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