location which serves as an administrative hub and primary program venue. As such, Medical Care Coordination is considered an integrated approach to care, rather than simply a location where care is provided.

Medical Care Coordination teams work with the patient directly as part of an integrated care team. Depending on the size of the program and volume of patients, the program may employ additional case workers who are directly supervised by one or both of the care managers. In the case of a smaller program, the medical and patient care managers both work directly with all patients on an ongoing basis.

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

The retention outreach specialist will directly engage clients who are at-risk of falling out of care or are lost to care. The incumbent will be responsible for reaching the patients through all available means of communication, including but not limited to phone calls, text messages, emails, physical mail, and community outreach to parks, food pantries, and shelters. The person in this role must have experience directly supporting LGBTQ+ individuals, people of color, active drug users, people with severe cognitive deficits, and/or street-involved (homeless) individuals. Preferably, the incumbent will have experience in with multiple of these communities.

Care coordination programs may choose to engage additional providers for specific services (e.g., behavioral health, substance abuse) or will be expected to establish comprehensive service agreements with such providers that will facilitate the program's access to those additional services. Memoranda of Understanding (M.O.U.) between the grantee and the provider/agency must be submitted to the Los Angeles County Department of Public Health - Division of HIV and STD Programs.

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

PATIENT RETENTION

Programs providing Medical Care Coordination services will develop and implement an outreach plan that guides the program's efforts to engage:

- Patients who have fallen out of care
- Patients who are aware of their HIV status, but not in care ("unmet need")

Please refer to the "Patient Retention" section of this standard for guidance in communication and follow-up with patients.

In addition to these activities targeted to individuals, programs will also conduct outreach activities to educate HIV services providers and other supportive service organizations about the availability and benefits of Medical Care Coordination services for people living with HIV within Los Angeles County. Programs will work in collaboration with HIV primary health care and support services providers, as well as HIV testing sites. The patient retention specialists will keep a record of outreach activities to share with Los Angeles County Department of Public Health - Division of HIV and STD Programs when requested.

STANDARD	MEASURE
Medical Care Coordination programs will provide outreach to potential providers and patients who: • Have fallen out of care • Are aware of their status, but not yet in care	Patient retention plan and activities on file at provider agency. Programs will monitor current outreach/return to care rates and demonstrate efforts to improve them. Program monitoring to confirm activities.

PATIENT INTAKE

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

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

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

As part of the intake process, the client file will include the following information (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Verification of medical insurance
- Date of intake
- Client name, mailing address and telephone number. For patients without an address, a signed affidavit declaring they are homeless should be kept on file.
- Emergency and/or next of kin contact name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with State and local guidelines. Completed forms are required for each patient:

- Release of Information must be updated annually and include information specific to the organization. New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (confidentiality policy)
- Consent to Receive Services
- Patient Rights and Responsibilities
- Patient Grievance Procedures
- Notice of Privacy Practices (HIPAA)

STANDARD	MEASURE
Intake process will begin during first contact with patient (unless already on file in agency).	Intake tool is completed and in patient file to include (at minimum): • Documentation of HIV status • Proof of LA County residence • Verification of financial eligibility • Date of intake • Patient name, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by patient on file and updated annually.
Consent for Services will be completed.	Signed and dated Consent in patient record.
Patient will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in patient record.
Patient will be informed of privacy rights (HIPAA).	Signed and dated form in patient record.

PATIENT ASSESSMENT/REASSESSMENT

Assessment is the systematic and continuous collection of data and information about the patient and his or her need for Medical Care Coordination services. Assessment identifies and evaluates a patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources. The patient assessment, reassessments and Integrated Care Plans (ICPs) must be performed by the medical care manager and patient care manager team, or by staff with equivalent licensure and education (RN/MSW or related). The medical information and medical assessment portions of the assessment and reassessment must be completed by the medical care manager (or RN).

Comprehensive assessment is conducted to determine the:

- Patient's needs for treatment and support services
- Integrated Care Plan
- Patient's current capacity to meet those needs
- Ability of the patient's social support network to help meet patient needs
- Involvement of other health and/or supportive agencies in patient's care
- Areas in which the patient requires assistance in securing services

In addition, the assessment includes specific data abstracted from the patient medical record. The assessment organizes and synthesizes patient information from many sources.

Assessment is completed in a cooperative, interactive, face-to-face interview process. The assessment must be completed as soon as possible and will document the patient's needs, along with mutual decisions made regarding needs and services. While every effort will be made to complete the assessment within 30 days, referrals to needed services can begin before the assessment has been completed. If an assessment cannot be completed in 30 days, the reasons for non-completion will be

documented in the patient record. Comprehensive assessments and reassessments will be continually updated and completed when there are significant changes in a patient's status, when the patient has left and reentered Medical Care Coordination services, or (at minimum) once per year. Information gathered in the comprehensive assessment or reassessment will be used to develop or update the patient's integrated care plan (ICP).

In addition, when indicated, a patient's primary support person should be assessed for his or her HIV knowledge base, health status, expectations and ability to serve as patient's primary caretaker and support the patient in achieving the patient's health goals, treatment as prevention (i.e. Undetectable equals Untransmittable), and harm reduction behaviors.

Emergencies or medical and/or psychosocial crisis may require quick coordination decisions to mitigate the acute presenting issues before completing the entire intake/assessment. A brief, initial abbreviated assessment provides an opportunity to determine if the patient is in crisis and needs to begin the intervention process before formal assessment is completed.

Patient acuity levels will be assessed using the components of the intake and comprehensive assessment and based upon a patient's level of functioning and/or current need. Acuity measurements include aspects of both the medical and psychosocial domains. Acuity assessments will be completed by the medical/patient care management team using a countywide standardized acuity assessment tool that equally includes both medical and psychosocial concerns.

Based on all information gathered, patients will be aligned into the following categories:

- Self-managed: For patients presenting some need, but whose needs are easily addressed; refer to other Ryan White services. Moderate acuity: For patients presenting some need, but whose needs are relatively easily addressed;
- High acuity: For patients presenting the most complex and challenging needs; and
- Severe acuity: For patients presenting in crisis who require immediate, high frequency and/or prolonged contact.

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

Acuity levels will be updated on an ongoing basis, dependent upon patient need. Assessments must occur annually at least. Six month assessments are the minimum requirement for individuals aligned with *High acuity* or *Severe acuity*, but not less than once per year. Acuity level assessment/reassessment is an ongoing component in the course of the standard contact/visit.

After careful review of all intake, assessment and acuity materials, the Medical Care Coordination team will assign a primary contact to each patient that best matches the patient's presenting problem and/or primary concern to the worker's expertise.

STANDARD	MEASURE

Acuity levels will be assigned for all patients by care management team utilizing standardized, countywide acuity assessment tool.	Completed acuity tool on file in patient record. Patients will be assigned to one of the following categories: • Self-managed • Moderate • High • Severe
Patients unable to actively participate in Medical Care Coordination services will be referred to home-based case management, skilled nursing, psychiatric services, or hospice care.	Documentation of linked referral on file in patient record.
Patient acuity will be updated annually. Patients aligned with High acuity or Severe acuity will be assessed at least biannually.	Program monitoring and chart review to confirm.
RN and social work care management team will assign a primary contact to each patient.	Program monitoring and chart review to confirm.

INTEGRATED CARE PLAN (ICP)

An Integrated Care Plan is an individualized multidisciplinary service plan to be completed within 30 days of finalizing the comprehensive assessment. The Integrated Care Plan is based on the following (at minimum):

- Health status
- Age
- Medical history
- Mental health diagnosis and/or symptoms
- Addiction disorder diagnosis and/or symptoms Support systems
- Sources of financial support
- Community HIV resources
- Assessment of strengths, needs, resources, and basic life skills
- Housing stability
- Police contact
- Food security

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

The patient will be an active participant in developing the Integrated Care Plan. All interested parties should agree to the plan before beginning implementation.

Integrated Care Plans will include:

- Name of patient and care manager/case worker
- Date and signature of care manager/case worker and care management team
- Date and signature of the patient on the initial and subsequent ICPs
- Description of flexible short- and long-term patient goals, desired outcomes and dates of goal establishment
- Steps to be taken by patient, care manager/case worker and others to accomplish goals
- Timeframe by which goals are expected to be met
- Number and frequency of patient contacts based on acuity level:
    - Moderate acuity
    - High acuity
    - Severe acuity
- Concrete recommendations on how to implement Integrated Care Plan
- Contingencies for anticipated problems or complications
- Disposition of each goal as it is met, changed or determined to be unattainable
- Notation of benefits and entitlements to which the patient will apply
- Notation of functional barriers status and requisite next steps
- Disposition of the application for each benefit or entitlement as it is completed, changed or determined to be unattainable

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

STANDARD	MEASURE
Multidisciplinary ICPs will be developed in conjunction with the patient within 30 days of completing the comprehensive assessment.	ICP on file in patient record includes (at minimum): • Name of patient and care manager/case worker • Date/signature of case worker and care management team • Date/signature of the patient • Patient goals, outcomes and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of patient contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications • Disposition of goals • Benefits plan (as indicated)

IMPLEMENTATION AND EVALUATION OF ICP

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

In the implementation and evaluation phase, Medical Care Coordination staff are responsible for (at minimum):

- Providing linked referrals, patient advocacy and appropriate interventions based on the intake, assessment and ICP
- Monitoring changes in the patient's condition or circumstances, updating/revising the ICP and providing appropriate interventions and linked referrals.
- Monitoring lab values and treatment adherence
- Ensuring that care is coordinated among the patient, caregivers and service providers
- Conducting ongoing monitoring and follow-up with patients and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to services
- Advocating on behalf of patients with other service providers
- Empowering patients to develop and utilize independent living skills and strategies
- Assisting patients in resolving any barriers to completing referrals and accessing or adhering to services
- Actively following up on established goals in the ICP plan to evaluate patient progress and determine appropriateness of services
- Maintaining ongoing patient contact as outlined in ICP
- Actively following up within the next business day after discharge from the hospital when the medical team is aware of hospitalization. (If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, care coordination staff will document reason(s) for the delay.)
- Actively following up within one business day with patients who have missed a Medical Care Coordination appointment. (If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, care coordination staff will document reason(s) for the delay.)
- Collaborating with the patient's other service providers for coordination and follow-up

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

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

STANDARD	MEASURE

Care coordination staff will: • Provide referrals, advocacy and interventions based on the intake, assessment and Integrated Care Plan • Monitor changes in the patient's condition • Monitor lab values/adherence • Update/revise the ICP • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of patients • Empower patients to utilize independent living strategies • Help patients resolve barriers • Follow up on plan goals • Maintain ongoing contact based on	Signed, dated progress notes on file that detail (at minimum): • Description of patient contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the patient's condition or circumstances • Progress toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent • Care coordination staff's signature and title

BRIEF INTERVENTIONS

Brief Interventions are sessions that raise awareness of risks and motivates patient toward acknowledgement of problem. The goal of the brief intervention is to help the patient to see a connection between their behavior and their health and wellbeing. Based on the goals and objectives identified in the patient's ICP, MCC team members shall deliver brief interventions designed to promote treatment adherence and overall wellness for MCC patients. The brief interventions are not a substitute for long term care for patients with a high level of need; referrals to more intensive care may be warranted in those situations. For example, patients with severe mental health needs should be referred to the appropriate specialist. MCC intervention activities primarily focus on, but are not limited to:

- Promoting Antiretroviral Therapy Adherence (ART)
- Risk Reduction Counseling
- Engagement in HIV care
- Behavioral Health, and
- Disclosure Assistance

PATIENT SELF-EFFICACY AND CARE

Medical Care Coordination programs will teach patients and their caregiver's effective HIV disease self-efficacy skills to improve self-sufficiency health outcomes with attention to meeting the cultural needs and challenges of the patients. Staff will coach, educate and empower clients to interact effectively with all levels of service providers and to become increasingly informed and independent consumers. As appropriate, staff will encourage patients to actively participate in facilitating the multi- disciplinary communication between all of their providers to ensure continuity of treatment objectives and care.

STANDARD	MEASURE

Medical Care Coordination staff will teach patients and their caregiver's effective HIV disease self-efficacy skills.	Documentation of self-efficacy education on file in patient record.

REFERRAL AND COORDINATION OF CARE

Programs providing Medical Care Coordination services will actively collaborate with other agencies to provide referral to the full spectrum of HIV-related services.

Because resource referral and coordination is such a vital component of Medical Care Coordination services, programs must maintain a comprehensive list of target providers (both internal and external), for the full spectrum of HIV-related and other services. Program staff will maintain knowledge of local, state and federal services available for people living with HIV.

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

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

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

STANDARD	MEASURE
Medical Care Coordination programs will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals.	Referral list on file at provider agency.

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

CASE CONFERENCES

Multidisciplinary case conferences are a critical component of Medical Care Coordination services. Case conferences convene a patient's physician and other care providers to assess progress in meeting the needs identified in the patient's ICP and to strategize further responses.

Case conferencing is an opportunity to address major life transitions for the patient and should be conducted when possible under those circumstances. Programs are expected to convene case conferences based on patient need and acuity level. See Appendix B for recommended number of case conferences for patients based on acuity level.

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

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

STANDARD	MEASURE
Programs will convene case conferences that include the patient's physician and other care providers when feasible and appropriate.	Documentation on file in patient record to include: • Date of case conference • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow up

PATIENT RETENTION SERVICES

Retention Outreach Specialists (ROS) shall work to Re-engage into Care those patients that are lost to Follow-Up. This includes attempting to locate patients that have missed an HIV medical or MCC appointment. Locating patients may entail visiting the patient's last known address, contacting patents' other service providers, researching whether the patient is incarcerated, and other methods to bring the patient back into HIV care. ROS staff shall:

- Identify clinic patients not engaged in HIV medical care within the past 7 months.
- Work as an integral part of the medical care coordination (MCC) services team, including participating in team meetings.
- Act as liaison for newly diagnosed patients living with HIV to ensure expedited entry into HIV medical care.
- Act as liaison for clinic patients recently released from incarceration to ensure timely reengagement into HIV medical care.
- Work with out of care clinic patients to identify and address potential and/or existing barriers to engagement in medical care.
- Utilize motivational interviewing techniques to encourage patients to engage in and/or reengage into HIV medical care.

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

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

STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of patients.	Written policy on file at provider agency.
Programs will provide regular follow-up procedures to encourage and help maintain a patient in Medical Care Coordination services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Email • Physical mail • Text messages • Direct contact
Programs will develop and implement patient contact policy for homeless patients and those with no contact information to ensure they are not lost to follow-up.	Contact policy on file at provider agency. Program review and monitoring to confirm.

CASE CLOSURE

Case closure is a systematic process for disenrolling patients from Medical Care Coordination services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record. All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for case closure. Note that cases often remain open, and should not be closed, so that the Retention Outreach Specialists can attempt to locate and rescreen patients.

Cases may be closed when the client:

- Relocates out of the service area
- Has had no direct program contact in the past six months
- Is ineligible for the service
- Discontinues the service
- Uses the service improperly or has not complied with the client services agreement
- Is deceased

Patients should be rescreened when the client:

- Has had no direct program contact in the past six months
- Is enrolled in Medical Care and/or Medical Care Coordination services at another clinic
- Is incarcerated long term. Patient should be rescreened in six months to determine need.
- No longer needs the service

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

- Date and signature of both the medical and patient care managers
- Date of case closure
- Status of the Integrated Care Plan
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for reentry into services

STANDARD	MEASURE
Patients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in patient record.
Medical Care Coordination cases may be closed when the client: • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • Discontinues the service • Is deceased	Case closure summary on file in patient chart to include: • Date and signature of care coordination staff • Date of case closure • ICP status • Status of primary health care and service utilization • Referrals provided • Reason for closure • Criteria for reentry into services

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all Medical Care Coordination staff will be able to provide timely, linguistically and culturally-competent care to people living with HIV. Medical Care Coordination staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. Staff should also be trained by their agency on patient confidentiality and HIPAA regulations, and de-escalation techniques.

TRANSLATION/LANGUAGE INTERPRETERS

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

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

REFERENCES

Division of HIV and STD Programs, Los Angeles County Department of Public Health. Guidelines for the Provision of HIV/AIDS Medical Care Coordination Services in Los Angeles County. September 14, 2017. Retrieved from http://publichealth.lacounty.gov/dhsp/Contractors/MCC/MCCGuidelinesRevised2017.pdf.

Garland WH, Oksuzyan S, Mejia M, and Kulkarni S. Medical Care Coordination Services for Persons Living with HIV in Los Angeles County: A Robust Strategy to Strengthen the HIV Care Continuum. Los Angeles County Department of Public Health. October 2017.

Division of HIV and STD Programs, Los Angeles County Department of Public Health. Los Angeles County HIV/AIDS Strategy for 2020 and Beyond. December 2017. Retrieved from https://www.lacounty.hiv/about/.

APPENDIX A

DEFINITIONS AND DESCRIPTIONS

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

Intake determines a person's eligibility for Medical Care Coordination services.

Medical Care Coordination (MCC) integrates the efforts of medical and social service providers by developing and implementing an integrated care plan. A waiver for degree certification for the MCC team will be granted on a case by case basis, as determined by DHSP.

Medical Care Managers will be licensed RNs and be responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan.

Retention Outreach Specialists promote the availability of and access to Medical Care Coordination services to service providers and patients at higher risk of falling out of continuous care or are lost to care.

Patient Care Managers will hold a Master's degree in social work (MSW) or related degree (e.g., psychology, human services, counseling) and are responsible for the patient's psychosocial needs ad will track, address and or supervise these components of the Integrated Care Plan. A waiver for degree certification will be granted on a case-by-case basis.

Case Workers must possess either a Bachelor's degree in Nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling, Human Services, a license as a vocational nurse (LVN) or demonstrated experience working in the HIV field. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion.

Reassessment is a periodic assessment of a patient's needs and progress in meeting the objectives as established within the Integrated Care Plan.

Case closure is a systematic process of disenrolling patients from active Medical Care Coordination.

APPENDIX B

Frequency of Task by Patient Acuity

	Self-Managed	Moderate	High	Severe
Screening	Every 6 months	Annually	Annually	Annually
Assessment	Within 30 days of enrollment and annually thereafter	Within 30 days of enrollment and every 6 months thereafter	Within 30 days of enrollment and quarterly thereafter	Within 30 days of enrollment and every 60 days thereafter
Care Plan	Within 30 days of enrollment and annually thereafter, with assessment	Within 30 days of enrollment and every 6 months thereafter, with assessment	Within 30 days of enrollment and quarterly thereafter, with assessment	Within 30 days of enrollment and every 60 days thereafter, with assessment
Brief Interventions	As needed	At minimum, every 6 months	At minimum, quarterly	As needed, but at minimum every 60 days
Follow-up	As needed	At minimum, every 30 days	At minimum, every 30 days	At minimum, every 30 days
Case Conferences	Annually	At minimum, every 6 months	At minimum, quarterly	Within 30 days of assessment and monthly thereafter