

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

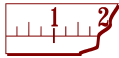
- Develop an exercise/activity plan adapted to the specific needs and abilities of the MEMBER
- Provide CM with written reports documenting assessments, interventions, plan, outcomes, and recommendations
- ❖ Physician specializing in the treatment of HIV/AIDS
- ❖ HIV/AIDS Social Services Agency
- ❖ Mental 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