Disease Management Guidelines

A working tool intended to assist with the development
of an individualized comprehensive plan of care

HIV/AIDS

Goal: Optimize management of the disease process and minimize risk of related complications

Action Steps:

✓ **CM will:**

- ❑ Explore and provide MEMBER/caregivers with information and education on available HIV/AIDS resources
- ❑ Contact Member's physician office to discuss HIV/AIDS management and obtain recommendations for plan of care
- ❑ Facilitate IDT with Caregiver, MEMBER, PCA, RN, Dietitian, mental health provider, social services agency case manager, HIV physician's clinical case manager, DHS ACIS worker, PT, OT, and/or other providers deemed appropriate to assess disease status, safety supervision needs, program and community appropriateness, and develop an individualized plan of care
- ❑ Obtain needed equipment and supplies as recommended by interdisciplinary team and approved by MEMBER's physician
- ❑ Provide referrals as required by plan, including, but not limited to:
  - ❖ Dietitian
    - _ Assess nutritional status
    - _ Assess MEMBER, PCA, and informal caregiver knowledge of nutritional requirements
    - _ Provide nutrition education relevant to MEMBER needs, including but not limited to:
      - Wasting syndrome
      - BIA measurements
      - Hydration
      - Appetite stimulants
      - Nutritional supplements
      - Lipodystrophy
      - Managing gastrointestinal side effects of medications
    - _ Provide CM with written report documenting assessments, education, food plan, outcomes, and recommendations
  - ❖ Physical Therapist/Occupational Therapist
    - _ Assess MEMBER ability for physical activity
    - _ Assess MEMBER need for safety and assistive devices

- ⎯ Develop an exercise/activity plan adapted to the specific needs and abilities of the MEMBER
- ⎯ Provide CM with written reports documenting assessments, interventions, plan, outcomes, and recommendations

❖ Physician specializing in the treatment of HIV/AIDS
❖ HIV/AIDS Social Services Agency
❖ Mental Health Provider
❖ Housing Assistance
❖ Food Resources
❖ Vocational Rehabilitation
❖ Medicaid
❖ Medicare
❖ Disability/Social Security
❖ Indian Health Services
❖ Ryan White Care Act
❖ Drug Assistance Programs
❖ Oklahoma State Department of Health
❖ Local Health Departments

❑ Provide_____home visits (frequency to be determined by MEMBER need) to:

- ⎯ Assess medical, psychosocial, and economic needs and explore needed resources
- ⎯ Observe and verify MEMBER's and caregiver's skills and knowledge levels
- ⎯ Provide information and support resources
- ⎯ Assist with life planning issues including, but not limited to:
  - ▪ Family planning
  - ▪ Insurance
  - ▪ Power of Attorney
  - ▪ Guardianship
  - ▪ End of life planning
  - ▪ Education and training goals
  - ▪ Financial planning
- ⎯ Monitor and evaluate outcomes and MEMBER adherence to plan, including, but not limited to review of:
  - ▪ Adherence to medication regimen
  - ▪ Results of lab and clinical testing, including CD4 and VL values
  - ▪ General health and status of any co-morbid conditions
  - ▪ Interventions/plans related to ancillary services (PT,OT, Dietary, etc)
  - ▪ Safety/supervision needs
  - ▪ Program and community appropriateness
  - ▪ High risk status
  - ▪ Stability of informal support system
  - ▪ Behaviors related to transmission and prevention of HIV
  - ▪ Level of function related to ADLs and IADLs

- Proper usage and maintenance of equipment
- Presence of adequate and appropriate supplies per guidelines and physician orders
- Regular medical visits
- Knowledge of resources and adherence to mental health care plan

_ Follow up on referrals

_ Obtain and review reports of each visit by all providers

_ Provide ongoing evaluation of effectiveness of plan

_ Collaborate and coordinate care with MEMBER, caregiver, and all providers

_ Amend plan as needed to meet changing MEMBER needs

❑ Skilled Nurse will provide_____ home visits (frequency to be determined by MEMBER need) to:

❑ Obtain comprehensive medical history

❑ Provide initial and ongoing assessment to include:

_ Systems review and general health

_ Disease process:
- Co-morbid conditions
- Opportunistic infections
- Nutrition/hydration status
  - Weight
  - Skin turgor
- vital signs
  - BP- target level < 140/90
  - Heart rate target level 60 – 100

_ Medication adherence

_ Monitoring of clinical lab values to include, but not limited to:
- CD4 target level: > 200
- viral-load target level:< 10,000 or undetectable
- drug resistance studies
- PPD skin test

_ Pain

_ Psychosocial needs

_ Mental health status

_ Functional status

❑ Assess MEMBER, PCA, and informal caregiver knowledge and skills

❑ Provide disease management education (relevant to MEMBER need) to include, but not limited to:

_ Disease process

_ Medication purpose, administration, side effects, and adverse reactions

_ Management of co-morbid conditions to include, but not limited to:
  - Cancer
  - Diabetes
  - Heart Disease
  - Peripheral Neuropathy
  - Arthritis

_ Signs and symptoms of complications to include, but not limited to:
  - Breathing problems
  - Mouth sores
  - Fever for more than two days
  - Weight loss
  - Sudden changes in vision
  - Diarrhea
  - Skin rash
  - Severe headache

_ Reducing risk for complications/opportunistic infections including, but not limited to:
  - Medication adherence
  - Nutrition
  - Pet/animal care
  - Water filtration
  - Exposure to soil
  - Food preparation
  - Waste disposal
  - House cleaning
  - Laundry
  - Hygiene
  - Standard precautions
  - Drug and alcohol use/abuse
  - Vaccinations

_ Stress management

_ Disease transmission and prevention:
  - Safe sex
  - Family planning/contraception
  - Prenatal care

_ Oral care

_ Pain management

_ Healthy lifestyle strategies

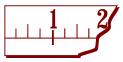
❑ Monitor and evaluate MEMBER adherence to disease management plan

❑ Monitor and evaluate MEMBER, informal caregiver, and PCA for proper use of equipment and supplies

❑ Provide CM with written reports of all visits, documenting assessments, educations, clinical interventions, outcomes, and recommendations

✓ **MEMBER and Informal Caregiver will:**

- ❑ Assume a primary role in planning and managing care to the extent able
- ❑ Provide accurate and complete information concerning past illnesses, hospitalizations, and medications
- ❑ Assist in developing and keeping a safe environment
- ❑ Inform providers when unable to keep an appointment
- ❑ Adhere to plan
- ❑ Immediately report to CM any difficulties with plan adherence, changes in health status or needs
- ❑ Verbalize understanding of risks and benefits of plan adherence
- ❑ Verbalize understanding of disease process, medication regimen, signs and symptoms of complications, risk behaviors, and when to seek emergency care.



Expected Outcomes:

- MEMBER and/or informal caregivers actively participate in developing and implementing the plan of care
- MEMBER, PCA, and/or informal caregivers can verbalize HIV/AIDS disease process, HIV/AIDS management plan, and target levels for CD4 count and viral load.
- MEMBER, PCA, and/or informal caregivers recognize symptoms of disease progression or complications and can verbalize when to call the physician
- MEMBER, PCA, and/or informal caregivers can demonstrate proper use of equipment and supplies
- MEMBER and/or informal caregivers have adequate information to make informed decisions, including the risks and benefits of adherence and non-adherence to plan