
MEDICAL CARE COORDINATION GUIDELINES

Los Angeles County
Department of Public Health,
Division of HIV and STD
Programs

Table of Contents

INTRODUCTION/PURPOSE	3
MEDICAL CARE COORDINATION SERVICES (MCC).....	4
Goals and Objectives	4
Target Population	5
THEORETICAL FRAMEWORK OF MCC.....	5
MCC PROCESS COMPONENTS.....	7
PATIENT FLOW CHART	9
PATIENT SCREENING	10
TRACKING ENROLLMENT STATUS	12
ASSESSING PATIENT NEEDS	14
Frequency of Assessment	18
Acuity Determination	18
DEVELOPING THE INTEGRATED CARE PLAN	20
Documenting Care Plan Progress or Barriers	21
BRIEF INTERVENTIONS	22
Brief Intervention: Promoting Antiretroviral Therapy (ART) Adherence	27
Brief Intervention: Risk Reduction.....	30
Brief Intervention: Engagement in HIV Care	31
Brief Intervention: Behavioral Health.....	35
Brief Intervention: Disclosure Interventions	39
FOLLOWING UP WITH PATIENTS	41
CASE CONFERENCING.....	44
ADMINISTRATIVE ITEMS	47
Team Member Qualifications.....	47
Casewatch Data Management System.....	48
Monthly Reporting	48
Monthly Report Section III.....	50
RESOURCES AND TIPS	55
Maintaining Patient Confidentiality	55
Conducting the Assessment	56
Tips for Eliciting Information	59
Successful Service Linkages	60
Effective Follow Up.....	61
Motivational Interviewing	62
Behavior Change Strategies and MCC Service Components.....	66
Works Cited	67
List of Appendices.....	72

ACKNOWLEDGEMENTS

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

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The Los Angeles County Commission on HIV

INTRODUCTION/PURPOSE

The field of HIV medicine has made significant strides in the past 30 years, with the development of well-tolerated, safe, and effective treatments. To stay healthy, people living with HIV and AIDS (PLWHA) are recommended to see their doctor at least twice a year and take their medicine every day to keep their viral load suppressed [1, 2]. Adherence to HIV care and medicine is critical as PLWHA with suppressed viral loads have better health outcomes and are less likely to spread HIV to their partners than those who are out of care and have unsuppressed viral load [3, 4, 5].

Despite the medical advances, many PLWHA in Los Angeles County (LAC) are not achieving optimal health because they are not receiving regular medical care and are not taking HIV medications. Figure 1 below compares the HIV continuum of care for PLWHA in LAC from 2009-2012. Of the approximately 40,000 persons living with HIV in LAC during this time period, only 57%-58% were retained in care (had 2 or more doctor appointments at least 90 days apart in the past year) and just over half (51-56%) had viral suppression (most recent viral load less than 200/copies/mL). These data demonstrate not only are PLWHA not being successfully retained in care or achieving viral suppression but also that that these outcomes have not been improving over time.

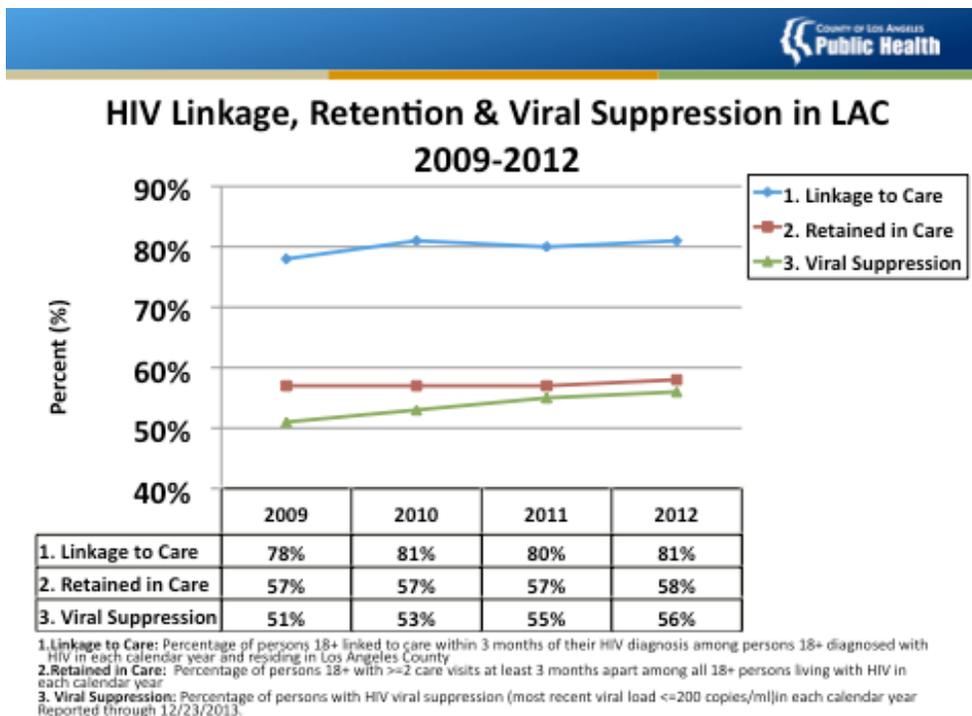


Figure 1. HIV Linkage, Retention and Viral Suppression in LAC, 2009-2012

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 [6]. 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 [7, 8, 9, 10, 11].

Using the standards set forth by the COH, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP) operationalized the MCC service model and developed service guidelines for the provision of these services. A 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. Coordinated care requires that interacting clinical, psychological and social needs are addressed simultaneously, rather than separately and episodically. In the MCC model, behavioral interventions and support services are coordinated with medical care to fully respond to patients' needs, and to promote treatment adherence and health outcomes [10].

MEDICAL CARE COORDINATION SERVICES (MCC)

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. 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.

Goals and Objectives

The goals of the MCC program are to:

1. Increase retention in HIV care;
2. Improve adherence to antiretroviral therapy (ART);
3. Link patients with identified need to mental health, substance abuse and housing support services; and
4. Reduce HIV transmission through sexual risk reduction counseling and education.

The program goals will be achieved by meeting the following key objectives:

1. To support patients in adhering to medical care and antiretroviral therapy (ART);

2. To promote sexual risk reduction to reduce patient acquisition of sexually transmitted diseases (STDs) and transmission of HIV infection;
3. To facilitate access and linkage to appropriate services in the continuum of care;
4. To increase patient capacity for self-care;
5. To eliminate duplication of services by integrating medical and non-medical case management for HIV-positive patients; and,
6. To increase service coordination among providers.

Target Population

Patients eligible for MCC services include individuals who:

- Reside in Los Angeles County¹;
- Are age 12 years or older;
- Have a household income equal to or below 400% Federal Poverty Level (FPL); and
- Are HIV-positive.

The MCC program targets patients who are at risk for poor health outcomes. These include patients meeting any of the following criteria:

- Had a viral load of less than 200 copies/mL;
- Not prescribed antiretroviral therapy but meet the clinical guidelines for antiretroviral therapy;
- Had not attended an HIV medical appointment in the past 7 months;
 - Includes recently diagnosed (within the past 6 months);
- Were diagnosed with an STD within the last 6 months;
- Had multiple and complex diagnoses (such as diabetes, hepatitis, or liver disease) that negatively affect a patient's health status and complicate HIV management;
- or
- Were incarcerated within the last 6 months.

THEORETICAL FRAMEWORK OF MCC

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, successful treatment also requires behavioral changes. For this reason, MCC is integrated into, and is a part of, a patient's clinical medical home, as **behavioral, rather than biomedical**, intervention. While the program's goals are biomedical in nature, i.e., to improve individual-level health outcomes through HIV viral load suppression, the role of the

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 team is to support patients 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 and/or substance use treatment services when needed
- Taking HIV and other medications regularly and as prescribed
- Using condoms to reduce STD acquisition and STD and HIV transmission

Ultimately, the success of the program relies on the MCC team's ability to educate and support behavioral changes that will lead to the improved health outcomes for patients. It is, therefore, important for the MCC team to apply behavior change theory to service delivery, and to enhance patient motivation to adopt protective health behaviors through effective counseling styles. Below is a brief introduction to the Transtheoretical Model, a behavior change theory, which guides the program and the MCC team in supporting behavior change throughout the process of MCC service delivery.

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 [12, 13]. These stages include: pre-contemplation, contemplation, preparation, action, maintenance, and termination. (Sometimes people add relapse as a seventh stage to the cycle of behavior change.)

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 can be 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 STD 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 process of change is 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 recurrence) 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. As Mark Twain said: “It’s easy to quit smoking. I’ve done it hundreds of times.” Therefore, it will be important to explore what the relapse means to them and the context within which it occurred. It 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 pre-contemplative 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.

MCC PROCESS COMPONENTS

MCC is an integrated, team approach to service delivery, which 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.
2. **Enroll** eligible patients into active MCC services. This process involves confirming patient eligibility and introducing the service to the patient.
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.
4. **Calculate** active MCC patients’ acuity. A patient’s acuity level is calculated when the assessment is entered into Casewatch, the DHSP data management system, and

determines service intensity. A gradual reduction in acuity is expected among patients enrolled in MCC with the goal of reaching a self-managed state.

5. **Develop** an integrated care plan (ICP) with patients receiving active MCC service. The ICP is a collaborative process between the Medical Care Manager, Patient Care Manager, and MCC patient and is informed by the assessment. Frequency of plan updates is minimally determined by patient acuity.
6. **Deliver** brief interventions designed to promote behavior change and wellness for active MCC patients. Brief interventions primarily focus on, but are not limited to:
 - a. Engagement in HIV care,
 - b. Promoting behavioral health,
 - c. Adherence to antiretroviral therapy,
 - d. Reducing sexual risk behaviors, and
 - e. Disclosure of HIV status
7. **Follow-up and 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.
8. **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.
9. **Transition** active MCC patients with acuity levels reduced to self-managed or status or, in rare cases, close cases (e.g., patient moves out of the County, is deceased).

In figure 2 below, the Patient Flow Chart, greater detail is provided on these processes.

PATIENT FLOW CHART

MCC Provider Patient Flow Chart (Revised 03-26-15)

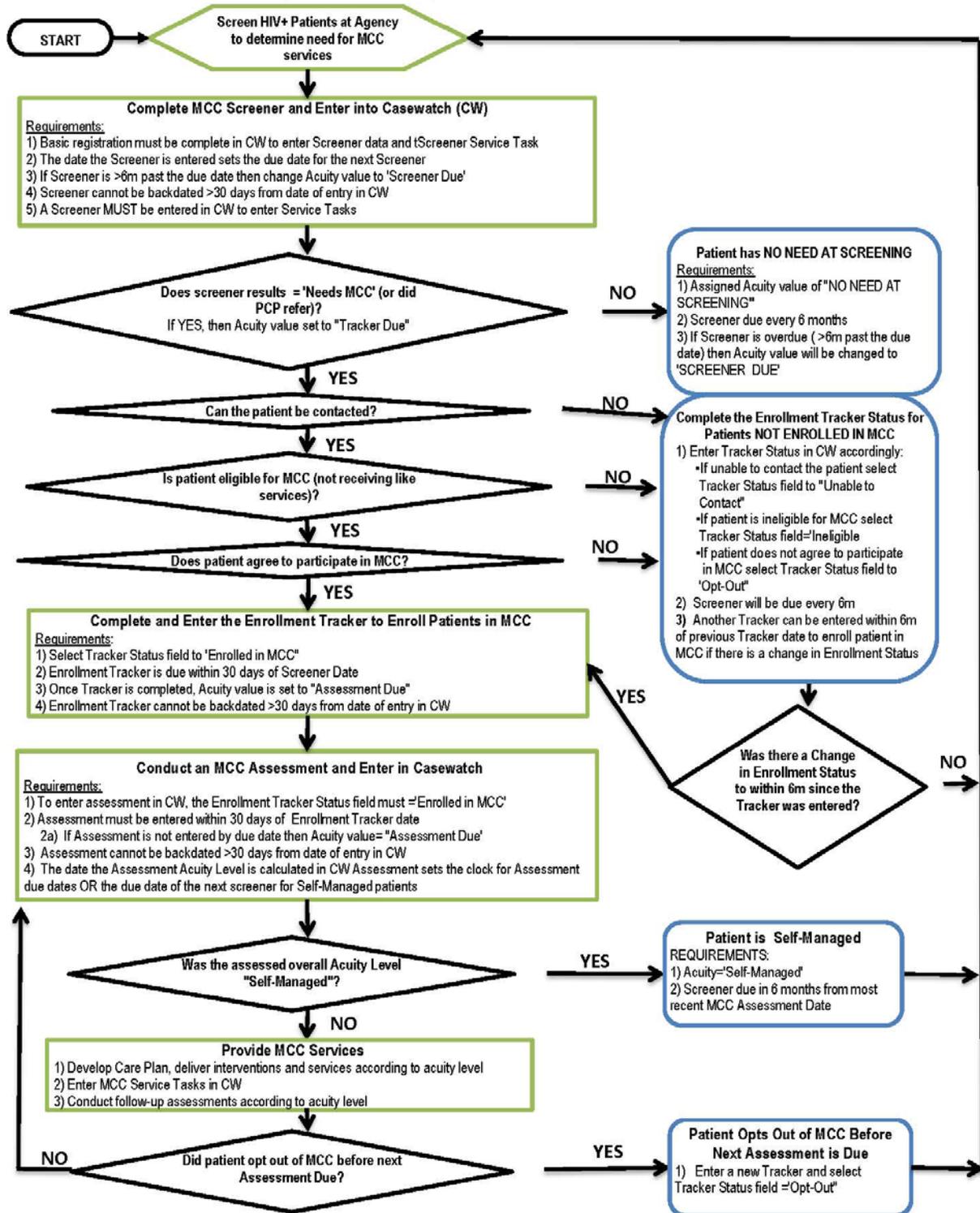


Figure 2: MCC Process Flowchart

PATIENT SCREENING

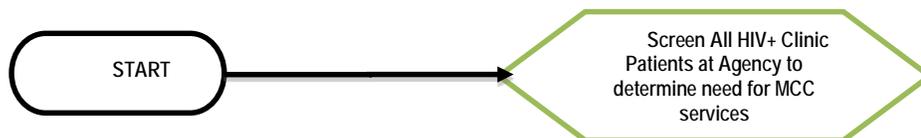
To determine whether a patient needs the assistance of the MCC team, they need to be **screened**. The process identifies and differentiates those patients who have no need from those patients who need MCC services.

Screening Strategies

The clinic can use a number of different strategies to screen clinic patients. Clinics can run queries of the clinic's electronic medical records (EMR) and/or appointment scheduling systems or review medical records to identify patients who are any of the following:

- Recently diagnosed with HIV (in the past 6 months);
- Out of HIV care (no HIV medical appointments in the past 7 months or more);
- Not on antiretroviral therapy (ART) but meet current clinical guidelines for treatment;
- Diagnosed with an STD in the past 6 months; and/or
- Currently on ART and have detectable viral load (greater than 200 copies/mL)

In addition to identifying patients through screening, primary care providers can directly refer to the MCC team any patient they feel are in need of MCC services patients regardless of whether they meet the screening criteria. This includes patients that have multiple medical and/or psychosocial co-morbidities that negatively affect health status. Reasons for provider referrals must be documented in the patient medical chart.



Once screened, the MCC team should contact eligible patients within **7 days** of identification;

Screeener and Outcomes Data in Casewatch

Complete MCC Screener and Enter into Casewatch (CW)

Requirements:

- 1) Basic registration must be complete in CW to enter Screener data and Screener Service Task
- 2) The date the Screener is entered sets the due date for the next Screener
- 3) If Screener is >6m past the due date then change Acuity value to 'Screener Due'
- 4) Screener cannot be backdated >30 days from date of entry in CW
- 5) A Screener **MUST** be entered in CW to enter Service Tasks

Without screener data entered into Casewatch, no services can be entered into Casewatch.

MCC Screener and Outcomes

Client Name ZZTEST,CLIENT PF# 9999999T

ISP ID# 201504936 Assessment Type MCC Screener and Outcomes

Screener Date 03/09/2015 Last Worked

1. Date of first service at this clinic 01/01/2015
 Has the client had a medical visit in the last 6 months? YES

2. Date of most recent HIV medical Visit 01/01/2015
 Date of First HIV-Positive Test 06/01/2004

3. Was ART prescribed in last 6 months Yes

4. Date of most recent Viral Load in past 6 months 01/01/2015
 Is the most recent viral load available? YES

5. Result of Most recent Viral Load (copies/ml) <20

6. Date of most recent CD4 Count in past 6 months 01/01/2015
 Is the Most recent CD4 available? YES

7. Result of Most recent CD4 Count 750

8. Was the Client diagnosed with an STI in past 6 months? No

9. Did client have any ER visits in the past 6 months [Y/N/U]? No

10. Was client hospitalized in the past 6 months [Y/N/U]? No

11. Was client incarcerated in the past 6 months [Y/N/U]? No

12. Active substance abuse interferes with HIV Care [Y/N/U]? No

Screener Result? No Need at Screening Override by provider referral? NO

Figure 3: Casewatch– MCC Screener and Outcomes Screen

If screener results =No Need at Screening:

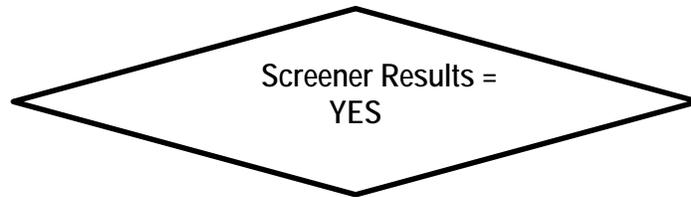
Screener Results mean that the patient had no need for MCC and was NOT referred (overridden) by provider.



For patients that have No Need at Screening, the MCC team will need to conduct another screening in 6 months. **All clinic patients that are not enrolled in MCC are routinely screened to determine their need for MCC services. This is done on a semi-annual basis to ensure that clinic patients with changing health statuses and life circumstances do not fall through the cracks.**

If screener results = Yes, then Patient has MCC Need at Screening:

Screener results mean that patient HAS NEED or was REFERRED by provider.



For patients that have MCC Need at Screening, the MCC team will need to contact this patient **within 7 days of identification and** offer them MCC services. Once a patient is identified as being eligible to enroll in MCC, the MCC team shall introduce the service to patients and confirming that they wish to participate. When introducing MCC services, the MCC program should be framed as part of routine HIV care and treatment. Team members should be introduced as part of the patient’s core medical team and explain that they will be routinely involved in the patient’s medical care.

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.”

TRACKING ENROLLMENT STATUS

For each patient where the Screener identified the patient as “Needing MCC,” the MCC team members shall attempt to contact the patient to determine whether they wish to participate in the program and whether they qualify for services. To complete the Enrollment Tracker the following questions need to be answered by the MCC team:

1. Can you contact the patient?
2. Is patient eligible for MCC (not receiving other like services such as home-based case management)?
3. Does patient agree to participate in MCC?

There are four tracking status options for patients based on responses the questions above:

1. Enrolled in MCC (Agrees to participate in MCC)
2. Unable to Contact (Cannot contact patient by phone after 3 reasonable attempts)
3. Opts out of MCC (Does not want to participate in MCC)
4. Ineligible (Receiving home-based case management, medical social work)

The MCC team documents patients’ MCC enrollment status in the Casewatch data management system within **fourteen (14) days** of enrollment. This documentation tracks patients from

screening or referral for MCC to program enrollment. It “sets” the clock for MCC patient monitoring activities including assessment, care plans, case conferencing and follow-up.

Non-Enrolled Patient Tracking

Options # 2-4 are considered “Non-Enrolled Patients” and patients with these options shall be tracked as such in the Casewatch system. Tracker Status must be complete within **14 days** of screening.

The decision to participate in MCC services is ultimately **the choice of the patient**. In the rare event a patient is identified as needing 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 tracked as Not-Enrolled in MCC and the MCC team will screen them at least every 6 months.

Patient Enrollment in MCC

If answer is YES to option #1, then the patient shall be "Enrolled in MCC". Complete Tracker Status accordingly in Casewatch. Tracker Status must be complete within **30 calendar days** of screening.

Complete the MCC Tracker for "Enrolled in MCC" in Casewatch

RULES:

1. Screener data must be complete AND Screener Results = 'YES' OR provider refers = 'YES' to enter data in Tracker Screen
2. Acuity='Tracker Due' until Tracker is completed.
3. Tracker is due within 30 days of Screener Date.
4. Tracker cannot be backdated >30 days from date of entry in Casewatch
5. **Conduct an MCC Assessment**

ASSESSING PATIENT NEEDS

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

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A thorough assessment must be conducted to determine patients' needs with regards to accessing HIV care and support services, HIV risk reduction, and optimal health functioning. Although many assessment tools may be used to assess patients in various domains, a comprehensive, standardized assessment tool has been specifically developed for MCC. The MCC Assessment is conducted through face-to-face interviews between the MCC Team (MCM and PCM) and MCC patients using a countywide standardized assessment tool programmed in Casewatch. The assessment determines:

- a) Patient's level of need for medical and psychosocial support services;
- b) the 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 of need for each domain (e.g., health status, housing, mental health) and to guide ICP development and the delivery of directed activities that include referrals and brief interventions.

It is essential that the assessment responses be entered into the Casewatch data management system for every patient receiving MCC services so that acuity levels can be calculated. *Must be entered into the Casewatch data system within **thirty (30) days of enrollment.***

Enter Assessment in Casewatch

RULES:

1. In order to enter the assessment in Casewatch, then the Tracker Status field must = 'Enrolled in MCC'
2. MCC Assessment data must be entered within 30 days of Tracker date.
 - 2a. If Assessment is not entered by due date then Acuity= Assessment Due'
3. Assessment cannot be backdated >30 days from date of entry in Casewatch
4. The date of the Assessment Assigned Acuity Date sets the clock for Assessment due dates OR the due date of the next Screener for self-managed patients

Assessment Domains

The following are the domains covered in the MCC assessment along with key notes to assist in conducting the assessment.

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.

- 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. **This section shall be abstracted from the patient's medical record prior to meeting with the patient, if possible.**

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

- Patients who meet ART treatment guidelines are on ART, including pregnant women;
- Patients who are on ART and have detectable viral load;
- Patients who have any active HIV-related complications;
- Patients with co-morbidities that interact with HIV (e.g., Hepatitis B or C); and
- Patients who have STDs

- II. **Quality of Life/Self-Care:** This area evaluates patients' health-related quality of life and functional health status [14, 15, 16, 17]. The priority issues identified are as follow:
 - Patients with fair or poor perceived health status; and,
 - Patients with limited capacity for self-care and daily living activities (impaired functional status

- III. **Antiretroviral Knowledge and Adherence:** **The questions in the section are asked only of patients who are currently prescribed ART.** The section identifies issues related to ART adherence and determines which patients are in need of support, education, and/or additional brief adherence interventions [18, 19] . The priority issues identified are as follows:
 - Patients who cannot explain what a viral load and CD4 count are;
 - Patients who cannot explain how ART effects viral load and CD4 count;

- Patients who cannot correctly name the medications for their current ART regimen;
 - Patients who report not taking all doses of their ART medications; and,
 - Patients with identified barriers to adherence.
- IV. Medical Access, Linkage and Retention: This section 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;
 - Patients who do not have a doctor who they see regularly for their HIV care;
 - Patients who have been hospitalized and/or in the emergency room in the past 6 months
 - Patients who usually or always miss their HIV care appointments; and,
 - Patients with identified barriers to HIV care;
- V. Housing: This section, 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 struggle with homelessness or temporary housing;
 - Patients who do not feel safe in their current housing situation.
- 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, 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; and
 - Patients who are unable to meet monthly living expenses.
- VII. Transportation: This section helps to evaluate a patient's ability to travel for HIV-related medical services. It is not scored as part of patient acuity but helps the MCC team to identify the following priority issues:
- Patients too sick to travel time to the clinic on public transportation; and
 - Patients that miss HIV care appointments because they do not have transportation.
- VIII. Legal Needs/End of Life Needs: This section is useful to understand incarceration history and determines if patients need assistance completing legal forms. It identifies the following priority issues:
- Patients who have been incarcerated;

- Patients who need a power of attorney, an advanced directive, a guardianship, wills and/or end of life legal documents; and
 - Patients without a health care proxy.
- 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. It assesses patients’ sources of support and stress, the types of support received, past or current violence/abuse, and HIV disclosure [20, 21, 19]. The priority issues identified are as follows:
- Patients who have not disclosed their HIV status to immediate social members
 - Patients who have experienced abuse or violence.
- X. Risk Behavior: The prevention, diagnosis, and treatment of STDs other than HIV are essential for the patient’s overall health and reduced risk for HIV transmission. This section is useful to identify issues related to sexual behaviors, HIV knowledge and HIV disclosure [22]. The identified priority issues are as follows:
- Patients who do not use condoms with sexual partners;
 - Patients who do not disclose their HIV status to sexual/needle-sharing partners; and,
 - Patients who want assistance to disclose HIV status to sexual/needle-sharing partners.
- XI. Substance 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 [23, 24, 25, 26]. The potential relationship between substance use and risk behaviors also highlights the need for a comprehensive assessment of alcohol and substance use (TCU Institute of Behavioral Research, Fort Worth, Texas 2006). The priority issues related to substance use and/or alcohol use are as follows:
- Patients whose alcohol and/or substance use interferes with their adherence to HIV care and/or medication regimen;
 - Patients who are currently trying to reduce or stop substance use and/or alcohol use; and,
 - Patients who want help to reduce or stop their substance use and/or alcohol use.
- XII. Behavioral Health: Mental health issues can reduce access to and engagement in regular HIV medical care, adherence to ART regimens and viral suppression, and can lead to increased substance use and risk behaviors [23, 24, 25, 26]. It explores patient’s mental health history and screens for symptoms of depression or anxiety [27, 28]. The priority issues related to mental health are as follows:

- Patients whose mental issues interfere with their adherence to HIV care and/or medication regimen;
- Patients who meet the screening criteria for depressive disorders;
- Patients who meet the screening criteria for anxiety disorders;
- Patients who are currently considering hurting themselves and/or others; and,
- Patients with mental health issues who are not ready to seek mental health services.

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



The full Performance Measures document which outlines how each domain is defined and calculated is available in Appendix A. All appendices are available and can be accessed on the DHSP website at:

<http://www.ph.lacounty.gov/aids/Contractors.htm>.

Frequency of Assessment

The frequency of future assessments is determined by a patient's acuity level on the prior Assessment. 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.

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 – no further assessment

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.

Acuity Determination

Acuity refers to the patient's level of functioning and determines the intensity of MCC services needed to improve the patient's level of functioning [29]. The acuity level is determined by responses on the assessment and is calculated once the assessment is

entered into the Casewatch Data Management System. Acuity is calculated as an **overall acuity level** and **domain-specific acuity levels**.

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.

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.

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:** These are patients that have been assessed, where the assessment determined acuity of "Self-Managed". Generally, the patient is stable, and capable of managing their HIV medical care with no or intermittent need for assistance.

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.

DEVELOPING THE INTEGRATED CARE PLAN

Developing the integrated care plan (ICP) is a collaborative process between the MCC Team members and the patient. It is a clear outline of tasks, informed by the overall and domain-specific acuity levels as well as the discussion with the patient in the course of completing the assessment, which the patient and MCC team agree to accomplish.

- a) **Summarize patient needs identified** during the assessment following its completion.
- b) **Solicit feedback** from the patient to ensure clarity and how needs identified relate to their treatment adherence and risk behavior.
- c) **Discuss with the patient which issues are most important/pressing** within the context of their treatment adherence or risk behavior and prioritize which issues to address first.
- d) The MCC team members **develop the ICP together** with the patient based on the discussion about their prioritized needs. List 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.
- e) **Share the ICP with the patient**, review the established objectives with the patient, and make any necessary changes based on the patient's feedback.
- f) Divide each objective into **manageable tasks** needed to achieve the objective.
- g) **Discuss any barriers or challenges** to completing the task. Strategize ways to overcome these concerns.
- h) **Identify a date** by when each task and objective must be completed. Allow realistic timelines.

Follow these guidelines to develop ICP objectives that are Specific, Measurable, Attainable, Relevant, and Timely (**S.M.A.R.T.**) 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?
- **Measurable:** Set criteria to measure progress towards the objective. How will you know if it is accomplished? For example, reduce missed medications from 3 times per week to 1 time per week by the end of 30 days from today.

- **Achievable/Attainable:** Ensure the objective can be reached. 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 require multiple tasks to achieve.
- **Relevant:** Ensure the objective aligns with the domains of need identified in the assessment, including reducing HIV/STD 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.

Complete ICP within **two (2) weeks** of assessment's completion. Frequency of plan updates is minimally determined by patient acuity.

Documenting Care Plan Progress or Barriers

Maintain appropriate documentation in patient record and in Casewatch. The ICP should be documented in the patient chart and 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.

The following data should be entered into Casewatch to document time spent on the ICP for each MCC team member involved:

- Date and time spent working on the ICP with the patient under the care plan service task; and
- If contact with patient for ICP planning was face-to-face or by phone.

Frequency of Care Planning

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 at least every 6 months
- **Self-Managed Patients:** Developing a care plan is not required for self-managed patients.

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:

“Brief...interventions are short, face-to-face conversations regarding motivation to change, and options for change which are provided during a window of opportunity or potentially teachable moment occasioned by a medical event.”
Dr. Craig Field, University of Texas.

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

PURPOSE OF BRIEF INTERVENTIONS:

HELP IDENTIFY TRIGGERS: Look at people places and things associated with negative behavior. Activities can include identifying times of the day associated with positive

experiences and looking at times associated with behaviors that put the patient at risk for negative outcomes.

PROVIDE EDUCATION: Teaching about the interactions between HIV medications and alcohol and other drugs. Educate patients on the affects that their behavior has on their immune system. Utilize worksheets, presentations, videos, etc.

ASSIST PATIENT WITH DEVELOPING COPING STRATEGIES for high-risk situations: Using behavioral rehearsals, role-plays and discussion to prepare for difficult encounters (i.e., meeting friends, telling family about health needs, etc.)

EXPLORE POSITIVE ALTERNATIVES: Looking at how to manage one's time now that negative behavior is not the organizing force. Suggesting or learning about new activities, hobbies and interests. Discussing how change and growth is often accompanied by fear.

HELP PATIENT LEARN FROM BEHAVIOR SEEKING: Listing the circumstances that preceded the last engagement in unhealthy behavior seeking: teasing out the changes in thinking, behavior and emotion that precipitated the behavior itself. Help the person to recognize his or her own particular warning signs.

PLAN AND DOCUMENT SOLUTIONS: Identifying high-risk situations and formulating a list of possible coping strategies. Assess regularly, review what worked and what did not.

PROVIDE REFERRALS: Refer patients to mental health, substance use treatment, etc. to treat the underlying problems. Try to encourage activities that support stress reductions, referrals to mental health professionals, including psychiatry. Psychotherapy that is aimed at gaining insight into the history of patient's behavior and restructuring their personality may assist the patient in meeting their goal of reducing behavior that negatively affects their health outcomes.

Moving Through the Stages of Change

The Stages of Change is a theoretical perspective that we can use to understand where a person is coming from in terms of their culture and behavior and help guide the Brief Intervention Session. In order to best work with patients, it is necessary to determine what stage of change a patient is in for a particular issue that include pre-contemplation, contemplation, determination, action, maintenance, and recurrence. Figure 4 below defines each stage of change and describes the appropriate task to move patients to the next stage.

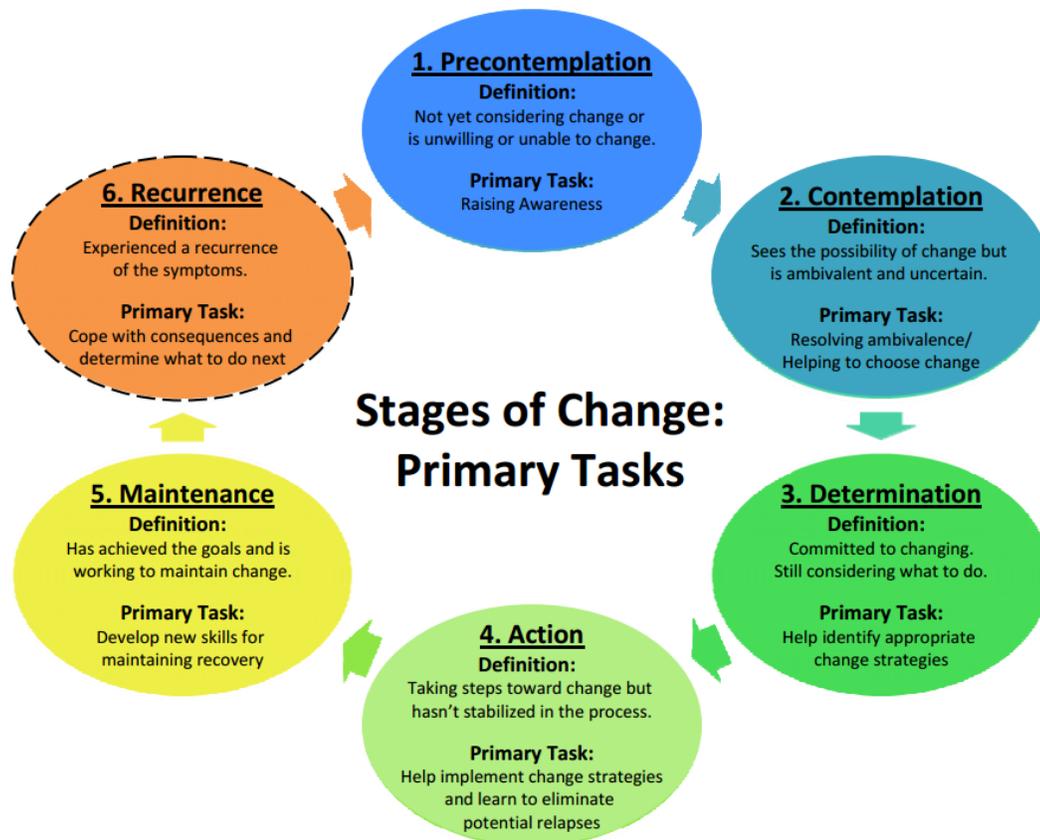


Figure 4: Primary Tasks for the Stages of Change [30]

Determining Readiness to Change

Before you can determine what stage a person is in on a certain issue, the question must be asked “On a scale of one to ten, how ready are you to change your behavior with regards to _____?” The “Readiness Ruler” shown below in Figure 5 is a useful tool to determine a patient’s readiness to change and the corresponding stage of change.

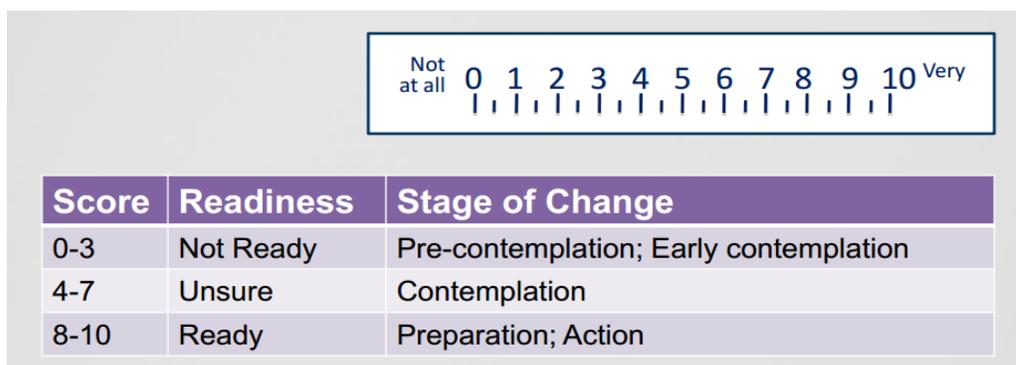


Figure 5: Readiness to Change Ruler

Stage of Change Intervention Matching Guide

Providers assess the patient’s stage of change and use the Stages of Change to guide their choice of appropriate interventions. To advance the patient’s progress most effectively, interventions are carefully stage-matched. Table 1 below outlines stages of change descriptions and corresponding intervention activities:

Table 1: Stages of Change: Intervention Matching Guide [30]

Stages of Change: Intervention Matching Guide		
<p style="text-align: center;">1. Pre-contemplation</p> <ul style="list-style-type: none"> • Offer factual information • Explore the meaning of events that brought the person to treatment • Explore results of previous efforts • Explore pros and cons of targeted behaviors 	<p style="text-align: center;">2. Contemplation</p> <ul style="list-style-type: none"> • Explore the person’s sense of self-efficacy • Explore expectations regarding what the change will entail • Summarize self-motivational statements • Continue exploration of pros and cons 	<p style="text-align: center;">3. Determination</p> <ul style="list-style-type: none"> • Offer a menu of options for change • Help identify pros and cons of various change options • Identify and lower barriers to change • Help person enlist social support • Encourage person to publicly announce plans to change
<p style="text-align: center;">4. Action</p> <ul style="list-style-type: none"> • Support a realistic view of change through small steps • Help identify high-risk situations and develop coping strategies • Assist in finding new reinforcers of positive change • Help access family and social support 	<p style="text-align: center;">5. Maintenance</p> <ul style="list-style-type: none"> • Help identify and try alternative behaviors (drug-free sources of pleasure) • Maintain supportive contact • Help develop escape plan • Work to set new short and long term goals 	<p style="text-align: center;">6. Recurrence</p> <ul style="list-style-type: none"> • Frame recurrence as a learning opportunity • Explore possible behavioral, psychological, and social antecedents • Help to develop alternative coping strategies • Explain Stages of Change & encourage person to stay in the process • Maintain supportive contact

[Additional tips and resources for using the Stages of Change and motivational interviewing strategies are included in the “Resources and Tips” section of this document.](#)

Brief Intervention Session Outline Example

Brief Intervention Sessions are conducted in an interactive manner through the use of open-ended questions and active listening, which focuses on developing objectives and strategies with the patient rather than simply providing information. The amount of time noted below are an **EXAMPLE** of approximately how much time can be spent in each area, however this will vary by topic.

- Introduce and orient patient to the session 1-2 minutes
- Enhance the patient's sense of self-risk 2-3 minutes
 - *What do you see as the riskiest things that you are doing?*
 - *What are you doing in your life that might be putting you at risk for negative health outcomes?*

- Explore the specifics of the most recent risk incident 2-3 minutes
 - *When was the last time that you experienced negative health outcomes?*
 - *What was happening then?*

- Review previous behavior change experiences 2-4 minutes
 - *Review and repeat*
 - *Change or add to plan*
 - *Encourage patient to keep trying*
 - *Reinforce your support*

- Summarize the risk incident and risk patterns 3-4 minutes

- Negotiate a behavior change step 4-5 minutes
 - *What might be better for you to do?*
 - *What is one thing you could do to begin?*
 - *What will you need to do first/next?*

- Identify sources of support and provide referrals 1-2 minutes

- Close the session 3-5 minutes

Total time: 18-28 minutes

Documenting Brief Interventions

The MCC team documents the delivery of all brief interventions to the patient both in the chart and in Casewatch. Progress notes shall clearly indicate that a brief intervention has occurred, what happened, and the patient's progress or response to the intervention. Interventions provided should match the ICP and needs identified in the assessment.

Required documentation in the patient chart includes:



- Date and type of contact (telephone, face-to-face or other) with patient;
- Time spent with, or working on behalf of, the patient;
- Description of what occurred during the contact;
- Description of how intervention addresses needs identified in the assessment and supports goals identified in the ICP;
- Brief interventions provided – what did you do;
- Response to the intervention – what was the patient's response?
- Barriers to completion of brief intervention delivery and actions taken to resolve them;
- Follow-up plan – what are the next steps for the patient and the MCC team; and,
- MCC team member's signature and professional title.

Required documentation in Casewatch for each MCC team member delivering the brief intervention includes:

- Date and type of contact (telephone, face-to-face or other) with patient
- Time spent with, or working on behalf of, the patient; and
- Type of intervention provided (report the service task)

Brief Intervention: Promoting 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 [31, 3, 32, 33, 34]. A high level of adherence to ARTs is needed for patients to fully benefit from treatment ([35]. 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 [36];

3. Identify potential barriers to adherence prior to starting or changing an ART regimen;
4. Assess adherence at least every 6 months;

While the MCM and PCM will deliver the majority of interventions to enhance treatment adherence, the Case Worker may provide *limited* treatment adherence counseling during routine follow up encounters with patients. This may include resolving socioeconomic barriers to HIV treatment access and adherence or discussing strategies that may help a forgetful patient to remember to take their HIV medication. However, the Case Worker should always update the MCM with any information shared by the patient about treatment adherence and defer more in-depth and/or medically focused treatment adherence interventions to the MCM and in some cases, the PCM.

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 all patients with high or severe acuity levels on the Adherence domain 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 [37].

AEP 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.



The complete manual for the Adherence Enhancement Program is available in Appendix B. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Patient Education

Information alone rarely changes behavior but is the foundation on which further interventions must be based. Without a fundamental understanding of HIV 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 STDs work in concert to promote HIV/STD risk reduction. Patients should know:

- 1.The difference between HIV and AIDS;
- 2.How HIV is transmitted;
- 3.How HIV treatment works; and
- 4.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.

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 impairments that limit independent living are identified and brought to the attention of the medical providers; and,
4. Patients' quality of life and 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 [11]. 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.

Condom Use – Hands On Skills Building

Correct and consistent condom use is an effective strategy to reduce HIV and STD transmission and acquisition. Teaching patients the skills necessary to correctly use condoms is critical to reduce HIV and STD 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.

Brief Intervention: Promoting Safer Sex and Risk Reduction

Risk reduction counseling builds on HIV/STD knowledge to motivate and empower patients with strategies to reduce their risk of HIV/STD 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 MCC team counsels 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/STDs 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 include the following:

1. How HIV and STDs are transmitted;
2. Basic information on how to reduce risk for HIV/STDs;
3. Skills necessary to reduce risk (e.g., using both male and female condoms, cleaning needles and works, obtaining new needles and works); and,
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.

Options/Opciones Risk Reduction Strategy

It is recommended that the MCC team 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 brief, clinic-based HIV risk reduction intervention for HIV-positive patients designed to be delivered by providers during routine visits [38].

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 STDs 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 MCC team delivers the intervention during scheduled MCC meetings. The first meeting takes approximately 5-10 minutes, and the team uses Motivational Interviewing 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 team checks in briefly with the patient (5-10 minutes) to review previously identified issues and progress on established risk reduction goals.



The complete manual for **Options/Opciones Risk Reduction Strategy** is available in Appendix C. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Brief Intervention: Engagement in HIV Care

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 [39, 40, 41, 42, 43, 44]. 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 with 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) [41], which the PCM and Case Worker will work to resolve with the patient through care coordination.

Early initiation of HIV treatment and long-term adherence leads to better health outcomes and reduces transmission of infection [39, 4]. Linkage to care shortly after HIV diagnosis provides opportunities for intervention to prevent HIV transmission [32]. Many persons living with HIV are not linked to care shortly after HIV diagnosis or do not stay in care.

The concept of “in care” encompasses relationships with the care system that may vary in their level of consistency and durability and that may change over time (see figure 6). The terms linkage to care, engagement/retention, and reengagement in care and re-entry to care reflect the degrees of relationship with the care system. Each step requires different intervention activities.

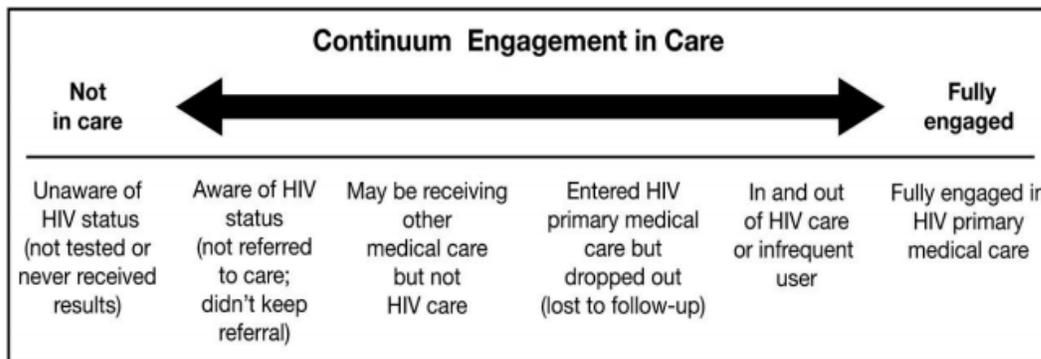


Figure 6: Levels of Engagement in the HIV Care Continuum [45]

A primary objective of MCC is to assist patients in accessing appropriate clinical and support services to help them 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.

Stages of Change/Interventions for Engagement in HIV Care

Patients will vary in their motivation or readiness to stay engaged in HIV care. Understanding where patients are along the behavior change continuum helps the MCC team to determine the types of strategies needed to improve attendance to and engagement in HIV care. These specific strategies are detailed in Table 2 below.

Stage	Change Strategy
Pre-contemplation : Patient is not aware of/does not see importance of receiving consistent medical care	<ul style="list-style-type: none"> ▪ 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.	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Through education and referrals, work with patient to reduce/address potential barriers to care; ▪ Describe to patient what to expect: <ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Support sustained attendance through self-efficacy building and positive feedback; ▪ Work with patient to improve sources of social support to minimize relapse

Table 2: Stages of Change and Tailored Change Strategies

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 [11]. Information from the Assessment can be used to show patients

improvement in their HIV knowledge and reductions in their acuity. Providing opportunities for positive feedback can strengthen and support behavior change.

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 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** [46]. After the first or second meeting with the patient, offer to show him/her around the clinic pointing out where:
 - 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 if:
 - appointment reminders are used (telephone calls or letters);
 - walk-in patients are seen or if same-day appointments are available; or
 - 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 the emergency room, etc.
 - **Monitor the appointment schedule and contact patients with missed appointments** [41]. The appointment schedule should be reviewed daily to identify any MCC patients coming in the clinic that day. MCC staff should contact any MCC patients (and patients assessed as 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** [41]. 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, particularly at the beginning of the visit. This strategy empowers patients to take responsibility for their own care.

Brief Intervention: Behavioral Health

HIV infection affects all dimensions of a person’s life: physical, psychological, social, moral and spiritual. People who test HIV-positive may experience a range of emotions including denial, anger, despair and suicidal thoughts (or ideation). Despite the growing evidence of the mental health needs of PLWHA, mental health and behavioral disorders are often overlooked and undertreated [47]. Undetected mental health problems such as depression, cognitive disorders, personality disorders, and co-occurring substance-related disorders (substance dependence, substance abuse, intoxication, and withdrawal) can have a profound effect on ART adherence, clinic attendance, HIV disease progression of disease and HIV transmission [48]. Given the potential impact of behavioral health issues on successful engagement in care, it is important to be aware of the different mental health needs of PLWHA at varying points in the continuum of care, and to design interventions and support services to address those needs.

- **Co-occurring mental health and substance abuse problems:** Mental health problems associated with HIV can have a major impact on willingness of providers to initiate ART and on subsequent treatment adherence and outcomes [49, 26, 47]. Mental health and

co-occurring substance abuse problems can contribute to further transmission of HIV due to risky behavior [48].

- **Response to HIV diagnosis:** For most people, finding out that they are HIV-positive raises personal concerns about death and dying, disclosure and stigma, changes in personal relationships, and uncertainties about the future. These stresses can precipitate anxiety and depression, which may contribute to delayed entry into or drop-out of HIV treatment [50].
- **Stigma and discrimination:** Social isolation, marginalization, and discrimination resulting from HIV stigma can have profound effects on the mental health of PLWHA and those caring for them [51, 52]. Stigma also has a direct effect on care-seeking behavior and health outcomes and must be addressed to optimize care for those living with HIV [53, 54].

In diagnosing both co-occurring mental health and substance use disorders (behavioral health), it may be difficult to determine which co-morbidity—substance abuse, mental illness, or HIV—to address first. So the MCC team in collaboration with HIV clinicians should become familiar with community mental health and substance abuse resources to provide referrals to care and treatment services for individuals with co-occurring disorders.

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 [51]. 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.

The Behavioral Health brief intervention includes 3 key components illustrated in figure 7 should be guided by patient need as identified in the MCC Assessment. Patients with high or

severe acuity in the Behavioral Health, Substance Use and Addiction Drug and Alcohol Use, or Support Systems and Relationships domains.

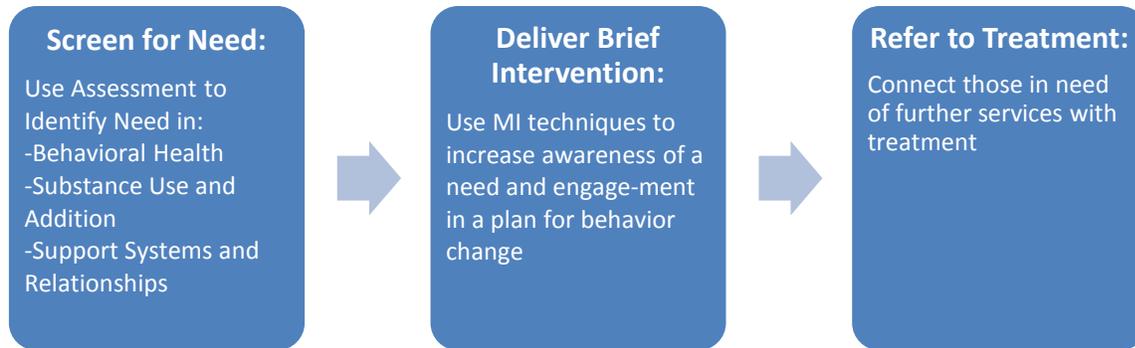


Figure 7: Behavioral Health Brief Intervention Components (adapted from “SBIRT for Mental Health and Substance Use Screen, Brief Intervention & Referral to Treatment: Implementation Guide for HIV Service Providers”)

Brief interventions for behavioral health are designed to motivate patients to change their behavior – reduce substance use (alcohol, drugs and/or tobacco), manage stress, and cultivate sources of support – in the immediate future. Brief interventions are intended for patients with less severe behavioral health issues (moderate acuity for the mental health and/or substance use domains) who do not need a referral to additional mental health or addiction treatment and services. During brief interventions, patients are:

- Advised in clear, respectful terms in order to decrease or abstain from substance use and/or improve or reduce mental health stressors;
- Encouraged to identify specific steps to reach their specific goals;
- Taught behavior change skills that will limit negative consequences; and
- Provided with a referral for further care, if needed, and offered support to successfully complete the referral.

For moderate acuity patients, the MCC team should follow up monthly, in order to monitor changes in mental health status and/or drug and/or alcohol use or to determine if or intensive treatment is needed. Because drug and/or alcohol use often co-occurs with mental illness [24], the MCC team should review both the Behavioral Health and Substance Use and Addiction sections of the Assessment for severe and high acuity patients to determine whether patients are having difficulties in both domains.

Referral to Treatment

In some cases, a more advanced treatment options are necessary that may include severe mental health issues and/or substance use that interfere with daily activities. 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. The referral to process consists of helping patients access specialized treatment, selecting treatment facilities, and facilitating the navigation of any barriers such as cost of treatment or lack of transportation that would hinder them from receiving treatment in a specialty setting. In order for this process to occur smoothly, MCC providers must initially establish and cultivate relationships with specialty providers, and then share pertinent patient information with the referral provider. Handling the referral process properly and ensuring that the patient receives the necessary care coordination and follow-up support services is critical to facilitating linkage.

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 to reduce potential for transmitting HIV (see **Promoting Safer Sex and Risk Reduction**).

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.

The Behavioral Health brief intervention was adapted from “SBIRT for Mental Health and Substance Use: Screen, Brief Intervention & Referral to Treatment: Implementation Guide for HIV Service Providers” published by the Center for Community Collaboration at the University of Maryland, Baltimore County [55]. The complete guide is available in Appendix D. An additional resource, ***HIV Provider Smoking Cessation Handbook***,



is included in Appendix E to support smoking cessation among persons with HIV. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Brief Intervention: Disclosure Interventions

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 [19]. Consider disclosure assistance as a tool to enhance social support and treatment adherence.



The following brief intervention was taken directly taken from “Rapid Response: Disclosure of HIV-Positive Status” published by Rapid Response Service [56]. The complete resource is available in Appendix F. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Disclosure is something with which every person living with HIV experiences and struggles. The process is complex, can be fraught with mixed emotions, and the outcomes can be unpredictable and difficult to handle. Despite the difficulty disclosure might pose, non-disclosure has detrimental impacts on the person living with HIV and is associated with personal distress, loneliness and social isolation [57, 58, 59, 60]. Furthermore, non-disclosure may lead to **medical non-adherence** as a way to conceal the disease from others [61, 62]. Not only is disclosure important for the person living with HIV, it is also important for those around him or her. For example, children who are unaware of their mother’s HIV-status can often perceive that something is wrong and become distressed when they are unable to express their feelings [63, 64]. In the context of society and community, disclosure is thought to be important for public health purposes in terms of preventing the spread of HIV. Furthermore, nondisclosure of one’s HIV-positive status before engaging in a sexual act can lead to criminal prosecutions. Given the personal, societal and legal importance of HIV disclosure, it is important to understand the experiences of HIV disclosure, as well as effective disclosure strategies and interventions for people living with HIV.

Key Take Home Messages

- HIV disclosure is a lifelong process. Reasons for disclosing/not disclosing change constantly. Many individuals have their own personal strategies and reasons for

disclosing, which are carefully planned to elicit positive outcomes. Common facilitators/reasons for disclosing are:

- Trust in the person receiving the disclosure;
 - Positive experiences with previous disclosure;
 - Existence of strong social support;
 - To gain social support;
 - To relieve the stress of keeping their HIV status a secret;
 - Obligation and duty to inform; self-acceptance of HIV-positive identity; and,
 - To share knowledge; and to control disclosure (i.e. to disclose before someone else exposes them).
- Common barriers to disclosing are:
 - Negative experiences with previous disclosures;
 - Fear of discrimination, stigma and rejection;
 - Lack of a strong social network;
 - Feelings of shame and guilt regarding one's HIV status;
 - Struggle with HIV+ identity; cultural factors (e.g. homophobia) within one's community;
 - Lack of HIV education and inability to cope with the outcome of the disclosure; and,
 - Concern about harming or burdening others.
 - The impacts and outcomes of HIV-disclosure are wide-ranging:
 - Negative outcomes include: rejection, abuse, violence, stigma and discrimination.
 - Positive outcomes include: more high quality social support, stronger family cohesion and relationships, reductions in anxiety and depression, and improvements in physical health.

HIV Disclosure Strategies

Careful planning and preparation for a disclosure increases the likelihood the person will receive positive reactions and achieve his or her disclosure goals. The planning process includes decisions on: who to disclose to, why to disclose, when to disclose, where to disclose and how to disclose. Based on reported negative experiences, people living with HIV advise against: disclosing because you feel pressured to; not planning before disclosure for both the actual event as well as coping with the outcomes; and disclosing too soon before dealing with personal emotions and feelings about the new diagnosis [61, 65, 66]. Approaches to HIV disclosure fall under three categories: disclose to everyone, disclose to no one, and selective and strategic disclosure [61, 67, 68, 59]. Those who choose to disclose to everyone face the highest risk of stigma and discrimination, but tend to be more prepared to deal with those

negative outcomes, have a high sense of self-esteem and have a “take me as I am attitude.” [61, 59].

In contrast, **those who disclose to no one** have lower self-acceptance, less access to social support networks, greater fears and concerns of stigma, and face the highest risk of social isolation and loss of close personal relationships due to disease related stress [61, 68, 59]. The selective approach to disclosure is most common among people living with HIV [61, 67, 68, 59]. Disclosing and not disclosing are both ways of coping, and the decision depends on strategically weighing the benefits and harms for each disclosure event. There isn't a single formula, and the decision differs for different targets of disclosure (e.g. friend, family, and spouse) and in different contexts. Even though these approach categories are helpful in summarizing disclosure experiences, they aren't static. Individuals' disclosure decisions change constantly over time depending on their circumstances. In the literature, effective and ineffective disclosure strategies discussed by people living with HIV are similar across contexts and settings.

HIV Disclosure Interventions

Interventions to promote HIV disclosure cannot be understood without considering the social and environmental context within which relationships and behaviors (sexual or otherwise) are negotiated. Interventions should acknowledge HIV-related stigma and marginalization of certain populations due to race, gender and sexual orientation, as stigma influences the likelihood of disclosure [69, 70].

Each of the interventions utilized practical components to help individuals plan for their disclosure: role-playing and behavioral exercises, discussing and thinking about what needs to be considered prior to disclosure, developing communication and language skills applicable to disclosure, and preparing for potential reactions and outcomes to disclosure.

FOLLOWING UP WITH PATIENTS

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. 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.

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 services, 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 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.

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. The frequency of patient follow-up depends on the patient's acuity and ICP. 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 following are the mandatory *minimal* intervals for follow-up 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 up 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.

Linkages to Service Referrals

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 [71, 9]. The most commonly needed support services are mental health, substance use treatment, financial assistance, housing assistance, legal services, and transportation. The PCM facilitates linkages to mental health and substance use 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.

Documenting Patient Follow-Up Activities

The MCC team documents all contact with or on behalf of the patient both in the chart and in Casewatch. Progress notes detailing activities related to follow-up and referrals 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;
- Progress made towards achieving goals identified in the ICP;
- Barriers identified in goal process and actions taken to resolve them;
- Referrals provided and whether patients were successfully linked;
- Barriers identified to referral linkage or completion of brief intervention deliver and actions taken to resolve them; and
- MCC team member’s signature and professional title.

Required documentation in Casewatch includes:



- Date and type of contact (telephone, face-to-face or other) with patient or other providers;
- Report time spent with, or working on behalf of, the patient in appropriate service task; and/or
- Report date and type of referral provided and follow-up to document whether referral was completed.

CASE CONFERENCING

Case conferences are multi-disciplinary meetings where health professionals collaborate on a coordinated plan to meet the health and service needs of patients. These are especially essential to provide seamless care for patients with complex multidisciplinary care needs and those with needs identified in the assessment domains. Case Conferencing gives multidisciplinary team members an opportunity to discuss patients' needs and determine the best follow-up plan in a collective fashion.

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 shall include primary care or HIV physicians, mid-level providers (e.g., nurse practitioners and physician assistants), mental health specialists, nutritionists, dentists, substance use 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.

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; and
- Adjust current service plans.

Frequency of Case Conference

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

Documenting Case Conferences

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 and in Casewatch. An example of a case conferencing form follows below.

Required documentation in patient's chart 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; and
- Results of implementing previous interventions/guidance.

Required documentation for each participating MCC member in Casewatch includes:



- Date of case conference; and
- Time spent in case conference under service task.

CASE CONFERENCE FORM

MCC Team: _____ Date _____

Patient Name: _____ Patient ID# _____

Participants Present (signature and title):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Presenting Problem/Issues:

Clinical Guidance/Plan of Action:

Follow-up/Outcomes:

_____ (MCM) Date: _____

_____ (PCM)

_____ (Case Worker)

MCC Team Signatures

ADMINISTRATIVE ITEMS

This section outlines additional requirements for the MCC Program.

Team Member Qualifications

The MCC team is comprised of:

- **Medical Care Manager (MCM):** The MCM must possess a valid license as a registered nurse (RN) in the state of California. The Medical Care Manager conducts assessment, integrated care planning, and monitoring of patients' progress in conjunction with the Patient Care Manager. Medical Care Management is designed to meet the needs of patients who are experiencing the following: medical adherence issues; significant changes in HIV health status or multiple health diagnosis that affect a patient's HIV status. MCMs are assigned to work with a Patient Care Manager to facilitate the best coordination with medical home team members. The MCM ensures the patient's biomedical needs are met and their care is coordinated. MCMs assist patients through the provision of brief interventions focused on patient education, treatment adherence, managing side effects, medical nutrition therapy, co-infections, preventative care and risk reduction. The MCM does NOT focus on Clinical Nursing duties.
- **Patient Care Manager (PCM):** The PCM must possess a Master's degree in one of these disciplines: Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or Human Services. The Patient Care Manager conducts assessment, integrated care planning, and monitoring of patients' progress in conjunction with the Medical Care Manager. The PCM ensures the comprehensive and thorough assessment of a patient's psychosocial needs, particularly as they relate to behavioral health and addiction issues. PCM also conducts brief interventions focused on improving a patient's status as it relates to addiction issues, mental health distress, risk reduction and disclosure interventions.
- **Case Worker(s) (CW):** The CW must possess either a Bachelor's degree in Nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling, Human Services, OR a license as a vocational nurse (LVN). CWs address the patient's socioeconomic needs and assist the MCM and the PCM with patient monitoring, following up service linkages, assisting the MCM and PCM in updating care plan results, following-up with patients and tracking outcomes. Additionally, the Case Worker should act 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.

Casewatch Data Management System

DHSP utilizes the Casewatch Data System to manage patient level data. Whether contractors use Casewatch directly, or sends electronic file through data transfer, data must be delivered to Casewatch on a regular basis.

1. What is a patient record? – a record in Casewatch for each patient that contains the basic (AKA patient) registration that includes residence, verification of HIV-positive status, income, and the eligibility review data (HRSA requirements for RW services).
2. A patient record with basic registration data is required to enter Screener, Tracker and MCC Assessment data as well as service data for the screener. The eligibility review is not required.
3. A complete and up-to-date eligibility review is required in the patient record to enter service data (time) for the Tracker, Assessment, and interventions. Eligibility must be updated at least every six months.
4. This means that a patient that is screened for MCC but does not need it only is required to have a patient record with basic registration data. The Screener data and the service time to complete the Screener can be entered into Casewatch. If a patient is screened and identified as needing MCC, data can be entered into the Screener, the Tracker and the Assessment, and service data for completing the Screener if the patient has a patient record with basic registration. For service data to be entered for time to complete the Tracker and the Assessment, the patient file is required to have the eligibility review data complete and current.



The Casewatch Data Companion describes the tasks and rules for data entry and monthly reporting for the MCC program and is available in Appendix H. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Monthly Reporting

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. A complete monthly report shall 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 Page
2. Section II: Patient Demographics
3. Section III: Services Summary Report
4. Section IV: Narrative

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. 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



A sample of the Monthly Report is available in Appendix I. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Please see Section III of the monthly report format on the pages that follow.

Monthly Report Section III

The Monthly Services Report, Section III includes four parts: Part A – Screener Outcomes and Enrollment Tracker Status; Part B – Patient Acuity Summary; Part C – Intervention and Follow-Up Activities; Part D – Referrals and Linkages; and Part E – Overdue Items.

Part A. Screener Outcomes and Enrollment Tracker Status									
	Screener Outcomes				Enrollment Tracker Status				
	A.1 Screening		A.2 Needs MCC	A.3 No Need at Screening	A.4 Total Patients Tracked		A.5 Opt Out, Ineligible	A.6 Unable to Contact	A.7 Enrolled in MCC
	Total # of Patients	Total # of Hours	# of Patients	# Patients	# of Patients	# of Hours	# Patients	# Patients	# Patients
This Month									
Year-to- Date:									

Part A – Screener Outcomes and Enrollment Tracker Status. This Part captures the results of MCC Screener Outcomes and Tracker Status by patient.

Screener Outcomes

A.1 - Screening: All patients screened and amount of time spent conducting screening tasks. This is the sum of A.2 – A.3

A.2 - Needing MCC: This captures the results of the screener where the **Screener Results = “Yes, Needs MCC”**

A.3 - No Need at Screening: This captures the results of the screener where the **Screener Results = No, “No Need at Screening”**

Enrollment Tracker Status

A.4 – Total Patients Tracked – Represents the total number of patients whose Enrollment Status was Tracked in Casewatch and hours spent by staff conducting tracking activities. This is the sum of A.5 – A.7.

A.5 – Opt Out, Ineligible: These are patients where the Enrollment Status was set to ‘Opt Out’ or ‘Ineligible’ because the patient did not want to participate in MCC or was ineligible for MCC services.

A.6 – Unable to Contact: These are patients where the Enrollment Status was set to ‘Unable to Contact’ because staff could not contact the patient

A.7 – Enrolled in MCC: These are patients where the Enrollment Status was set to Enrolled in MCC because the patient chose to participate in MCC

Monthly Service Report Section III

Part B. Patient Summary

This is Section III, Part B of the report. Part C summarizes patients served.

Staff Name, Position	B.1 Severe		B.2 High		B.3 Moderate		B.4 Self-Managed		B.5 Patients with no Acuity		B.6 Total Pts Enrolled		B.7 Total Non-Enrolled Pts Served		B.8 Total Patients Served	
	# Patients	# of Hours	# Patients	# of Hours	# Patients	# of Hours	# Patients	# of Hours	# Patients	# of Hours	# Patients	# of Hours	# Patients	# of Hours	# Patients	# of Hours
MCM																
PCM																
CW																
MCM																
PCM																
CW																
MCM																
PCM																
CW																
This Month:																
Year-to- Date:																
% of Patients Virally Suppressed YTD																

Columns B.1 – B.4 include all patients where the Enrollment Status = Enrolled in MCC that have an assessment in Casewatch, by acuity according to current assessment data and the hours represent ALL service hours patients received (Assessment, Care Plan, Brief Interventions, Referral, Follow-Up and Monitoring, and Case Conferencing).

Column B.5 is the total number of patients served that do not have an acuity assigned during the time period. They were enrolled but not yet assessed.

Column B.6 is the total number of all patients Enrolled that received services by the MCC Team. This is the sum of columns B.1-B.5.

Column B.7 is the total number of Non-Enrolled patients that received services by the MCC Team.

Column B.8 is the sum of all patients in Columns B.6 – B.7 and represents ALL patients served by the MCC team, regardless of enrollment status, during the reporting period.

Rows: Staff Name and Position: list of staff providing MCC services indicating number of patients and hours of service by patient acuity in adjacent columns. Then totals for services provided “This Month” and Year to Date.” Finally, the last row indicates the Percentage of patients that are virally suppressed Year to Date, by patient acuity.

Note: Pull Viral Load data from the most recent assessment. If viral load data is missing, then calculate as **NOT** virally suppressed.

Monthly Service Report Section III

Part C. Monitoring, Brief Interventions and Follow-Up Activities for Enrolled Patients

Staff Name, Position	C.1 Implementation, Monitoring & Follow Up Activities		Brief Interventions												C.8 Total	
			C.2 Medication Adherence Counseling		C.3 Risk Reduction Counseling		C.4 Disclosure Assistance		C.5 Engagement In Care		C.6 Behavioral Health		C.7 Total Patients Receiving Brief Interventions			
	# Patients	# of Hours	# of Patients	# of Hours	# of Patients	# of Hours	# of Patients	# of Hours	# of Patients	# of Hours	# of Patients	# of Hours	# of Patients	# of Hours	# Patients	# of Hours
MCM																
PCM																
CW																
MCM																
PCM																
CW																
Monthly Total:																
Year-to-Date Total:																

This part of the report still captures the total number of all patients served and direct service hours delivered by patient encounter type (columns) Implementation, Monitoring & Follow Up and Brief Interventions (Medication Adherence Counseling; Risk Reduction Counseling; Disclosure Assistance; Engagement in Care; and Behavioral Health) for “This Month” and “Year-to-Date”

Column C.1 includes all patients where the Enrollment Status = Enrolled in MCC that have an assessment in Casewatch and who had hours reported for the ‘Implementation, Monitoring and Follow Up’ task

Columns C.2-C.6 includes all patients where the Enrollment Status = Enrolled in MCC that have an assessment in Casewatch and who had hours reported for the Brief Interventions (Medication Adherence Counseling; Risk Reduction Counseling; Disclosure Assistance; Engagement in Care; and Behavioral Health) tasks

Column C.7 is the sum of all patients and all hours in Columns C.2 through C.6 to reflect total enrolled patients receiving Brief Interventions and the total hours of Brief Interventions during the reporting period

Column C.8 is the sum of all patients and all direct service hours in Columns C.1 and C.7 and represents ALL enrolled patients and hours

Monthly Service Report Section III

Part D. Referrals And Linkages									
	D.1 Housing Services		D.2 Mental Health Services		D.3 Addiction Treatment		D.4 Totals		D.5 Percentage
	Number of Patients Referred	Number of Patients Linked	Number of Patients Referred	Number of Patients Linked	Number of Patients Referred	Number of Patients Linked	Number of Patients Referred	Number of Patients Linked	% Patients Linked
This Month:									
Year-to-Date:									

This part of the report captures the number of unduplicated patients from Part A, Column A.1 that were referred and linked to services in the reporting period.

Row This Month is the Monthly Program Total for reporting period

Row Year-to-Date is the Program Total annual reporting period

Column D.1 is the number of patients in A.1 that were referred and linked to Housing Services in the reporting period

Column D.2 is the number of patients in A.1 that were referred and linked to Mental Health Services in the reporting period

Column D.3 is the number of patients in A.1 that were referred and linked to Housing services in the reporting period

Column D.4 is the sum of patients in Columns D.1 through D.3 that were referred and linked in the reporting period

Column D.5 is the number of patients linked in Column D.4 divided by the number of patients referred in Column D.4

Note: Addiction Treatment Services: “Addiction Treatment Services” is a revised label for the “Substance Abuse” category included in the previous report template. “Addiction Treatment Services” refers to the same type of referrals as “Substance Abuse.”

Monthly Service Report Section III

Part E. Overdue Item Status			
	E.1 Overdue Screener	E.2 Overdue Enrollment Tracker	E.3 Overdue Assessment
	# of Patients	Total # of Patients	# of Patients
This Month			
Year-to-Date:			

Column E.1 identifies patients who were initially Screened, where their 6 month Screener is Overdue in Casewatch

Column E.2 includes unduplicated patients where the Screener Status = 'Needs MCC' that DO NOT have a current Enrollment Tracker entered in Casewatch

Column E.3 includes patients where the Enrollment Status = Enrolled in MCC that DO NOT have a current assessment entered in Casewatch

RESOURCES AND TIPS

This section provides various resources and tips that may be helpful in providing MCC services.

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 patient has the right to revoke this release by written request at any time. 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.



See Appendix G.1 and G.2 for a sample of the Consent to Release Medical Information and the Casewatch consent forms in English and Spanish, respectively. All appendices are available and can be accessed on the DHSP website at: <http://www.ph.lacounty.gov/aids/Contractors.htm>.

Electronic patient data

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.

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) Placement of 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

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.

Conducting the 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.

- 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.

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.² 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

² A potential form of abuse affecting PLWHA, in particular, is the threat of disclosing their HIV status to others.

shown rates of IPV/DV among young men who have sex with men is comparable to heterosexual women.³

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 do 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?”**

- 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 PLWHA, 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 STDs). When dealing with STDs, however, remind the patient that traditional HIV risk reduction methods may not be as effective at reducing other STD’s, as some infections are more easily transmitted via oral sex (e.g., gonorrhea) and skin-to-skin contact (e.g., syphilis, herpes and HPV).
- 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).

³ 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.

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.

Successful Service Linkages

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.⁴
5. Review what patient should expect, including length of time they should expect to wait, and what they will be required to provide during the appointment, if applicable.
6. Assess and address any other barriers to accessing the referral. Identify strategies to overcome these barriers with the patient.
7. 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.

⁴ 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)

Remember to document referrals given and whether or not the referral was linked in the patient chart as well as in the Casewatch referral module.

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.

Motivational Interviewing⁵

Motivational interviewing (MI) is a more directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence [72]. 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; and
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.
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:

⁵ This section is taken/adapted from "What is MI?" Behavioral and Cognitive Psychotherapy 23, 325-334.

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 patient 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.

Motivational Interviewing Techniques: OARS

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.

- **Open-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."*

- **Affirmations** 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?”*

- **Reflective 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.

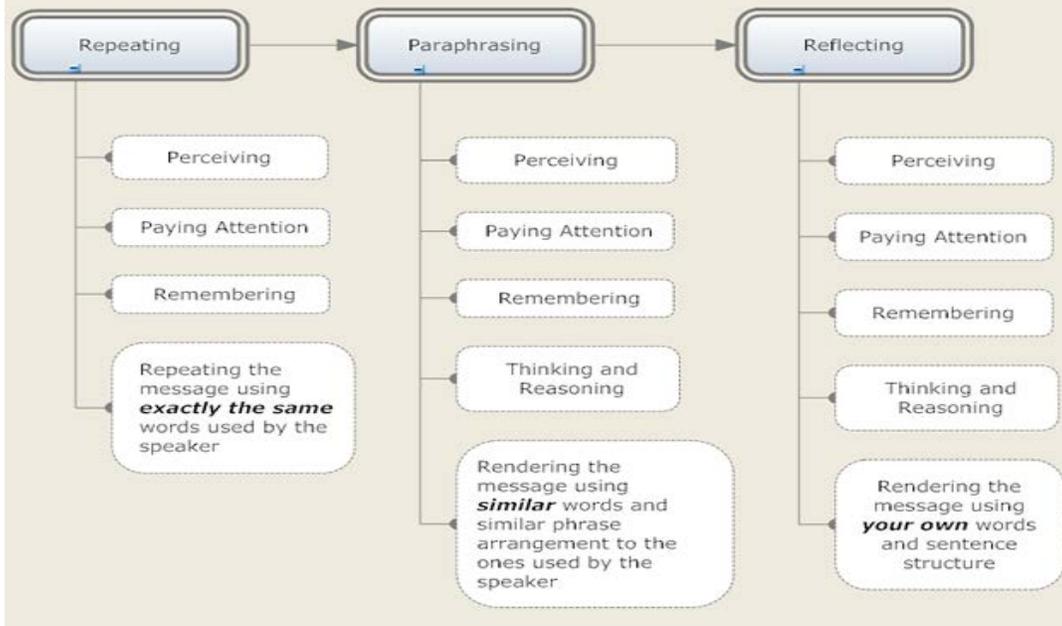
Example:

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.

Degrees of Active Listening



6

- **Summarizing** 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."

- **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.

⁶ Citation unknown. Last accessed on October 31, 2012 from: http://en.wikipedia.org/wiki/Active_listening.

Behavior Change Strategies and MCC Service Components

The figure below explains how changes of change and motivational interviewing strategies can be used for specific service components of MCC. While the choice of strategy used is best determined by the patient and his/her specific circumstances, figure 7 illustrates recommended matching of strategies.

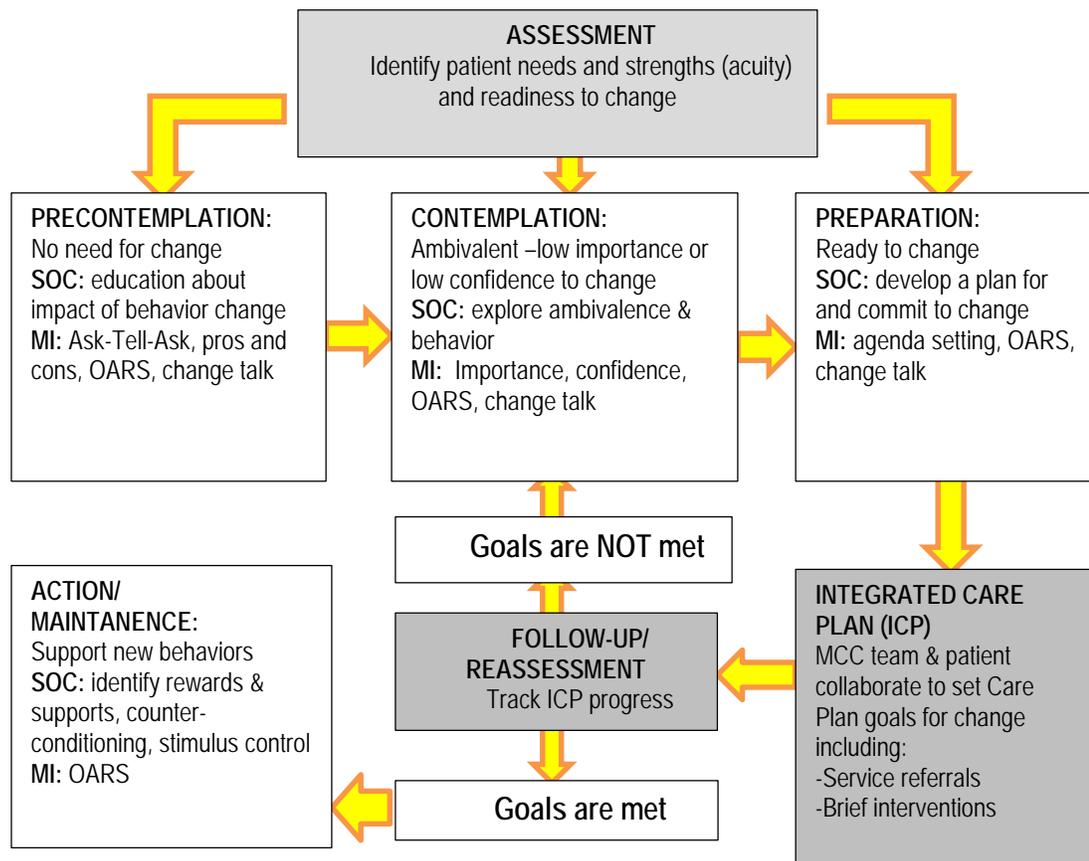


Figure 8: Matching Stages of Change and Motivational Interviewing Strategies to Key MCC Program Processes (adapted from Abramowitz, et al.); SOC=stages of change; MI=motivational interviewing; OARS=open-ended questions, affirmations, reflections and summaries

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List of Appendices

- Appendix A: Performance Measures
- Appendix B: Adherence Training Manual
- Appendix C: Options/Opciones Risk Reduction Strategy Manual
- Appendix D: SBIRT for Mental Health and Substance Use: Screen, Brief Intervention & Referral to Treatment: Implementation Guide for HIV Service Providers
- Appendix E: HIV Provider Smoking Cessation Handbook
- Appendix F: Rapid Response: Disclosure of HIV-Positive Status
- Appendix G.1: Casewatch Consent Form - English
- Appendix G.2: Casewatch Consent Form - Spanish
- Appendix H: Casewatch Data Companion
- Appendix I: Report Template

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