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MEDICAL CARE COORDINATION PROGRAM GUIDELINES

v.2026.0

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

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WHAT'S NEW IN 2026

After over 10 years of program implementation experience, and in response to program evaluation data and feedback from people with HIV and the Medical Care Coordination (MCC) workforce, the MCC program has been updated. The MCC Program Guidelines that follow reflect these updates and re-prioritizations.

Key updates include:

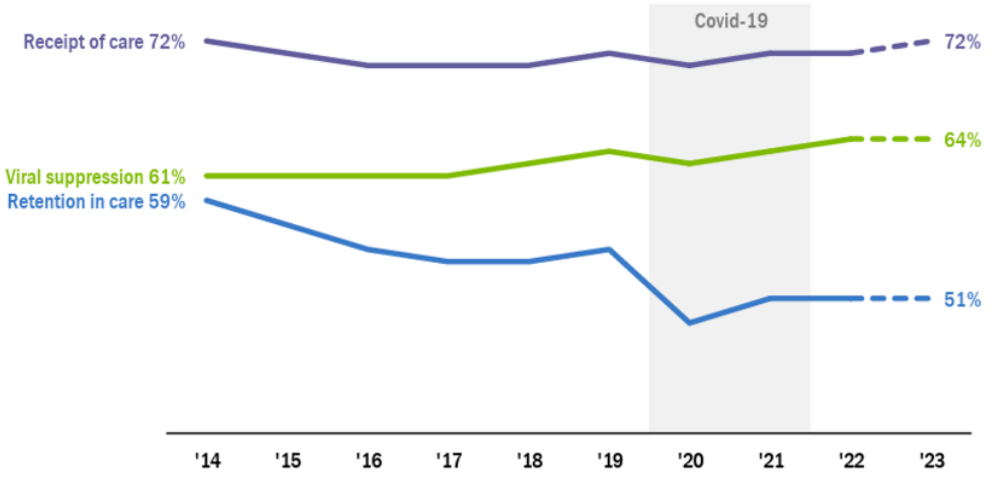
- A new, streamlined assessment that is less burdensome for patients and staff (see Appendix A). Patient self-administration of the assessment is offered as an optional approach for programs to consider, if appropriate for their patient population.
- A new data management system called e2 Los Angeles County Ryan White Program ("e2LA") that replaces HIV Casewatch.
- The Retention Outreach Specialist (ROS) moved from the MCC program to a new service category, Patient Support Services (PSS). Agencies will develop systems of care to ensure coordination between the MCC and PSS services are available at their clinical sites.
- The definition of "out of care" for program eligibility purposes has been changed to having no medical appointments in *over 12 months.*
- Acuity scoring has been updated to High, Moderate, and Low. We collapsed the prior Severe and High acuity scores into a single category and renamed Self-Managed as Low.
- Updates to the recommended minimum frequency of activities by patient's overall acuity (see Table 1).
- Documentation in your agency's electronic medical records (EMR) is prioritized in order to optimize multidisciplinary care coordination for MCC patients.

It is recommended that all MCC staff, including supervisors and program managers, read through the new guidelines to ensure a full understanding of all aspects of the program. Requests for additional technical assistance are encouraged, and trainings will be provided, as well.

ABOUT THE MEDICAL CARE COORDINATION PROGRAM

Over the past 35 years, the development of safe, well-tolerated, and effective treatments has significantly improved both the life expectancy and quality of life for people with HIV (PWH). PWH who maintain a suppressed viral load experience better health outcomes and are unable to transmit HIV to their sexual partners compared to those who are not in care and have an unsuppressed viral load (Cohen MS, 2011; Das, Chu, GM, & al, 2010).

However, many PWH in Los Angeles County (LAC) experience barriers to care and are therefore not accessing HIV medications and other supportive services. Despite advancements in the biomedical treatments available, only modest improvements in the percent of PWH achieving viral suppression (+3%) have been made in LAC between 2014 to 2023 (Division of HIV and STD Programs, Department of Public Health, County of Los Angeles, 2023). These data underscore the necessity to adopt an integrated approach combining evidence-based biomedical treatments with tailored behavioral support interventions to enhance retention in HIV care and promote viral suppression as we strive to meet the Ending the HIV Epidemic goal of 95% viral suppression in LAC.



[1] Receipt of care: numerator includes PLWDH with ≥1 CD4/VL/Genotype test in 2023; denominator includes PLWDH diagnosed through 2022 and living in LAC at year-end 2023 based on most recent residence. Retention in care: numerator includes PLWDH with ≥2 CD4/VL/Genotype tests at least 3 months apart in 2023; denominator includes PLWDH diagnosed through 2022 and living in LAC at calendar year-end 2023 on most recent residence. Viral suppression: numerator includes PLWDH whose last VL test in the calendar year was suppressed (HIV-1 RNA<200 copies/mL); denominator includes PLWDH diagnosed through 2022 and living in LAC at year-end 2023 based on most recent residence. PLWDH without a VL test in 2023 were categorized as having unsuppressed viral load.
[2] Due to reporting delay, 2023 HIV data are provisional as indicated by the dashed line.

Figure 1. Receipt of HIV care, retention in care, and viral suppression for PWH aged >13 years living in LAC, 2014 – 2023

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 and Extension Act of 2009 focused on improving the integration of medical care with psychosocial service provisions (Wilson, 2006; U.S. Congress, 2009). In alignment with both reauthorizations, the Los Angeles County Commission on HIV (COH) developed the MCC service standards based on a synthesis of care coordination approaches utilized in the treatment of HIV and other chronic illnesses, including traditional case management, chronic disease management and integrated treatment models (Leigal, 2006; Oewens, Wollershiem, Hermens, & al, 2005; Sherer, Stieglitz, Narra, & et al, 2002; Swedeman, Ingram, & Rotheram-Borus, 2009).

The LAC Department of Public Health, Division of HIV and STD Programs (DHSP) operationalized the MCC program in 2013 to manage HIV medical care among populations experiencing multiple and complex needs that fluctuate in acuity throughout one's lifetime. The MCC program employs a coordinated and multidisciplinary approach to simultaneously address the clinical, psychological, and social needs of an individual, rather than separately and episodically.

Evaluation of the MCC program since its inception has shown improvement in viral suppression and retention in care 12 months after enrollment in MCC. As such, the MCC program has been adopted by other cities and jurisdictions nationally. Findings have also shown that PWH who report stimulant use, housing instability, and depressive symptoms have lower rates of viral suppression than other MCC participants (Li, Su, Garland, & Oksuzyan, 2020). Given these disparities, and in response to feedback from PWH in LAC and the MCC workforce, DHSP has updated the MCC Program Guidelines.

MCC PROGRAM GOALS AND OBJECTIVES

The goals of the MCC program are to:

1. Increase viral load suppression;
2. Improve adherence to antiretroviral therapy (ART); and
3. Link patients with identified needs to mental health, substance use, housing and other support services.

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

1. The MCC team will screen their HIV patient population every 6 months to identify MCC service needs;
2. Patients with identified needs for MCC program services will be offered to participate in MCC and assessed using a standardized tool to determine the acuity of unmet medical and psychosocial support service needs;
3. A patient-centered, acuity-informed care plan will be developed by the MCC team and the patient to guide service delivery;
4. The MCC team will provide brief interventions, case management, and service referrals to MCC patients to address their unmet needs; and
5. The MCC team will conduct interdisciplinary case conferences as needed to facilitate care coordination across services.

MCC TEAM ROLES

The MCC program uses a multi-disciplinary team consisting of a Medical Care Manager (MCM), a Patient Care Manager (PCM), and a Case Worker (CW). The MCC team members work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PWH. The MCC team is comprised of the following positions:

MCC Team Supervisor: The MCC Team Supervisor is responsible for overseeing the daily operations of the MCC program and providing clinical guidance to the MCC team to ensure high-quality care and program compliance with MCC guidelines and contract requirements. This can include oversight of the MCC patient panel and monitoring, and analyses of data related to the program. Additional responsibilities include providing trainings and professional development opportunities and conducting performance evaluations while coordinating with internal and external partners to optimize delivery of patient-centered care to address the medical, social, and emotional needs of PWH. The MCC Team Supervisor does not carry their own case load but can provide supervision and guidance to the MCC team for the patients being served.

Medical Care Manager (MCM): The MCM is responsible for conducting assessments, developing integrated care plans, and monitoring patients' progress in conjunction with the PCM. The MCM is focused on meeting the needs of patients who are experiencing medical adherence issues, significant changes in health status, or those with multiple comorbidities. The MCM ensures a patient's biomedical needs are met and their care is coordinated. They assist patients through the provision of brief interventions and other support services focused on health education, treatment adherence, side effect management, medical nutrition, sexual health, and management of comorbidities. The MCM is critical as team lead of clinical interventions such as addressing polypharmacy and assisting patients with understanding and managing all of their current, active medications. The MCM is expected to have a current license to practice as a Licensed Vocational Nurse (LVN) or Registered Nurse (RN).

Patient Care Manager (PCM): The PCM is responsible for conducting assessments, developing integrated care plans, and monitoring patients' progress in conjunction with the MCM. The PCM is focused on meeting the needs of patients who are experiencing behavioral health challenges that affect their health status and their ability to manage their HIV. The PCM ensures the patient's psychosocial needs are met and their care is coordinated. They assist patients through the provision of brief interventions and other support services that address their substance use, mental health, sexual health, and psychosocial support needs. The PCM is critical as team lead for mental health services, substance use disorder (SUD) treatment and harm reduction interventions and understanding and addressing a patient's community and social support needs.

The PCM is expected to have a master's degree in social work or other related behavioral health fields.

Case Worker (CW): The CW addresses a patient's socioeconomic needs and assists the MCM and the PCM with monitoring patients and following up on service linkages and tracking outcomes. Among other service provisions, they can serve as subject matter experts on housing and community resources. Additionally, the CW should act as the liaison between HIV navigation programs and testing sites and the medical clinic to ensure that new patients are rapidly and seamlessly enrolled in medical care in a timely fashion.

ABOUT MCC DOCUMENTATION

Documentation in the patient's chart in the EMR is critical for care coordination purposes. It ensures that all the patient's providers, including their HIV primary care provider, are able to stay up to date on the patient's progress and engagement with the MCC program.

The only MCC-specific documentation required in e2LA, beyond what is required for all patients receiving Ryan White services, is the MCC assessment. All other activities should be documented in the same system where your agency keeps all other case management progress notes and files. The Care Plan and Referrals modules in e2LA are also available as useful tools for the MCC team to utilize.

Throughout these guidelines, details about documentation best practices are described. Please also see Appendix B for more detailed guidance and recommendations on documentation best practices.

MCC PROGRAM WORKFLOW

The MCC program workflow below outlines the coordination, monitoring, and optimization of the delivery of MCC services to ensure patients receive appropriate, effective and efficient care. The MCC program workflow is as follows:

1. **Screen** all clinic patients utilizing the MCC screening criteria.
    - Each clinic should establish the best way to gather a list from which to screen all PWH at their clinic such as by querying the clinic's electronic medical record (EMR) system. From this list, the team is expected to conduct chart reviews to determine patient eligibility.
    - Any patients who are new to the clinic or returning after a prolonged period of being out of care should be screened as soon as possible. HIV clinical provider referrals are also accepted as eligibility for the program and a system for these referrals should also be established.
2. **Intake** patients into the MCC program. This involves contacting them to offer MCC services and obtaining written consent to participate in the program if they wish to participate. A best practice is to coordinate with the HIV clinical team and speak to patients directly when they are on-site for clinic visits.
3. **Assess** patients using the MCC assessment tool (see Appendix A) provided by DHSP to identify needs that the MCC team can assist the patient with to optimize their health outcomes. Assessments should be documented in e2LA. A patient is considered "**enrolled in MCC**" once they have completed the MCC assessment.
4. **Determine acuity.** A patient's acuity level is calculated when the assessment is entered into e2LA. The acuity score (Low, Moderate, or High) provides a framework for the MCC team to guide their approach with the patient and determine the intensity of service delivery that is needed.
5. **Develop an integrated care plan (ICP)** that is patient-centered and informed by the knowledge gathered during the assessment. Creation of the ICP is a collaborative process between the MCC team and the patient.
6. **Deliver brief interventions** designed to promote behavior change and wellness. Brief interventions are not pre-established program activities, but rather patient-centered conversations using motivational interviewing techniques that encourage self-reflection and support patients through the stages of behavior change.
7. **Refer** patients to other supportive services within the clinic or in the community, as needed.
8. **Follow-up and monitor progress** by maintaining contact with the patient to support their efforts in meeting their goals and checking in on referrals and other care coordination activities.

9. **Conduct case conferences** as needed with a multidisciplinary team to ensure coordinated patient care. Participants other than the MCC team may include clinicians, clinical nursing staff, mental health specialists, nutritionists, peer navigators, SUD counselors, and others directly involved in the patient's care.

The MCC team can identify potential bottlenecks, improve communication, and streamline processes to enhance the patient's HIV care experience and outcomes. Because patients may be engaged in other services that could overlap with the services provided in the MCC program, the MCC team needs to ensure coordination between all services received by a patient to avoid duplication of efforts and promote seamless care. The MCC team should proactively communicate with other providers and document these efforts in the patient's chart.

The MCC Program Workflow in Figure 2 is a visual representation of the MCC service process and highlights key components. The MCC Program Workflow can also be found in Appendix C.

MEDICAL CARE COORDINATION PROGRAM WORKFLOW

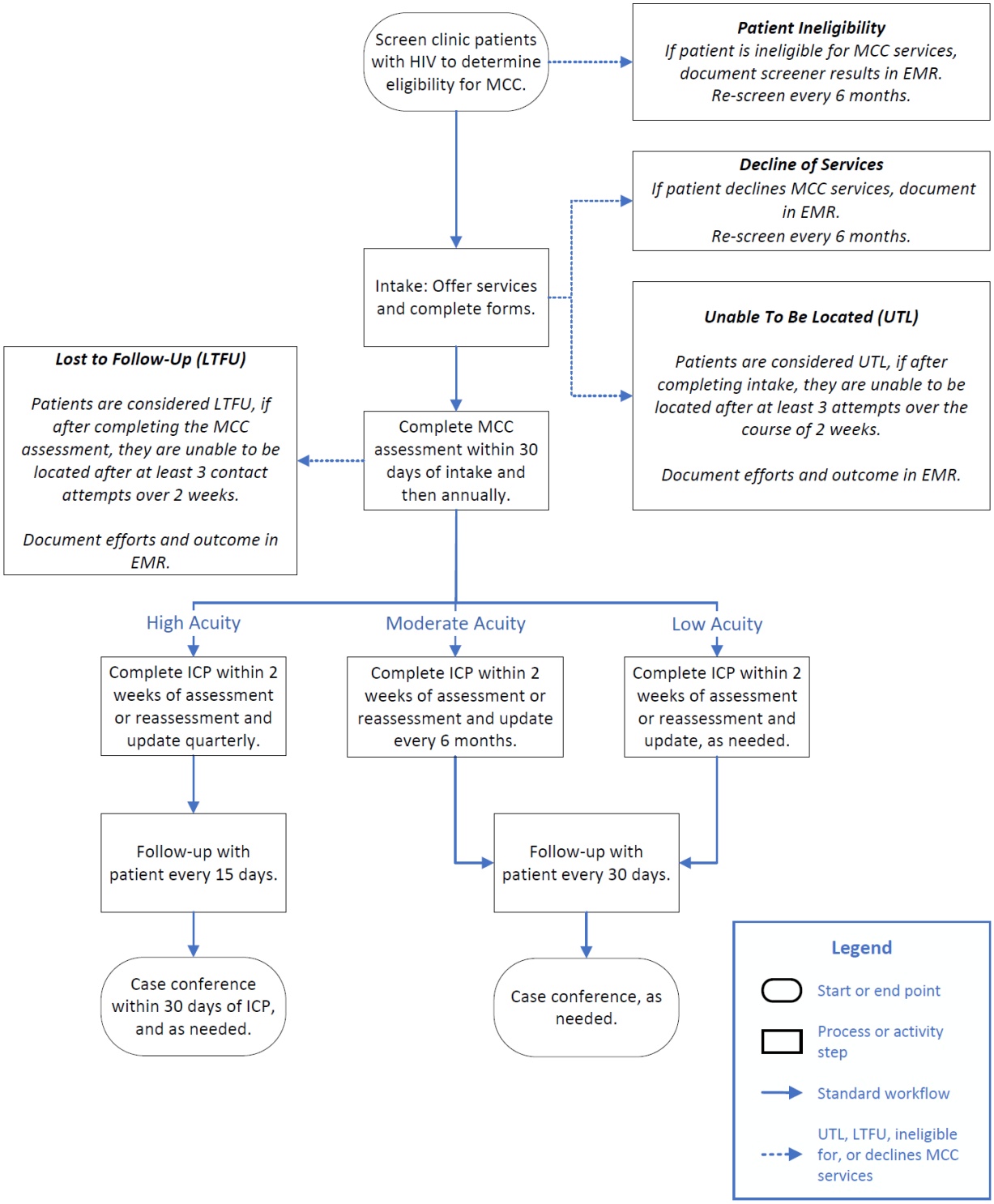


Figure 2. Medical Care Coordination Program Workflow

PATIENT SCREENING

Patient screening using the program eligibility criteria listed below assists the MCC team in identifying patients who are newly diagnosed, have been out of care, or at the highest risk for falling out of care and experiencing poor health outcomes. Patients who are new to the clinic should be screened as part of their new patient intake. Those who do not meet the screening criteria, or those who decline MCC services, should be rescreened every 6 months and offered MCC services, as needed.

The MCC eligibility criteria include any one or more of the following:

- Recently diagnosed with HIV (in the past 6 months);
- Out of HIV care (no HIV medical appointments greater than 12 months);
- Not virally suppressed (last viral load test with greater than 200 copies/mL);
- Experiencing unstable housing or homelessness (in the past 6 months);
- Have an active SUD;
- Diagnosed with severe mental illness and not receiving mental health care;
- Have been incarcerated in past 12 months; or
- Are referred to the program by their HIV provider.

Your agency can use several different strategies to screen patients. Clinics can run queries of their EMR or other relevant databases and care monitoring systems to identify patients who meet any of the criteria.

Documenting Patient Screening

MCC screening results, including both positive and negative screeners, should be documented in the patient's medical chart in the EMR. This is also where reasons for provider referrals will be noted as well. Screener results will be entered only into e2LA for patients who complete an assessment.

INTAKE INTO MCC

During the intake process, the MCC team will contact the patient to offer MCC services. This involves describing the MCC program including how the MCC team works in coordination with their HIV medical provider. It is often more successful to have the medical provider introduce the patient to the MCC team in person when they are already in the clinic for their medical appointment. This warm hand-off approach can improve engagement in the program in comparison to the "cold call" approach.

For patients who agree to participate, the MCC team will explain and ask the patient to sign any of the forms listed below that have not already been completed as part of their clinic and Ryan White Program registration process.

- Limits to Confidentiality
- Release of Information (HIPAA)
- MCC Consent to Receive Services
- Patient & Client Bill of Rights and Responsibilities
- Patient grievance procedures

Another, more general requirement of the Ryan White Program is a signed e2LA Consent to Receive Services form (also referred to as Global Consent in e2LA). This form is designed and provided by DHSP. All other forms are developed by your agency.

Some important reminders:

- The Release of Information (HIPAA) and Limits to Confidentiality forms require annual renewal to maintain accurate authorization and compliance.
- The e2LA Consent to Receive Services form requires renewal in e2LA every three (3) years.
- All other required forms need to be signed by the patient only once.

See Appendix D for additional details and templates.

Documenting Intake Into MCC

The MCC team should ensure documentation of intake efforts is recorded in the patient's medical record in the EMR. A brief progress note supports care coordination and program oversight. MCC staff can also consider standardized templates and quick phrases when appropriate.

Unable to be Located and Lost to Follow-Up

A patient is considered "unable to be located" (UTL) if the MCC team was not able to contact the patient to engage and offer them services. A patient is considered "lost to follow-up" (LTFU) if they had completed the MCC assessment but eventually stopped engaging or returning phone calls. For patients who miss an MCC appointment, the MCC team should make efforts to contact the patient during the appointment time and convert to a phone

appointment if the patient is willing to do so. If the MCC team is not able to contact the patient during the scheduled appointment time, they should ensure that they contact the patient within 24 business hours after the missed appointment.

In both scenarios, the MCC team is expected to make at least 3 attempts to reach the patient over the course of 2 weeks before determining a patient as UTL or LTFU. When feasible, at least 1 attempt should be completed in the field, such as visiting the patient's last known address, if other contact methods are unsuccessful. The MCC team is encouraged to request technical assistance with DHSP to receive additional training on patient locating, field outreach, and field safety methods.

See Appendix E for additional strategies to engage patients in care.

Ryan White Program Eligibility

Because MCC is a Ryan White grant-funded program, patients must meet the Ryan White Program eligibility criteria:

- Are living with HIV;
- Reside in Los Angeles County;
- Are age 12 years or older; and
- Have a household income equal to or below 500% Federal Poverty Level (FPL). See HHS Poverty Guidelines for annual updated FPL calculations.

If your agency already has the required and up-to-date Ryan White program eligibility information and documentation on file, or the patient has already been enrolled in Ryan White through another LAC program and their eligibility is up to date in e2LA, further Ryan White intake is not required to avoid burden on the patient. If the Ryan White eligibility process has not yet been completed, it can be included as part of the MCC program intake process.

ASSESSING PATIENT NEEDS

The MCC assessment is a countywide standardized assessment tool used to:

1. Identify and evaluate a patient's medical, physical, psychosocial, environmental, and financial strengths, needs, and resources (Los Angeles County Commission on HIV , 2024);
2. Provide acuity calculations to assist with patient prioritization and program evaluation; and
3. Assist the MCC team in addressing patient-identified, health-related social needs through referrals to community resources and multidisciplinary support services.

The assessment tool is typically conducted through in-person, face-to-face interviews between the MCC team (specifically, by the MCM and PCM) and patient. However, self-administration and telehealth are optional approaches that clinics may consider as well.

MCC assessment responses need to be entered into e2LA for every patient receiving MCC services. Responses are scored to calculate an overall acuity as well as acuity levels for certain domains (e.g., housing, mental health) to guide individual care plan development and the delivery of directed activities that include referrals and brief interventions.

A patient is considered "**enrolled in MCC**" once they have completed the MCC assessment. MCC assessments should be completed and entered into e2LA **within thirty (30) days** of intake into the MCC program.

Assessment Domains

The MCC assessment covers a broad spectrum of health-related needs and aims to focus on issues that highly impact a person's ability to stay engaged in HIV care. The following are the domains covered in the MCC assessment:

1. Aging
2. Child Care
3. Education
4. Employment
5. Engagement and Retention in Care
6. Financial
7. Health Literacy
8. Housing
9. Legal
10. Medication Adherence
11. Mental Health
12. Nutrition and Food Access
13. Sexual Health
14. Substance Use
15. Transportation

While the MCC assessment aims to include topics that are critical to HIV care and coordination, the tool also considers implementation and survey length and is therefore not exhaustive of all patient needs. When engaging patients, the MCC team can use other assessment tools to identify other needs not specified in the assessment or the acuity scoring system. The MCC team can also write their own scripts for how they want to deliver the assessment and may include additional questions to dive deeper into the issues that are raised. See Appendix F for

more details and resources for how the MCC team can address the assessment domains as well as other commonly identified health-related needs and domains.

Crisis Intervention and Immediate Referrals

In some extenuating circumstances, the MCC team may need to provide urgent services and make immediate referrals to appropriate services prior to completing the assessment. Example scenarios may include but are not limited to patients who:

- Are not engaged in medical care and need immediate linkage;
- Are taking medication but will run out prior to their next medical appointment;
- Report suicidal or homicidal thoughts/intent;
- Present with untreated serious mental illness; or
- Are pregnant and not receiving prenatal care.

Documenting Crisis Intervention

Any crisis intervention services provided to a patient should be documented in the patient's medical record in the EMR and the MCC Team Supervisor should be notified. DHSP is aware that not all crisis intervention services provided by the MCC team will be accounted for in e2LA, depending on whether the patient's Ryan White eligibility paperwork has been completed. We support and encourage the MCC team in these efforts and recommend programs to include these activities in the narrative section of their monthly report.

ACUITY SCORE AND SERVICE DELIVERY

Domain-specific acuity levels (low, moderate, and high) are calculated based on the patient's responses to key questions in the corresponding sections of the assessment. Domain-specific acuity is useful for guiding targeted service delivery (brief interventions) and tracking improvement for identified needs. For example, if the medication adherence domain acuity score is high, it would alert the MCC team to the increased need in that area of the patient's life and help guide the intensity of response and intervention by the MCC team to increase the patient's adherence to the medication.

The overall acuity score is calculated based on domain-specific scores using a particular formula. When calculating the overall acuity score, the domain-specific scores for medication adherence, housing, substance use, mental health and financial are weighted more heavily to reflect the increased impact these domains have on HIV care outcomes and the increased staff time that may be needed to address and support patients with needs in these areas.

Interpretation of the overall acuity are as follows:

- For people who score **less than 25** of the total possible points on the assessment, the overall acuity level is **low**.
- For people who score **between 25 and 40** of the total possible points on the assessment, the overall acuity level is **moderate**.
- For people who score **above 40** of the total possible points on the assessment, the overall acuity level is **high**.

The acuity score determines the intensity of services, guides the frequency of service delivery, and can be used to track overall patient progress. Table 1 describes the core components of MCC service delivery, and the minimum frequency expected for each activity in relation to the patient's acuity score.

Table 1. Minimum Frequency of Activity by Overall Acuity Level

MCC Activities	High	Moderate	Low
Assessment	Within thirty (30) days of intake and then annually		
Care plan	Within two (2) weeks of assessment or reassessment and updated quarterly	Within two (2) weeks of assessment or reassessment and updated every six (6) months	Within two (2) weeks of assessment or reassessment and updated as needed
Follow-up	Every fifteen (15) days	Every thirty (30) days	
Case Conference	Within thirty (30) days of care plan and as needed thereafter	As Needed	

THE INTEGRATED CARE PLAN

The integrated care plan (ICP) is developed through a collaborative process between the MCC team and the patient. The ICP is a clear outline of **goals, objectives and action steps** prioritized by the patient and informed by the results of the assessment and the insights and expertise of the MCC team. A patient-centered care plan considers the person's individual needs, and it is created in collaboration with them.

When reviewing the assessment results, the MCC team can explore the patient's responses to learn more about their strengths, such as existing psychosocial supports and resources, positive coping strategies, and level of motivation. Patient challenges, such as lack of supports or resources, are also explored. The strengths and challenges identified can then be incorporated into the development of the ICP.

Below are the typical steps involved in developing an ICP with the patient after completion of the assessment:

1. **Summarize the results and needs identified** by the assessment after its completion.
2. **Solicit feedback** from the patient and inquire if there are any other issues not covered in the assessment that they want to share or address.
3. **Discuss with the patient which issues are most important to them.** Explore their strengths and challenges. Reflect what they share as their priorities.
4. Introduce the ICP concept. Explain that this will help guide your work together and **recommend that the ICP focus on the patient's top priorities**.
5. **Develop the ICP together with the patient** based on the discussion about their prioritized needs.
    a. Help the patient identify their overarching **goals**. Examples could include "quit smoking" or "reduce methamphetamine use."
    b. Create **SMART objectives** appropriate to the patient's readiness to change. See the Developing Goals and SMART Objectives section below.
    c. Elicit from the patient the **action steps** they are ready to take to accomplish those objectives.
6. **Discuss any barriers or challenges** to completing the action steps. Explore strengths and strategize ways together to overcome these concerns.
7. **Identify a date** for when you and the patient will follow-up on progress toward completing their objectives.

Developing Goals and SMART Objectives

When developing the goals for an ICP, the MCC team can elicit from the patient their top priorities and the changes they would most like to work on. Usually no more than 2 or 3 goals are recommended at one time to not overwhelm the patient and keep the efforts of the patient and the MCC team focused.

For the goals that are to be included in the ICP, the MCC team will help the patient develop SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) objectives in order to turn their general health goals into concrete, clear, and actionable steps. SMART objectives have demonstrated its value toward patients creating healthier habits and achieving better health outcomes (Handley, MacGregor, & Schillinger, 2006; White, Bautista, & Lenz, 2020). Table 2 describes each aspect of the SMART approach in more detail.

Table 2. SMART Criteria and Description

Criteria	Description
Specific	Clearly define the objective, including who will take what action related to this goal.
Measurable	Set criteria to measure progress and success towards the objective. What quantity of action will be taken? How often will this action be taken? For example, increase physical activity from 1 day per week to 3 days per week.
Achievable	Ensure the objective is realistic and reachable, considering the available resources and constraints. An objective that is too easy will not allow a person to grow, while an objective that is unrealistic will only discourage and frustrate the patient. A good objective *should* challenge and stretch someone outside of their comfort zone.
Relevant	Ensure the objective is meaningful and aligned with something the patient is willing and able to prioritize and work towards.
Time-Bound	By what deadline will this action be carried out? Develop a realistic timeframe or target date to achieve the objective. Timelines that are too short risk automatic failure while timelines that are too long may lead to procrastination.

Documenting the Integrated Care Plan

The ICP should include, at a minimum, goals, SMART objectives, action steps, and follow-up information, and be documented in the patient's chart in the EMR to ensure care coordination across all patient care team members. Inclusion of the patient's signature ensures that the plan is endorsed by them.

The Care Plan module in e2LA can be a useful tool for creating ICPs. As part of the Care Plan module, MCC staff can set follow-up dates for each SMART objective which can then be used to create a tracker system and support staff with patient panel management. Completing the tool in e2LA is not required and the MCC team can develop their own approach. An ICP template example can be found in Appendix G.

BRIEF INTERVENTIONS

Based on findings from the assessment, the MCC team will deliver brief interventions (BIs) as a key component of their service provision. BIs are a technique used to support behavior change and are utilized often as part of harm reduction and substance use treatment services. BIs have been shown to improve outcomes for PWH in relation to substance use, quality of life measures (e.g., employment, education, housing stability), and sexual health behaviors (Satre, Leibowitz, Leyden, & Catz, 2019; Dawson-Rose, Draughon, & Cuca, 2017).

BIs are structured, patient-centered, non-judgmental counseling sessions grounded in a patient and provider partnership. The role of the patient is to explore their own health behaviors and their internal motivations for change. The role of the provider is to listen rather than tell, to support rather than argue, to meet resistance with reflection, and to communicate respect and acceptance for the patient and their feelings. Throughout BIs, the provider will offer guidance and gentle persuasion to help the patient actualize change that arises from within rather than being imposed from outside. It is then the patient's personal choice for deciding future behavior.

BIs are not a substitute for long term care for patients with a high level of need. Referrals to more intensive care, such as referrals to inpatient substance use treatment programs, may be warranted in those situations.

Where to Start: The Transtheoretical Model

Understanding a patient's readiness for change allows providers to tailor interventions, identify potential barriers or motivators, improve patient engagement, and support long-term success. The Transtheoretical Model (TTM), also known as the Stages of Change Model, describes how behavior change involves specific stages of readiness to change (pre-contemplation, contemplation, determination, action, maintenance, and recurrence). With the use of stage-matched interventions, providers can help their patient move through the various stages. (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992)

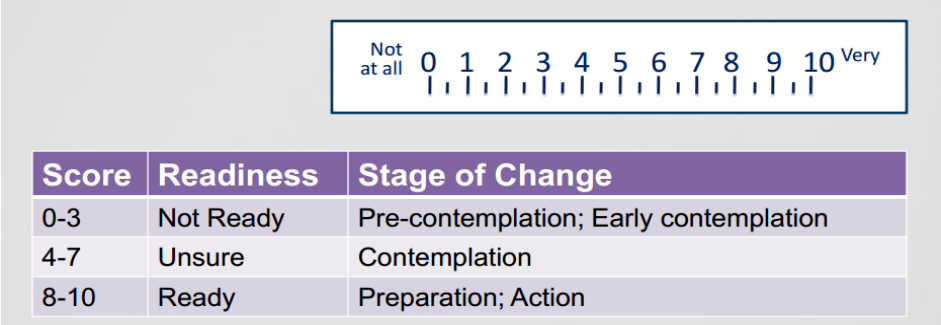
Key principles of TTM include:

1. **Change is gradual and occurs over time.** It is unrealistic to expect a patient to make a long-standing behavior change after a single intervention or within a short time frame. Providers can assess a patient's specific stage of readiness in relation to a specific behavior, and then focus on moving to the next stage using stage-specific and tailored interventions that are delivered over multiple sessions.
2. **The behavior change process is multi-dimensional.** People may be at different points in their readiness to change for different health behaviors. TTM focuses on their relationship to change of a particular behavior, not their relationship to change in general.
3. **Interventions are stage specific.** Depending on the stage a patient is in, certain interventions may be more effective. Those who are in a "Contemplation" or

"Preparation" stage usually respond best to verbal processes, focusing on insight and education. Interventions focused on trying something new, for example, will be less successful at these stages compared to the "Action" stage.

4. **Change is non-linear.** Patients may move between stages and the pace at which individuals progress through these stages can vary significantly. Some patients may remain in a single stage for months or years while others may fluctuate between stages. Providers should collaborate with patients to develop strategies that support patients where they are.
5. **Recurrence is an expected part of the change process**. Patients revert to earlier stages due to challenges or setbacks. This is not seen as a failure but rather as a learning opportunity, emphasizing that change is not a linear process. It will be important to explore what the recurrence meant to them and the context within which it occurred.
6. **Individualization is an effective approach to increase the likelihood of a patient's success.** Behavioral change is a personal and unique process for each patient. This principle emphasizes tailoring interventions and strategies to a patient's specific needs, motivations, and circumstances (e.g., individualized care planning). The "Readiness to Change Ruler" is a simple, yet effective tool used in BIs to assess a patient's readiness, confidence, and sense of importance to change.

The MCC team can use the Readiness to Change Ruler and ask patients to rate their readiness to make a behavior change or their sense of importance for accomplishing a specific goal on a scale from 0 to 10. Zero represents "not ready" or "not at all important" and 10 represents "ready" or "very important" as demonstrated visually in Figure 3.



Score	Readiness	Stage of Change
0-3	Not Ready	Pre-contemplation; Early contemplation
4-7	Unsure	Contemplation
8-10	Ready	Preparation; Action

Figure 3. Readiness to Change Ruler

As an example, if discussing a patient's readiness to quit smoking, the MCC team may ask, "On a scale from 0 to 10, how ready do you feel to quit smoking?" The patient would then select a number, and based on their response, the MCC team can tailor the conversation or intervention.

For patients who rate their readiness as low (e.g., 0-3), the MCC team may ask:

- "What would need to change for you to feel more ready?"

- "What are the biggest challenges you feel are holding you back?"

For patients who rate their readiness as high (e.g., 8-10), the MCC team may ask:

- "What steps could you take right now to get started?"
- "What resources or support would help you succeed?"

Figure 4 offers suggestions and ideas for interventions and approaches considered appropriate to a person's stage of change. In the early stages, the MCC team can provide education and explore pros and cons. As the patient becomes ready for action, the MCC team can move to discussing strategies, action steps, and support.

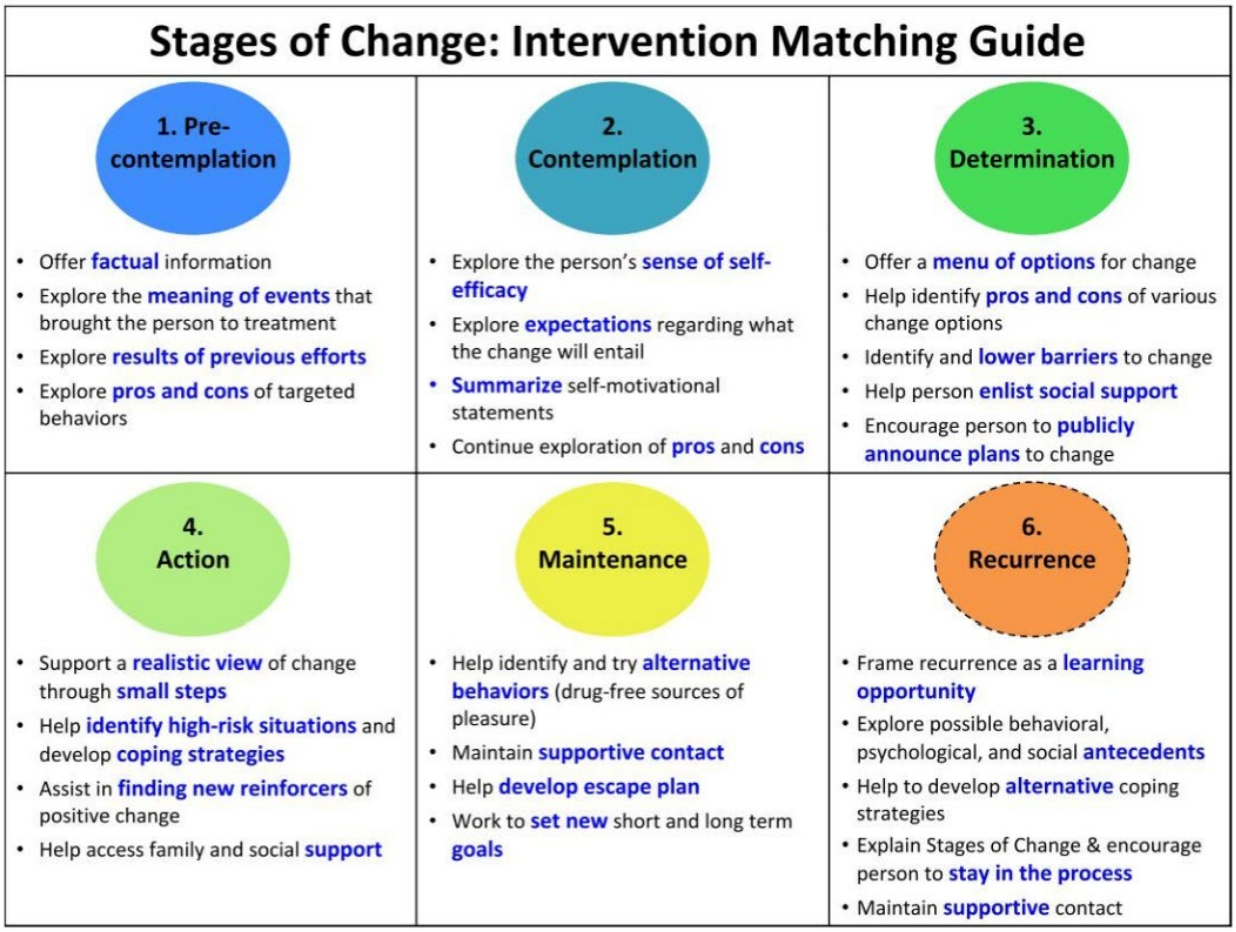


Figure 4. Stages of Change Intervention Matching Guide (Center for Substance Abuse Treatment, 1997)

Motivational Interviewing

Motivational interviewing (MI) is a style of communication that is often used during BI and can assist a patient in resolving ambivalence about their behavior change and in considering the types of change that make sense for them to support their own health. MI is characterized by the following:

- MI is a guiding style of communication that is in between following (good listening) and directing (giving information and advice).
- MI is designed to empower people to change by helping them identify their own meaning, importance and capacity for change.

It is important to note that MI requires the MCM and PCM to engage with the patient as an equal partner and refrain from instructing, directing, or giving unsolicited advice. It is not a way to "get people to change." MI takes practice and time to master and requires self-awareness on the part of the provider (Miller & Rollnick, 2009).

While the principles and skills of MI are useful in a wide range of conversations, MI is particularly useful to help a patient examine their situation and options when any of the following are present:

- **Ambivalence is high** and a patient is stuck in mixed feelings about change;
- **Confidence is low** and a patient doubts their abilities to change;
- **Desire is low** and a patient is uncertain about whether they want to make a change; or
- **Importance is low** and the benefits of change and disadvantages of the current situation are unclear.

MI has core skills known as "**OARS**" that can help guide the MCC team in leading these types of conversations with patients:

- **O**pen-ended questions draw out and explore the patient's experiences, perspectives, and ideas in their own words rather than closed-ended questions that can be answered with a simple "yes" or "no."
- **A**ffirmation of strengths, efforts, and past successes help to build the patient's hope and confidence in their ability to change.
- **R**eflection is based on careful listening and trying to understand what the patient is saying. By rephrasing or repeating back what the patient has shared, they can feel heard and understood. This is a foundational skill of MI and how to express empathy.
- **S**ummarizing ensures shared understanding and reinforces key points made by the patient.

Putting it all Together: Implementing Brief Interventions

BI sessions are conducted in an interactive manner through the use of MI techniques. The goal is to help the patient think through what is important to them and what motivates them in order to set the foundation for behavior change. BIs can be as short as 5 minutes or as long as 30 minutes. Table 3 is a sample outline of a BI session using a discussion about substance use to demonstrate the recommended steps and potential timeframes.

Documenting Brief Interventions

The MCC team documents the delivery of all BIs in the patient's chart in the EMR in the form of progress notes. Progress notes shall clearly indicate and describe that a BI has occurred, including the patient's response to the intervention. Documentation of brief interventions should include at a minimum:

- Description of the identified need that was addressed;
- Summary of what occurred during the brief intervention; and
- Follow-up plans and next steps for both the patient and MCC team.

Table 3. Brief Intervention Session Outline Example

Steps	Timeframe
Introduce and orient patient to the session. • *Ask permission to talk about [X]: "Is it okay if we talk about [X]?"*	1-2 minutes
Build rapport. • *I would like to learn a little more about you.* • *What are some important things in your life? OR What is a typical day for you?* • *How does your use of [X] fit in with your day/life?*	4-5 minutes
Explore pros and cons. • *What do you like about using [X]? What else?* • *What do you like less about using [X]? What else?* • *Summarize and restate what the patient said: So on the one hand [PROS] and on the other [CONS].* • *What do you make of that?*	2-4 minutes
Provide feedback. • ***Elicit**: What do you know about the possible effects of [X]? Would it be okay if I shared some additional information with you?* • ***Provide**: Share one or two relevant facts.* ***Elicit**: What do you think about that?*	4-5 minutes

Use Readiness to Change Ruler.
• *Given what we talked about, on a scale of 1–10, how important would it be for you to change any aspect of your use of [X]?*
  ○ *Why did you choose [#] and not a lower number like [#]?*
  ○ *If they choose a score of 1: What would need to happen for you to consider making a change?*
• *Reflect back reason for change.*
	2-4 minutes

Negotiate an action plan. • *If you decided to make a change, what would it look like for you?* • *If unsure: Use Elicit-Provide-Elicit model for suggestions.* • *On a scale of 1–10, how confident are you that you could do __? Why did you choose [#] and not a lower number like [#]?* • *Reflect the reasons for feeling confident.* • *What might help you get to a higher number?* • *Summarize change talk.*	4-5 minutes
Identify and offer sources of support and provide referrals as needed.	1-2 minutes
Close the session. • *Thank you for taking the time and speaking with me today.*	1-2 minutes
Total Time	19-29 minutes

REFERRALS

Referrals to resources and other needed services is an essential component of the support the MCC team can offer to patients. The MCC team shall maintain a comprehensive and up-to-date list of providers offering HIV-related and other services that are commonly needed for their patient population. Some programs may even develop a memorandum of understanding with outside agencies they work closely with to enhance the coordination of care for patients. The Referral module in e2LA can also be helpful for streamlining referrals to other Ryan White services.

As with the MI technique, making referrals should not be used as a way of directing patients to the services the MCC team thinks they need. Referrals should be **connected to the goals and changes** a patient is ready to take on. The MCC team is responsible for working with patients to increase likelihood of successful linkage to all referrals.

In making a referral, the MCC team shall engage in warm handoffs by directly introducing the patient to the outside provider. Warm handoffs can be completed in-person, by phone, or via video to ensure a seamless transition and reduce the chances of the patient being lost to follow-up. Warm handoffs build trust between the patient and provider and increase the likelihood of engagement in that service. In some cases, an MCC team member may accompany a patient to an appointment at an outside agency.

Often amongst the MCC team, the PCM takes the lead on linkages to mental health and substance use-related services, the MCM is responsible for linkage to medical care-related services such as oral health, nutrition, or pharmacy services, while the CW leads the linkages to socioeconomic services such as benefits enrollment, legal or transportation programs. See Appendix H for additional information on best practices for supporting patients through successful linkage to service referrals.

For patients with high mental health or substance use acuity, the MCC team should work closely with the medical provider to decide on the most appropriate action plan. If patients indicate that they are a danger to self or others, contact the clinic supervisor immediately.

Documenting Referrals

Progress notes about referrals should be maintained in the patient's chart in the EMR for coordination of care purposes and should include the following referral information:

- Type of referral provided;
- Explanation of how the referral addresses goals or identified needs; and
- Follow up to document whether the patient linked to the referred service.

MONITORING PATIENT PROGRESS AND FOLLOWING UP

The MCC team is expected to monitor patient progress. This can include reaching out to providers at the outside agencies a patient is working with in order to discuss and coordinate care. It also includes regular review of the patient chart for lab results or notes from other clinic providers to assist the team in staying up to date on the patient's progress and their activities outside of MCC appointments.

The most important way the MCC team can monitor progress is by maintaining regular contact, or "following up" with the patient to support their efforts in meeting the action steps and goals outlined in their ICP. Frequency of follow up with the patient is minimally determined by the patient's acuity (see Table 1) but may also need to be adjusted based on the patient's level of need or their wishes and comfort with regular communication. Following up with the patient is vital to providing ongoing support and ensuring the patient has the resources they need.

Follow-up activities consist of face-to-face meetings, telephone conversations, or other forms of communication with the patient. **Note: Follow-up must involve a conversation with the patient; leaving a voicemail or message is not considered follow-up**. Multiple attempts to reach a patient may be necessary and use of an emergency contact may be needed if attempts to reach the patient using their direct contact information does not work. The MCC team may also use other forms of communication as follow-up strategies, such as email or text messaging, in accordance with their agency's established HIPAA-compliant protocols to maintain patient confidentiality.

Documenting Patient Progress and Follow-Up

The MCC team documents all contact with or on behalf of the patient in the patient's chart in the EMR. Progress notes detailing activities related to follow-up can include:

- Description of attempted contacts;
- Date and type of contact (telephone, in person, etc.) with patient or other providers;
- Description of what occurred during the contact (can include brief interventions, health education, or other types of interactions);
- Updates on actions, changes, barriers, referrals, or other relevant aspects of the patients progress;
- Next steps;
- Time spent; and
- MCC provider signature (electronic signatures are acceptable).

CASE CONFERENCES

Case conferences are collaborative meetings where multidisciplinary health professionals come together to coordinate plans to meet the health and service needs of patients. These are essential to provide seamless care for patients with complex care needs identified in the assessment or throughout the course of their care.

Case conferencing sessions are attended by a variety of professionals, and it is an opportunity to receive consultation from providers from different specialties and perspectives. Participants can include primary care and HIV physicians, mid-level providers (e.g., nurse practitioners and physician assistants), mental health specialists, nutritionists, dentists, SUD counselors, navigators, and others directly involved in the care of the patient. The MCC team should take part in these established meetings as members of a patient's core medical team.

Case conferencing is typically used to:

- Identify or clarify issues regarding a patient's status, needs, and goals;
- Map roles and responsibilities;
- Review activities including progress and barriers toward goals;
- Strategize solutions; and
- Adjust current service plans.

Frequency of case conferencing is minimally determined by a patient's acuity (see Table 1). Case conferencing can also take place just among the MCC team on a more informal basis (e.g., outside of regularly scheduled meetings.) When performed in the clinic setting with the medical team before or between patient visits, this type of case conference is frequently referred to as a "huddle" and should also be documented in progress notes.

Documenting Case Conferences

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

- Date of case conference;
- Name and titles of case conference participants;
- Identified medical and psychosocial issues and concerns;
- Results of previously implemented guidance (if available);
- Description of new recommended guidance; and
- Action plan for interventions or next steps to be implemented and responsible parties.

DISENROLLMENT

Whether a patient has been lost to follow-up or requests to discontinue MCC services, a disenrollment process should be implemented. Patients may be disenrolled from MCC if they:

- Relocate out of Los Angeles County;
- Have fallen out of care despite multiple attempts by staff to contact the patient and there has been no direct program contact in the past 6 months;
- Are no longer eligible for the service at the time their reassessment is due;
- Request to discontinue the service;
- Have transferred care to another agency or provider;
- Use the service improperly or have not complied with the patient services agreement; or
- Are deceased.

When appropriate, the disenrollment process should include assisting patients with resources or other transitional support for continued success. For example, if a patient has become ineligible for MCC services after working through their ICP goals with the MCC team, the MCC team can provide information about other relevant programs or explain how the patient can talk to their medical provider to see if a provider referral back to MCC is needed.

Documenting Disenrollment

The MCC team documents disenrollment in the patient's chart in the EMR. Disenrollment summaries should include:

- Date of disenrollment;
- Reason(s) for disenrollment;
- Status of the ICP;
- Status of primary health care and support service utilization; and
- Referrals provided.

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