STOP HIV Clinical Outreach Team Intensity Categorization

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| --- | --- | --- |
| **Level 1- Most Intense** | Profile of activities | Comments |
|  | Contact 2-3+ times per week |  |
|  | >1 immediate basic need not met: homeless, food insecurity, danger to self or other |  |
|  | Co-morbidities, particularly Addictions/MH issues |  |
|  | Medically unstable (VL detectable, OIs, etc.)  Significantly immunocompromised |  |
|  | Inappropriate usage of acute care (none or too often) |  |
|  | Frequent contacts with police or emergency services |  |
|  | Disconnected or without primary care |  |
|  | Require appointments to be booked & require accompaniment |  |
|  | Requires significant HIV education |  |
| **Level 2-Moderate** |  |  |
|  | Contact 1+ times per week |  |
|  | Immediate needs addressed (housed, food access, safety) but may need improvement with these, ie in temporary shelter |  |
|  | Less frequent contact with acute care |  |
|  | HIV medical needs may still be large |  |
|  | Less frequent contact with police and emergency services |  |
|  | Not fully engaged with primary care |  |
|  | Requires assistance to attend & book appointments |  |
| **Level 3-Less Intense** |  |  |
|  | Contact once every two weeks or less |  |
|  | Minimal outreach needed |  |
|  | Medically stable or near stable |  |
|  | Stable housing almost in place |  |
|  | Transitioning to stable status/ discharge with episodic crisis |  |
|  | Engages with primary care independently or with reminders only |  |
| **Level 4-Stable** |  |  |
|  | Undetectable HIV viral load |  |
|  | Medically stable |  |
|  | Engaged with primary care team with HIV experience (minimum of 1 visit in past 6 months + b/w q3mths) |  |
|  | Self management skills (transmission prevention education, Self monitoring of physical status, awareness of appropriate resources) |  |
|  | Demonstrated ability to successfully self manage ARV and mental health or addiction medications over a 3 month period |  |
|  | Stable housing |  |
|  | Has supports in community including mental health and addictions |  |
|  | Decreased frequency of contact with acute care, appropriate use only |  |
|  | Decreased frequency/ minimal contact with police and emergency services |  |
|  | Frequency of outreach visits limited or none. Meets 1x quarterly with Peer Navigator or attends peer discussion group. |  |
|  | Client preference- feels ready, accepts transition plan |  |
|  | Crisis Plan in place |  |

**Transition Criteria from Intensive Case Management:**

(previously referred to as “Discharge”)

|  |  |
| --- | --- |
| Transition Criteria | Accomplished (Yes/ No) |
| Undetectable HIV viral load | ✓ |
| Medically stable | ✓ |
| Engaged with primary care team with HIV experience (minimum of 1 visit in past 6 months + b/w q3mths) | ✓ |
| Self management skills (transmission prevention education, Self monitoring of physical status, awareness of appropriate resources) | ✓ |
| Demonstrated ability to successfully self manage ARV and mental health or addiction medications over a 3 month period | ✓ |
| Stable housing | ✓ |
| Has supports in community including mental health and addictions | ✓ |
| Decreased frequency of contact with acute care, appropriate use only | ✓ |
| Decreased frequency/ minimal contact with police and emergency services | ✓ |
| Frequency of outreach visits limited or none | ✓ |
| Client preference- feels ready, accepts transition plan | ✓ |
| Crisis Plan in place | ✓ |
| Communication of transition plan with referral source | ✓ |
| Communication of transition plan with current care team (including how/when to re-refer to STOP Team if needed) | ✓ |

**Self-Management**

Similar to other chronic diseases, HIV requires lifetime changes in physical health, psychological functioning, social relations, and adoption of disease-specific regimens. The shift from acute to chronic illness requires a self-management model in which patients assume an active and informed role in healthcare decision making to change behaviors and social relations to optimize health and proactively address predictable challenges of chronic diseases generally and HIV specifically.

| **Category** | **Element** | **Description of Element** | **Strategies/Initiatives to Assist Achieving this Element** |
| --- | --- | --- | --- |
| 1. **Physical health** | Understanding illness and wellness | Client has an understanding of HIV/AIDS Disease and Treatment. | * HIV/AIDS education programs   + In person   + On Line * Access to a resource line for information and linkage to community agencies. * Materials in multiple languages |
|  | Health promoting behaviors | Client takes action to sustain or increase their wellness. Recognition that poverty and lack of resources are barriers to health behaviors. | * Support for development of a Wellness Plan.   + Access to exercise programs, nutritional consults and stress management strategies. * Access to Case Management resources to support discrete non clinical needs. * Harm reduction education and support including:   + access to peers   + Smoking cessation programs |
|  | Treatment assessment | Ability for client to set goals related to a treatment regime, monitor their own adherence and request episodic support for adherence challenges. | * Client educated on treatment readiness and ARVs   + In person or manual   + On line * Tools to assist with readiness to start or delay treatment * Tools/harm reduction education to remain in care if client decides to delay treatment * Adherence support (reminders- text, email, phone call). Literature supports, might decrease nursing time to follow up with clients. * Ability for client to track medications and blood work (manual, on line) * Access to pharmacists for medication consults. * Access to Clinical Case Management resources for defined periods of time to address adherence issues * Access to peer support. |
|  | Self monitoring of physical status | Client actively participates in self-monitoring of key physical status indicators. | * On-line tools to support tracking   + Weight   + CD4/VL levels   + Blood work   + Blood Pressure   + Symptom management   + Medication adherence |
|  | Accessing appropriate treatment and services | Client has appropriate and timely access to providers with HIV competencies. | * Linkage to Providers with HIV competencies. * Timely access to Specialist Services based on referral from Primary Care Provider * Access to Clinical Case Management support for defined period of time to address clinical support needs. |
|  | Preventing transmission | Client has an understanding of ways to prevent the transmission of HIV.  Ct aware of disclosure legalities. | * Education on preventing transmission   + in person   + on line * Access to condoms, needle exchange etc. |
| 1. **Psychological functioning** | Self-efficacy and empowerment | Client demonstrates ability to assert control over disease and life. Understanding that behavior affects medication and treatment regimes. | * Self-efficacy training and support * Peer support * Collaborative development of a Wellness Plan with provider. |
|  | Cognitive skills | Planning, contracting, using data in decision making, problem solving, and reinforcement for successes. | * Providers with skills to complete motivational interviews * Assist clients to set goals and building contracts |
|  | Reducing negative emotional states | Client has an understanding of the relationship between stress and the immune system and the importance of monitoring for signs of depression and anxiety. | * Education on stress management strategies * Strategies to support managing stress   + Exercise   + Support Groups   + Peer Support * Provider screening for anxiety and depression. * Access to mental health supports |
|  | Maintaining identity shifts | Client is striving for normalcy rather than concealing HIV or making it the center of identity. | * Peer Support * Support Groups |
| 1. **Social relationship** | Collaborative relationships with healthcare providers | Health Professionals who are comfortable with HIV disease and are supportive of the client in self-management.  Clients who are comfortable asking questions or questioning medical directives. | * Continued education of Primary Care Providers on HIV Competencies * Education of Providers on Self-Management * Client education on self-management and advocacy. |
|  | Social support | Client recognizes the importance of a social support network. | * Access to Support Groups * Access to Peer Support * Client initiates contact with positive social networks. |
|  | Disclosure and stigma management | Support client when they are ready to disclose status. | * Education on how to disclose * HIV Education for family members * Involvement in HIV Specific Service Organizations without stigma threat * Peer Support |
|  | Positive social and family relationships | Client recognizes the importance of establishing and maintaining positive social and family relationships where possible. | * Peer Support * Strategies on building positive social and family relationships * Education and counseling for sero concordant and sero discordant couples |