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Heart of Florida United Way

Part B Networking Meeting

March 23rd, 2022

Yasmin Andre, Director
Doris Huff, Planning & Evaluation
Whitney Marshall, Planning Council Support Manager
Mikaela Mendoza-Cardenal, Clinical Quality Manager

Introductions

Welcome!

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Heart of Florida United Way

- Name
- Agency
- Role

Upcoming SEAETC Webinars

- **STI Project** on 03-30-2022 @ 1:00 PM (one hour)
- **Cutting Edge Concepts in HIV Care** on 04-08-2022 @ 12:00 PM (one hour)
- **Creating a Diverse and Welcoming Clinic Atmosphere** on 04-14-2022 @ 12:00 PM (one hour)

www.seaetc.com/calendar/

- **Cultural Sensitivity Training: Understanding Latino Culture as an Important Part of our Community Garden** on 04-28-2022 @ 9:00 AM (two hours)

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AIDS Drug Assistance Program

FDOH Brevard

Brianne Kane

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Central Florida HIV Planning Council

Town Hall and Upcoming Events

Whitney Marshall

Town Hall

Recap and Response Highlights

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- Over 75 attendants representing all five service categories and multiple agencies
- We were looking for client experiences with barriers to care
- Responses were solicited both in-person and Mentimeter

Response highlights:

- Impact of stigma
- Outdated resource lists or unhelpful referrals
- Lack of senior care
- Lack of proper communication from providers to clients
- Need for increased training for providers

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Upcoming Events

Town Hall and CFHPC Meetings

https://centralfloridahivpc.com/calendar/

Transportation for clients provided by CFHPC from any county

- Upcoming Town Hall will be dedicated to soliciting feedback from **case management providers**
- Planning Council Business Meeting on **Wednesday, March 30th** from **6:00 PM to 8:00 PM**
- Ryan White Community Meeting on **Tuesday, April 19th** from **6:00 PM to 8:00 PM**

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Ryan White Updates

Medical Case Management Certification Program

Certification Program

Medical Case Management/Intensive Case Management

- Two components:
  1. 10 hours completed virtually
  2. Two days in-person training
     - Tuesday June 7th and Wednesday June 8th, 2022

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Eligibility Documentation

Proof of Residency Update and Questions

Eligibility Documentation

Proof of Living in Florida Update

- **Pay stubs** are acceptable as proof of living in Florida for eligibility purposes
- If using pay stubs, client must confirm their continued employment through proof of income
  - I.e., if client changes jobs (determined through their proof of income), then the original pay stub as proof of living in Florida is no longer valid and will need to be updated

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Eligibility Documentation

Touching Base

Questions or clarifications?

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Care Plans: A Technical Overview

Commonly Seen Issues, Revised Template, Case Study, Best Practices

Care Plans

Technical Overview

- Based on data from Comprehensive Needs Assessment and completed Acuity Assessment (most recent version)
- Care plans should be:
  - Collaborative
  - Empowering
  - Meaningful
  - Realistic & creative
  - Proactive & reactive

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"With rare exceptions, all of your most important achievements on this planet will come from working with others—or, in a word, partnership."

Paul Farmer

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Care Plans

Commonly Seen Issues

- ☒ NMCM (Level 1) clients with care plans
- ☒ MCM (Level 2) clients missing care plans
- ☒ Overreliance on templates
- ☒ Identical lab values across multiple care plans, or no lab values at all
- ☒ Little to no identification of barriers to care
- ☒ Care plans updated at an inconsistent frequency

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Care Plans

Technical Overview

- Currently, care plans are being updated semi-annually at minimum
- Per service standards, care plans need to be updated monthly

Path to monthly care plans:

October 2021 Network Meeting
- Introduction of new acuity assessment tool to recategorize case loads

November 1st, 2021
- Begin using new acuity asst. tool on all MCM clients

December 2021 Network Meeting
- Acuity asst. tool check-in
- Second case study

January 1st, 2022
- Funding reallocation for newly projected caseloads
- **Network Meeting:** case notes

March 2022 Network Meeting
- Care Plans: Technical Overview

April 1st, 2022
- Begin using monthly care plans for MCM clients with new acuity asst. complete
- *Prioritize completing acuity asst. for all MCM clients*

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Service Categories

Non-Medical Case Management	Referral for Healthcare Support	Medical Case Management
Eligibility Determination & Recertification	Brief Intake	Brief Intake
RDA Assessments	Referral support for clients who are not eligible for MCM	Referral support for eligible MCM clients
Case Notes	Case Notes	Acuity Assessments
Consents		Case Notes
		Comprehensive Needs Assessment & Reassessment
		Care Plans
		Treatment and Adherence Counseling
		Linkage and Retention Support

Note: Total caseload represented by **Non-Medical Case Management.** This category will be synonymous with eligibility.

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Frequency of Contact

Level (Weighted)	Care Plan	Acuity Reassessment	Collaboration	Frequency of Contact
RS – 1 (0-46)	N/A	RDA every 6 months	Recommended as needed	Every 6 months and as needed
MCM – 2 (47-62)	Reviewed and updated monthly	Acuity every 6 months	Case conferencing required	1 Face-to-face contact required every 3 months and 2 additional contacts required monthly.
MCM – 2 (63-78)	Reviewed and updated monthly	Acuity every 6 months	Case conferencing required	1 Face-to-face contact and 2 additional contacts required monthly.
MCM – 2 (79-93)	Reviewed and updated monthly	Acuity every 6 months	Case conferencing required	2 Face-to-face contacts and 2 additional contacts required monthly.

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Care Plans

Who? What? Where? When? Why?

Who needs a care plan?

What should a care plan look like?

Where do we keep the care plan?

When do we update care plans?

Why do we use care plans?

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Care Plans

Who? What? Where? When? Why?

All clients who are classified as receiving medical case management (MCM) services must receive a care plan.

→ Who receives a care plan?

- Clients who score level 2 on the acuity assessment tool
- Clients who have only recently achieved viral load suppression* (within 12 months)
- Clients with extenuating circumstances (with agency supervisor approval)

*Viral Load <200 copies/mL

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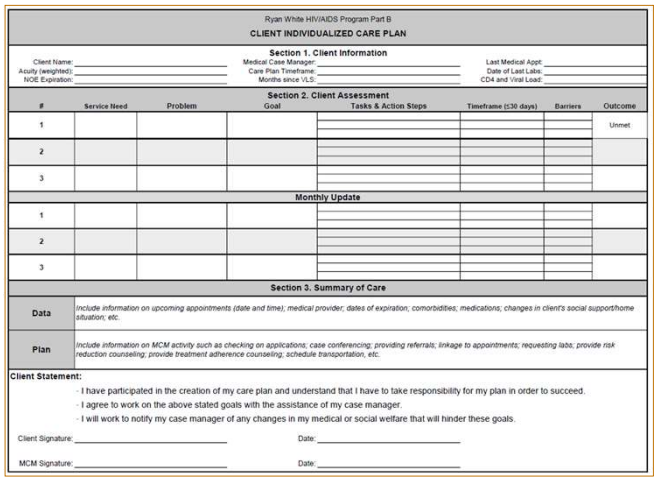
Care Plans

Who? **What?** Where? When? Why?

→ What should a care plan look like?

- New template, required as of 04-01-2022 for all MCM clients
- Similar elements, but broken up into three sections
- Review past goals and upcoming goals on same sheet



Ryan White HIV/AIDS Program Part B

CLIENT INDIVIDUALIZED CARE PLAN

Section 1. Client Information

Client Name: _____ Medical Case Manager: _____ Last Medical Appt: _____
Acuity (weighted): _____ Care Plan Timeframe: _____ Date of Last Labs: _____
NOE Expiration: _____ Months since VLS: _____ CD4 and Viral Load: _____

Section 2. Client Assessment

#	Service Need	Problem	Goal	Tasks & Action Steps	Timeframe (≤30 days)	Barriers	Outcome
1							Unmet
2							
3							
Monthly Update							
1							
2							
3							

Section 3. Summary of Care

Data	*Include information on upcoming appointments (date and time); medical provider; dates of expiration; comorbidities; medications; changes in client's social support/home situation; etc.*
Plan	*Include information on MCM activity such as checking on applications; case conferencing; providing referrals; linkage to appointments; requesting labs; provide risk reduction counseling; provide treatment adherence counseling; schedule transportation, etc.*

Client Statement:

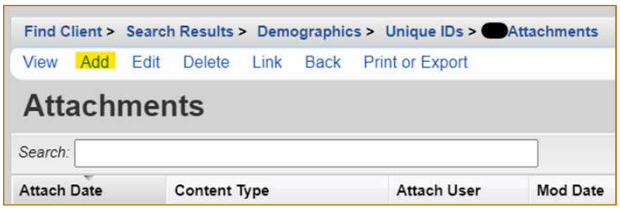
- I have participated in the creation of my care plan and understand that I have to take responsibility for my plan in order to succeed.
- I agree to work on the above stated goals with the assistance of my case manager.
- I will work to notify my case manager of any changes in my medical or social welfare that will hinder these goals.

Client Signature: _____ Date: _____

MCM Signature: _____ Date: _____

Care Plans

Who? What? **Where?** When? Why?



Don't forget to obtain client's signature and offer client a copy for their records.

(Can be used to help establish personal record-keeping habits!)

→ Where do we keep the care plan?

- Upload care plan to CAREWare → Unique IDs → Attachments
- If keeping paper documents, file with eligibility documentation

Care Plans

Who? What? Where? **When?** Why?

MCM Service Standards (Revised 12-06-2021)

"2.4 ***Care Plan:*** An individual care plan shall be developed *with the participation of the client* within 30 days of the comprehensive needs assessment. The care plan shall be based on prioritized identified needs, acuity level, and shall address client's cultural needs…

MCM/ICM shall conduct reviews and adaptation of the care plan *at least* monthly, throughout the client's enrollment with MCM/ICM services.

The care plan shall be updated, revised or amended *at least* monthly *in response* to goals or changes in client's life. Tasks, referrals, and services *should be updated* as they are identified or completed.

→ When do we complete/ update care plans?

- Within 30 days of completing Comprehensive Needs Assessment
- Reviews, adaptations, and updates will be completed *at least* monthly
- Document task/referral/service completion in case notes as completed

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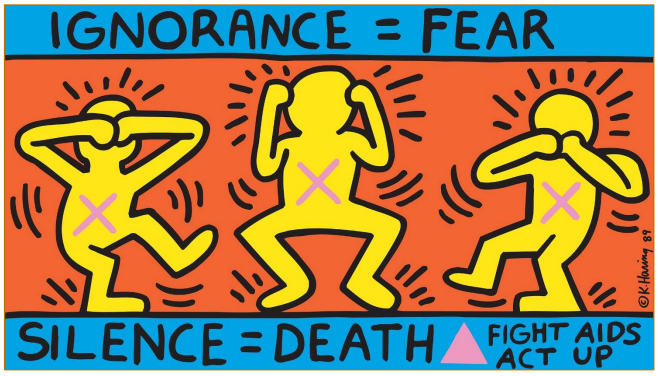
Care Plans

Who? What? Where? When? **Why?**



→ Why do we use care plans?

- Supportive, intensive one-on-one environment supplemented with actionable interventions leads to better health outcomes

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Care Plans

Best Practices

- ✓ Ensure all clients on your caseload have been correctly classified as MCM or NMCM using the most recent acuity assessment tool
- ✓ Use Excel spreadsheet to easily update care plan
- ✓ Avoid the use of templates where possible
- ✓ Incorporate results of Comprehensive Needs Assessment and Acuity Assessment when developing interventions

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Care Plans

Best Practices

- ✓ Set SMART goals
- ✓ Use care plan as an **empowerment** tool through collaborative planning
- ✓ Be creative and individualized when developing interventions
- ✓ Celebrate client achievements, however "small"
- ✓ Reflect on efficacy of past interventions using spreadsheet

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Care Plans

Case Study

We will be partially completing a care plan together based on our MCM client Alexis from October's acuity assessment training

Identify:

- A service need (e.g., retention, nutrition, mental health)
- Its corresponding problem (e.g., missing appointments, limited food access, suicidal tendencies)
- Goal (e.g., attend lab review appointment, maintain healthy eating habits, begin psychotherapy)
- Tasks & action steps (e.g., set phone reminder, access food pantry, follow up on MH referral)
- Realistic time frames (e.g., this week, within 2 weeks, by end of the month)
- Barriers (e.g., computer literacy, busy work schedule, personal stigma against therapy)

These will be relative to acuity, individual needs, health literacy, social support, etc. What is a goal for one client could be an action step for another client.

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Care Plans

Case Study

Identify:

- Service need
- Problem
- Goal
- Tasks & action steps
- Realistic time frames
- Barriers

Client Alexis is a college-educated, single, heterosexual black cis woman who was diagnosed with HIV (not AIDS) and herpes in 2010. She has not yet disclosed her status to her family or friends, and has not had sex in over five years. Alexis recently reached out to an ASO because she lost her job, health insurance, and dental insurance eight months ago. Client is currently living with her elderly mother and is able to borrow her mother's car for appointments.

During intake, Alexis admitted to the case manager that she has been stretching out the last of her Biktarvy, and sometimes not taking it at all due to depression from being unemployed. Intake labs were completed on 02-14-22 and reflect HIV viral load = 229 copies/mL, CD4 = 410; labs were reviewed by medical provider on 02-23-2022.

Client also admits to drinking a bottle of wine a day and has been isolating for a few months. She reports no issues with her appetite or oral health concerns.

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Care Plans
Conclusion

Questions or clarifications?

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Evaluation

Evaluation

Mentimeter

Please go to menti.com

Code: 3347 9163

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Provider Announcements & Updates