

# 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

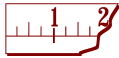
- Develop an exercise/activity plan adapted to the specific needs and abilities of the MEMBER
- Provide CM with written reports documenting assessments, interventions, plan, outcomes, and recommendations
- ❖ Physician specializing in the treatment of HIV/AIDS
- ❖ HIV/AIDS Social Services Agency
- ❖ Mental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