MANITOBA
HIV PROGRAM

Procedure: 4.7 Care planning
Approval date: July 12, 2024
Approved by: Director, MB HIV Program

PURPOSE

This procedure provides direction to the PATHS team for care planning within the service delivery model.

BACKGROUND

Care planning is an ongoing process that begins when a client is assigned to a PATHS pod and ends when they have transitioned to longer term primary care services. Care plans offer direction to the clinical team and an opportunity to evaluate care provision. Tools and timelines have been developed to support PATHS in this process and are outlined below.

<u>PATHS client assignment</u>

Clients are assigned to a PATHS pod by the Manitoba HIV Program Client Engagement Coordinator.

The Manitoba HIV Program Client Engagement Coordinator will:

- Fax referral form and any additional collateral to the PATHS pod
- Attend caseload meeting to discuss referral with PATHS pod
    - The client is considered assigned following the meeting
- Fax confirmation of PATHS pod assignment to referring provider
- Update database to reflect assignment

The PATHS pod will:

- Assign the most appropriate case manager
    - Efforts should be made to alternate assignment between the nurse and social worker. Complex medical needs may benefit from a nurse case manager.
    - Assignment determined at the caseload meeting
    - Use PATHS forms for all documentation: “PATHS RN”, “PATHS SW”, “PATHS OW” and complete embedded macros

<u>Case Management</u>

Rather than sending clients to various provider for services, the PATHS team provides the services (within their scope of practice) that the client requires. When referrals and service coordination is indicated, the team supports the client to ensure they receive care. While the team shares a caseload, one clinical person will be designated as the case manager and will be responsible for additional tasks in the client’s care.

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The PATHS case manager will:

- Update or create the chart in EMR
  - Change the chart status to PATHS
  - Liaise with the existing care team of client's assignment to PATHS by contacting the most responsible provider
  - Update the "outreach" band with "PATHS - (name and contact number of case manager)"
- Request collateral
  - Contact with referring provider for additional information including locating details
  - Review eChart: Encounters, inpatient, medications, labs for relevant collateral
  - Contact Public Health and other relevant providers involved in client's care
- Direct contact with client
  - Prioritize engagement for newly referred clients. Frequent contact and support is a helpful strategy to build rapport and trust with the client.
  - When located, offer PATHS support and services and discuss next steps for engagement with focus on building rapport
  - Support and introduce team members to the client
  - If client shares additional providers, including justice involvement, explore client's willingness to provide consent. If given, request additional collateral.
- Complete the "PATHS Intake" form after the first direct contact with the client

<u>PATHS Acuity Scale</u>

The "PATHS Acuity Scale" is a thorough tool to identify client care needs in a variety of medical, behavioural, and environmental categories that relate to overall health. The assessment tool can articulate barriers to engagement in HIV care and informs the development of a care plan. The tool prompts regular review and evaluation of care provision while monitoring changes in the client's care needs over time.

The initial assessments are completed over multiple interactions using subjective and objective assessment. Collateral received should also be reviewed with relevant information included.

The 15 categories of the acuity scale are:

- Completed by the nurse:
  - Medical stability
  - Mental health
  - Substance use
  - HIV knowledge/risk reduction
  - Treatment plan adherence
  - Nutritional needs

- Completed by the social worker:
    - Activities of daily living
    - Housing
    - Support system and meaningful activities
    - Children/dependents
    - Violence
    - Culture and spirituality
    - Financial
    - Legal
    - Self-efficacy
- The nurse and social worker will seek opportunities to complete initial assessments using the templates provided
- Update the EMR bands with details from the initial assessments in corresponding bands
- The team should use a consistent location on the client's EMR for all tasks (ex. the "ongoing care" band or an embedded care plan form utilized by the host site and conducive for the pod
- The "PATHS Acuity Scale" form will be completed by the case manager
    - Documented in the EMR within two months of meeting the client. If the client is not able to be located consistently and assessed within this timeframe, discuss with the Clinical Education Coordinator for direction
    - Include pertinent clinical details in addition to the numeric score for each category
    - Summarize any client goals and care team recommendations for each category
    - If categorical information is not readily available from the client and collateral sources, make note of this in the details of the assessment with the recommendation to seek further information for subsequent acuity scales
    - Update the EMR bands with details from the initial assessments
    - Scan completed initial assessment templates to the EMR as additional documentation to accompany encounter notes
- The existing "PATHS Acuity Scale" will be reviewed every six months by the case manager
    - Review and update each category with relevant clinical information, goals, and recommendations

<u>Additional clinical forms</u>

Using the clinical information gathered from the initial assessments and relevant collateral, the nurse will complete any additional forms required by the host site, which may include intake, monitoring, and annual review forms.

- Communicate with the assigned physician, relevant progress notes attached for their review and direction

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PATHS Transition Checklist and Plan

Transition planning begins at the time of assignment to the PATHS pod. Promoting stability and independence should be considered throughout service provision. The length of time assigned to the PATHS pod will be determined by assessing the client's needs and supporting the client to acquire the skills, resources, and supports to address these needs over time.

When a client meets criteria and is ready to transition to primary care services, the PATHS pod will:

- Follow the direction outlined in policy 4.4 Transition criteria and process
- Complete the "PATHS Transition Checklist and Plan" form