MEDICAL CARE COORDINATION STANDARDS OF CARE

Los Angeles County Commission on HIV

LOS ANGELES COUNTY
COMMISSION ON HIV

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IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
- Service Standards: Ryan White HIV/AIDS Programs

Introduction

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The purpose of the standards is to ensure that all RWHAP service providers offer the same fundamental components of the given service category. Additionally, the standards set the minimum level of care Ryan White-funded service providers may offer clients, however, service providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV (COH) developed the Medical Care Coordination (MCC) service standards to establish the minimum service necessary to provide coordinated medical and non-medical care to people living with HIV regardless of where services are received in the County. The developed of the standards included review of an alignment with the 2018 HIV/AIDS Medical Care Coordination Service Guidelines from the Los Angeles County Department of Public Health Division of HIV and STD Programs, as well as feedback from service providers, people living with HIV, members of the COH's Standards and Best Practices (SBP) Committee, COH caucuses, and the public-at-large. All service standards approved by the COH align with the Universal Standards of Care and Client Bill of Rights and Responsibilities (Universal Standards) approved by the COH on January 11, 2024.

Medical Care Coordination Overview

The Medical Care Coordination model is an integrated service model to fully respond to patient's unmet medical and non-medical support needs (e.g. mental health, substance use, and housing) through coordinated case management activities to support continuous engagement in care and adherence to antiretroviral therapy. This information was adapted from the 2018 HIV/AIDS Medical Care Coordination Service Guidelines.

MCC services include:

- Comprehensive assessment/reassessment
- Development and monitoring of an Integrated Care Plan
- Brief interventions
- Referrals
- Case conferences
- Patient retention services

The goals of MCC include:

- Increase retention in HIV care
- Improve adherence to antiretroviral therapy (ART)
- Link patients with identified need to mental health, substance use, specialty care, and housing resources, and other support services
- Reduce HIV transmission through sexual risk and substance use reduction counseling and education

The terms *mental health* and *behavioral health* are often used interchangeably. For the purposes of the Medical Care Coordination service standards, *mental health* is used and is intended to encompass a broad range of related diagnoses and services necessary to achieve optimal patient health outcomes. All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

MEDICAL CARE COORDINATION MODEL

All patients receiving medical care in Ryan White-funded clinics are routinely screened for Medical Care Coordination (MCC) based on clinical and psychosocial criteria. The patients who are identified as candidates for MCC services or who are directly referred by their medical provider are then enrolled into the MCC program.

Physical co-location of the medical outpatient clinics and MCC programs and medical team is necessary and will be determined based on the needs of the program, the patient population, and the providers delivering the service. MCC programs must operate from a central location that serves as an administrative hub and primary program venue. MCC is an integrated approach to care, rather than a location where care is provided.

MCC teams are integrated into the medical home as part of the medical care team to ensure the Medical Care Manager, Patient Care Manager, Case Worker, and Retention Outreach Specialist are able to work together and directly with the patient. The Medical Care Manager is responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan, which is developed by the MCC team and patient, for anyone eligible for the service. The Patient Care Manager will work with the Medical Care Manager to address the patient's psychosocial needs, and track and supervise these components of the Integrated Care Plan.

Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Depending on the size of the program and volume of patients, the program may employ additional case workers who are directly supervised by the care manager. In the case of a smaller program, the Medical and Patient Care Managers directly support all patients on an ongoing basis.

The retention outreach specialist will directly engage patients who are at-risk of falling out of care or are lost to care. The retention outreach specialist is responsible for reaching the patients through all available means of communication, including but not limited to phone calls, text messages, emails, physical mail, and street outreach to parks, food pantries, and shelters.

All members of the MCC team have a responsibility to serve as a contact to each patient for continued care and support. Care coordination programs may choose to engage additional providers for specific services (e.g., mental health, substance use,) or may establish comprehensive service agreements with such providers that will facilitate the program's access to those additional services. Memoranda of Understanding between the grantee and the provider/agency must be submitted to the Los Angeles County Department of Public Health Division of HIV and STD Programs.

KEY SERVICE COMPONENTS

MCC services are patient-centered activities that focus on facilitating access to, utilization of, and engagement in primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. All MCC services should aim to increase the patient's sense of empowerment, self-advocacy, and medical self- management, as well as enhance the overall health status of the patient. Programs must ensure patients are given the opportunity to ask questions and receive accurate answers regarding services provided by MCC staff and other professionals to whom they are referred. These discussions build the provider-patient relationship, serve to develop trust and confidence, and empower patients to be active partners in decisions about their health care. In addition, MCC services will be culturally and linguistically appropriate.

The overall emphasis of ongoing MCC services should be on facilitating the coordination, sequencing, and integration of primary health care, specialty care, and all other services in the continuum of care to achieve optimal health outcomes.

MCC services in Los Angeles County will include (at minimum):

- Comprehensive assessment/reassessment
- Integrated Care Plan
- Brief interventions
- Referrals, coordination of care, and linkages
- Case conferences
- Patient retention services

Section 1.0—Patient Eligibility

Patient eligibility is determined at intake, which includes the collection of demographic data, emergency contact information, relative/significant other, and eligibility documentation. Although Medical Care Coordination is a Ryan White Program, patients do not need to be receiving Ryan White funded medical care or support services to receive MCC services.

Ryan White Program eligibility includes individuals who:

- Reside in Los Angeles County
- Are age 12 years or older
- Have a household income equal to or below 500% Federal Poverty Level, and
- Are living with HIV

An intake process, which includes registration and eligibility, is required for every patient's point of entry into the MCC service system. If an agency or other funded entity has the required patient information and documentation on file in the agency record or in the countywide data management system, further

intake is not required to avoid burden on Patient. Patient confidentiality will be strictly maintained and enforced.

The Patient file will include the following information (at minimum):

- Date of intake
- Patient name, mailing address and telephone number. For patients without an address, a signed affidavit declaring they are homeless should be kept on file.
- Proof of Los Angeles County residency.
- Verification of financial eligibility for services
- Verification of medical insurance
- Emergency contact's name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with State and local guidelines.

- Release of Information. Service providers must specific what information is bring released and to whom.
- Confidentiality policy
- Consent to Receive Services
- Client Bill of Rights and Responsibilities. Service providers are to provide a copy of the document to patients.
- Patient Grievance Procedures Division on HIV and STD Programs (DHSP) Customer Support Program
- Notice of Privacy Practices (HIPAA)

1.0 PATIENT ELIGIBILITY		
	STANDARD	**DOCUMENTATION**
1.1	Eligibility determined by provider.	Patient file includes: • Los Angeles County resident • Age: 12 years or older • Household income equal to or below 500% Federal Poverty Level
1.2	Required forms are discussed and completed.	Signed and dated forms: • Release of information • Confidentiality policy • Consent to receive services • Commission on HIV Client Bill of Rights and Responsibilities • Grievance procedures • Notice of privacy practices (HIPAA)

Section 2.0—Patient Assessment and Reassessment

The Medical Care Coordination assessment is the systematic and continuous collection of data and information about the patient and their need for Medical Care Coordination services. The assessment is a countywide standardized acute assessment tool and use used to identify and evaluate a patient's medical, physical, psychosocial, environmental, and financial strengths, needs, and resources. While the assessment helps guide discussion between the MCC team and the patient, and ensure specific

domains are addressed, it is not exhaustive. The patient assessment and reassessments must be conducted collaboratively and in a coordinated manner by the Medical Care Manager and Patient Care Manager team. The medical information and medical assessment portions of the assessment and reassessment must be completed by the Medical Care Manager.

The comprehensive assessment determines the:

- Patient needs for treatment and support services, and capacity to meet those needs
- Integrated Care Plan
- Ability to the patient's social support network to help meet patient needs
- Involvement of other health and/or supportive agencies in patient care
- Areas in which the patient requires assistance in securing services

Patient acuity levels will be determined based on responses of the comprehensive assessment. Emergencies or medical and/or psychosocial crisis may require quick coordination decisions to mitigate the acute presenting issues before completing the entire intake/assessment. Acuity levels will be updated through reassessment dependent on patient need but should be conducted annually at minimum. Reassessments should also verify the need for a patient to remain in MCC.

The acuity levels are as follows:

- **Self-managed**: For patients presenting some need, but whose needs are easily addressed; refer to other Ryan White services.
- **Moderate acuity**: For patients presenting some need, but whose needs are relatively easily addressed.
- **High acuity**: For patients presenting the most complex and challenging needs; and
- **Severe acuity**: For patients presenting in crisis who require immediate, high frequency and/or prolonged contact.

Acuity levels may be adjusted based on MCC team's understanding of patient needs not captured on the assessment/reassessment.

2.0 PATIENT ASSESSMENT AND REASSESSMENT		
STANDARD		DOCUMENTATION
2.1	Acuity level assigned to patient based on assessment results.	Completed tool kept on file in patient record. Patient acuity level assigned as: • Self-managed • Moderate • High • Severe
2.2	Reassessments are conducted based on patient need, but annually at minimum to update patient acuity.	Program monitoring and reassessment on file.
2.3	Patients unable to actively participate in Medical Care Coordination services will be referred to Home-based Case Management, skilled nursing, psychiatric services, or hospice care.	Documentation of linked referral on file in patient record.

Section 3.0—Integrated Care Plan

The Integrated Care Plan (ICP) is an individualized multidisciplinary service plan to be completed following the completion of the comprehensive assessment. The ICP is patient centered with the patient as an active participant in its development together with the Medical Care Manager and Patient Care Manager. The plan should be guided by needs identified by domains from the assessment and additional information expressed to the MCC team.

Assessment domains are based on the following:

- Health Status
- Quality of Life/Self-Care
- Antiretroviral Knowledge & Adherence
- Medical Access, Linkage and Retention
- Housing
- Financial Stability
- Transportation
- Legal Needs/End of Life Needs
- Support Systems and Relationships
- Risk Behavior
- Substance use and Addiction
- Mental Health

In rare cases, due to the type of treatment, immediacy of services and/or their confidential nature (e.g., mental health, legal services), the ICP may be limited to referencing, rather than detailing, a specific treatment plan and/or the patient's agreement to seek and access those specific services.

3.0 INTEGRATED CARE PLAN		
	STANDARD	DOCUMENTATION
3.1	Integrated Care Plan will be developed collaboratively with the patient within 30 days of completing the assessment.	Integrated Care Plan on file includes: • Patient name • Patient Care Manager (PCM) name • Medical Care Manager (MCM) name • Date and patient signature • Date and PCM and MCM signature. Electronic signatures are acceptable.

Section 4.0—Progress Notes/Monitoring Patient Progress

Integrated Care Plan implementation and evaluation involve ongoing contact and interventions with, or on behalf of, the patient to ensure goals are addressed that work towards improving a patient's health and resolving psychosocial needs. Current dated and signed progress notes, detailing activities related to implementing and evaluating, will be kept on file in the patient record.

The following documentation is required (at minimum):

- Date, type, and description of all patient contact, attempted contact and actions taken on behalf of the patient
- Changes in the patient's condition or circumstances
- Progress made towards achieving goals identified in the ICP
- Barriers identified in reaching goals and actions taken to resolve them
- Current status, results, and barriers to linking referrals and interventions
- Time spent with, or on behalf of, the patient
- Care coordination staff's signature and professional title
- Follow up within 1-5 business day with patients who miss an MCC appointment. If follow-up activities are not appropriate or cannot be conducted within the prescribed time, care coordination staff will document reason(s) for the delay.
- Collaborating with the patient's other service providers for coordination and follow-up

4.0 PROGRESS NOTES/MONITORING PATIENT PROGRESS		
	STANDARD	DOCUMENTATION
4.1	Medical Care Coordination team will monitor: • Implementation of Integrated Care Plan • Changes in the patient's condition or circumstances • Lab results • Adherence to medication • Completion of referrals • Delivery of brief interventions • Barriers to care and engagement	Progress notes on file include: • Date, type, and description of all patient contact, attempted contact, and actions take on behalf of patient. • Changes in the patient's condition or circumstances. • Progress made toward achieving goals. • Barriers to reaching goals and actions taken to resolve them. • Current status and results of recommended referrals. • Current status and results of recommended interventions. • Time spent with patient. • Care team signatures. Electronic signatures are acceptable.

Section 5.0—Brief Interventions

Brief interventions are short sessions that raise awareness of risks and motivates patient toward acknowledgement of an identified behavioral issue. The goal of the brief intervention is to help the patient see a connection between their behavior and their health and wellbeing. Based on the goals and objectives identified in the patient's Integrated Care Plan, Medical Care Coordination team members shall deliver brief interventions designed to promote treatment adherence and overall wellness for MCC patients. The brief interventions are not a substitute for long-term care for patients with a high level of need; referrals to more intensive care may be warranted in those situations. For example, patients with severe or complex mental health needs should be referred to the appropriate specialist.

MCC intervention activities primarily focus on:

- Promoting Antiretroviral Therapy Adherence
- Risk Reduction Counseling. This includes sexual and substance use risk reduction counseling.
- Engagement in HIV care
- Mental Health
- Re-engagement in HIV care
- Disclosure Assistance
- Housing support and referrals
- Other activities that improve the overall patient wellness

5.0 BRIEF INTERVENTIONS		
	STANDARD	DOCUMENTATION
5.1	Brief interventions may focus on: • Promoting Antiretroviral Therapy (ART) adherence. • Risk Reduction Counseling • Engagement in HIV care • Mental health	Documentation of recommended interventions in progress notes.

Section 6.0—Patient Self-Efficacy and Care

Medical Care Coordination teams will teach patients and their caregiver's effective HIV disease self-efficacy skills to improve self-sufficiency health outcomes with attention to meeting the cultural needs and challenges of the patients. Staff will educate patients and caregivers about maintaining an undetectable viral load will result in little to no risk of HIV transmission. MCC teams will educate and empower patients to interact effectively with all levels of service providers and to become increasingly informed and independent consumers.

6.0 PATIENT SELF-EFFICACY AND CARE		
	STANDARD	DOCUMENTATION
6.1	Medical Care Coordination team will educate patients on the importance of maintaining an undetectable viral load, the importance of adhering to care, and increase their capacity to engage their own care.	Documentation of education on file in patient record.

Section 7.0—Referrals

Programs providing Medical Care Coordination services will actively collaborate with other agencies to maximize their capacity to provide referrals to the full spectrum of HIV-related services. Programs must maintain a comprehensive list of service providers--both internal and external-- for the full spectrum of HIV-related and other services. The MCC team should refer patients to appropriate services based on needs identified in the assessment and reassessment and described in the Integrated Care Plan.

Programs will develop written protocols, or use existing agency protocol, for referring patients to other providers, networks and/or systems. Referrals must be tracked and monitored to ensure linkage to referrals are documented. MCC teams are responsible for working with patients to increase follow through in linking referrals.

7.0 Referrals		
	STANDARD	DOCUMENTATION
7.1	MCC team will provide referrals as needed based on assessment and reassessments. Agency or medical care home will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals.	Identified resources for referrals at provider agency (e.g. lists on file, access to websites).
7.2	If needed, engage additional providers for specific support services (e.g. mental health, substance use).	Memoranda of Understanding (MOU) on file.

Section 8.0—Case Conferences

Multidisciplinary case conferences, formal and informal, are a critical component of Medical Care Coordination services and help integrate the MCC team into the medical care team. Case conferences convene a patient's MCC team and other key care providers (e.g. physician, nurse practitioner, physician assistant) to assess progress in meeting the needs identified in the patient's Integrated Care Plan and to strategize further responses. Case conferences are an opportunity to address major life transitions and changes in health status for the patient with other members of the care team and should be conducted when possible. Programs are expected to convene case conferences based on patient need and acuity level.

Documentation of case conferences shall be maintained within each patient record and include:

- Date of case conference
- Names and titles of participants
- Medical and psychosocial issues and concerns identified
- Description of recommended guidance
- Follow-up plan
- Results of implementing guidance and follow-up

8.0 CASE CONFERENCES		
	STANDARD	DOCUMENTATION
8.1	Medical Care Coordination team will convene case conferences, formal and informal, to ensure coordination of care for patient.	Documentation on file includes: • Date • Names/Titles of participants • Identified medical and psychosocial issues and concerns • Description of recommended guidance

		• Follow-up plan • Results of implemented guidance

Section 9.0—Patient Retention

Agencies or medical homes providing Medical Care Coordination services will develop and implement a plan that guides the agency's efforts to re-engage patients into care:

- Patients at the clinic who have fallen out of care
- Patients who are aware of their HIV status, but not in care (i.e. unmet need)
- Patients at risk for falling out of care

Retention Outreach Specialists (ROS) are responsible for following up with patients that the MCC team has not been able to engage or re-engage through existing resources. This includes attempting to locate patients that have missed an HIV medical or MCC appointment. Locating patients may entail visiting the patient's last known address and/or sites of frequent socialization (e.g. food pantry, parks, community centers), contacting patients' other service providers, researching whether the patient is incarcerated, or other methods to bring the patient back into HIV care.

Retention Outreach Specialist will:

- Identify clinic patients not engaged in HIV medical care within the past 7 months.
- Work as an integral part of the Medical Care Coordination services team, including participating in team meetings.
- Act as liaison for clinic patients recently released from incarceration to ensure timely reengagement into HIV medical care.
- Work with out of care clinic patients to identify and address potential and/or existing barriers to engagement in medical care.
- Utilize motivational interviewing techniques to encourage patients to engage in and/or reengage into HIV medical care.

Programs will strive to retain patients in medical care coordination services. To ensure continuity of service and retention of patients, programs should follow existing agency specific policies regarding broken appointments. Follow-up may include telephone calls, written correspondence and/or direct contact. Programs will demonstrate due diligence through multiple efforts to contact patients by phone or by mail and document efforts in progress notes within the patient record. In addition, programs will develop and implement a contact policy and procedure to ensure that patients who are homeless or report no contact information are not lost to follow-up.

9.0 PATIENT RETENTION		
	STANDARD	DOCUMENTATION
9.1	Agency or medical home will develop procedures or follow existing agency-specific policies to work with patients: • At the clinic who have fallen out of care	Documentation attempted patient contact on file.

	• Who are aware of HIV status, but not in care • At risk for falling out of care	

Section 10.0—Disenrollment

The disenrollment process includes formally notifying patients of pending disenrollment and completing a disenrollment summary to be kept on file in the patient record. All attempts to contact the patient and notifications about disenrollment will be documented in the patient file, along with the reason for disenrollment. Note that cases often remain open, and should not be closed, so that the Retention Outreach Specialists can locate and rescreen patients.

Patients may be disenrolled if:

- Relocates out of the service area
- Has had no direct program contact in the past six months despite multiple attempts by staff to contact the patient
- Is ineligible for the service
- Discontinues the service
- Uses the service improperly or has not complied with the patient services agreement
- Is deceased
- No longer needs the service

When appropriate, disenrollment summaries will include a plan for continued success and ongoing resources to potentially be utilized. At minimum, disenrollment summaries will include:

- Date and signature of both the Medical and Patient Care Managers
- Date of disenrollment
- Status of the Integrated Care Plan
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for reentry into services

10.0 DISENROLLMENT		
	STANDARD	**DOCUMENTATION**
10.1	Medical Care Coordination team will follow up with patients who have missed appointments and may be pending disenrollment.	Number of attempts to contact and mode of communication documented in patient file.
10.2	Cases may be disenrolled when the patient: • Relocated out of the service area • Has had no direct program contact in the past six months despite multiple attempts by staff to contact the patient • Is ineligible for the services	Justification for disenrollment documented in patient file.

	• Discontinues the service • Uses the service improperly or has not complied with the patient services agreement • Is deceased • No longer needs the services	

Section 11.0—Staffing Requirements and Qualifications

Individuals on the Medical Care Coordination team must be in good standing and hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all MCC staff will be able to provide timely, linguistically, and culturally competent care to people living with HIV. MCC staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs.

Staff should also be trained by their agency on patient confidentiality and HIPAA regulations, and de-escalation techniques. It is recommended that MCC teams across agencies convene at least once a year to discuss best practices, outcomes, and exchange ideas on how to best provide patient care through MCC.

The minimum requirements for MCC staff are:

- Medical Care Manager must possess a valid license as a registered nurse (RN) in the state of California.
- Patient Care Manager must possess a master's degree in one of these disciplines: Social Work, Counseling, Psychology, Marriage, and Family Counseling, and/or related Human Services field.
- Case Worker(s) must possess a bachelor's degree in nursing, Social Work, Counseling, Psychology, Human Services; OR possess a license as a vocational nurse (LVN) or have demonstrated experience working in the HIV field.
- Retention Outreach Specialist shall possess the following requirements:
    - Experience in conducting outreach to engage individuals; and
    - Shall have good interpersonal skills; experience providing crisis intervention; knowledge of HIV risk behaviors, youth development, human sexuality, or substance use disorders; ability to advocate for patients; and be culturally and linguistically competent.

The core MCC team members above may engage other specialists, such as but not limited to, mental health therapists, housing specialists, and geriatricians to address the needs of the patient.

11.0 STAFFING REQUIREMENTS AND QUALIFICATIONS		
	STANDARD	DOCUMENTATION
11.1	Medical Care Coordination team will include:	Documentation of required licenses on file:

	• Medical Care Manager
	• Patient Care Manager
	• Case Worker(s)
	• Retention Outreach Specialist
	
	The core MCC team members above may engage other specialists, such as but not limited to mental health therapists, housing specialists, and geriatricians to address the needs of the patient.
		• Medical Care Manager: RN license in the State of California
		• Patient Care Manager: master's degree in social work, counseling, psychology, marriage and family counseling, and/or related human services field.
		• Case Worker(s): bachelor's degree in nursing, social work, counseling, psychology, human services OR possess a license as a vocational nurse (LVN) OR have demonstrated experience working in the HIV field.
		• Retention Outreach Specialist:
		  ○ Experience in conducting outreach to engage individuals; and
		  ○ Shall have good interpersonal skills; experience providing crisis intervention; knowledge of HIV risk factors, youth development, human sexuality, or substance use disorders; ability to advocate for patients; and be culturally and linguistically competent.

Section 12.0—Translation/Language Interpreters

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. Medical Care Coordination staff must develop procedures for the provision of such services, including the hiring of staff able to provide services in the native language of limited English proficiency patients and/or staff reflective of the population they serve.

11.0 STAFFING REQUIREMENTS AND QUALIFICATIONS		
	STANDARD	DOCUMENTATION
11.1	Medical Care Coordination programs will develop or utilize existing agency-specific policies to provide interpretation services to patient at no cost.	Policy on file at agency.

Definitions and Descriptions

Assessment is a cooperative and interactive face-to-face interview process during which the patient's medical, physical, psychosocial, environmental, and financial strengths, needs and resources are identified and evaluated.

Intake determines a person's eligibility for Medical Care Coordination services.

Medical Care Coordination (MCC) integrates the efforts of medical and social service providers by developing and implementing an integrated care plan.

Medical Care Managers will be licensed RNs and be responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan.

Retention Outreach Specialists promote the availability of and access to Medical Care Coordination services to service providers and patients at higher risk of falling out of continuous care or are lost to care.

Patient Care Managers will hold a master's degree in social work (MSW) or related degree (e.g., psychology, human services, counseling) and are responsible for the patient's psychosocial needs ad will track, address and or supervise these components of the Integrated Care Plan.

Case Workers must possess either a bachelor's degree in nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling (requires a master's degree), Human Services, a license as a vocational nurse (LVN) or demonstrated experience working in the HIV field. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion.

Reassessment is a periodic assessment of a patient's needs and progress in meeting the objectives as established within the Integrated Care Plan.

Disenrollment is a systematic process of disenrolling patients from active MCC services.

APPENDIX A—Division on HIV/STD Programs Customer Support Program

The Division of HIV and STD Programs' (DHSP) Customer Support Program aims to assist consumers of HIV and STD services who have experienced difficulty accessing services from DHSP-funded providers throughout Los Angeles County. If you or someone you know is a consumer of HIV and STD services who have experienced difficulty accessing services from DHSP-funded providers throughout Los Angeles County, the Customer Support Program can assist with accessing HIV or STD services and addressing concerns about the quality of services received.

Please contact the Customer Support Program via email dhspsupport@ph.lacounty.gov , online http://publichealth.lacounty.gov/dhsp/QuestionServices.htm or by telephone at (800) 260-8787. By contacting the Customer Support Program, you will **not** be denied services. Your name and personal information can be kept confidential.