Suggested Guidelines for HIV Case Management for Pregnant Women in Michigan

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Michigan Department of Community Health
Division of Health, Wellness and Disease Control
HIV/AIDS Prevention and Intervention Section
Continuum of Care

SUGGESTED GUIDELINES FOR HIV CASE MANAGEMENT FOR PREGNANT WOMEN IN MICHIGAN

TABLE OF CONTENTS

INTRODUCTION 2

INTAKE..3

ASSESSMENT/REASSESSMENT 3

SERVICE PLAN DEVELOPMENT..3

COORDINATION, FOLLOW-UP, AND MONITORING OF MEDICAL TREATMENT AND OTHER SERVICES 4-6

INTRODUCTION

This document serves as a guide for case managers who provide case management services to pregnant women. This will assist in providing quality and consistency of HIV case management services throughout the State of Michigan for agencies funded by the Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control, HIV/AIDS Prevention and Intervention Section.

HIV case management is an effective mechanism for coordinating services necessary to help persons living with HIV enhance the quality and length of life. Because of the unique needs of women who have HIV and who are pregnant, a higher level of service should be provided to ensure women and their families receive the necessary medical and support services to ensure access to and retention in medical care. Additionally, pregnant women with HIV should be offered family-centered services which facilitate support, create connections (referrals and linkages) between the client and caregivers, and promote the empowerment of women, their families, and members of their support network in developing care plans based on client and family needs. Case managers should assist pregnant clients in accessing respite care, child care, housing, food, transportation, mental health services, etc., and should focus on the medical and psychosocial needs of the entire family.

HIV CASE MANAGEMENT FOR PREGNANT WOMEN: Suggested Guidelines

1.0 Intake

Standard	Measure
1.1 The intake should include information about HIV status of children living with the client, whether the children, father of the baby and/or current partner have been tested and are receiving medical care and treatment (well child and/or HIV primary/specialty care).	1.1 Verification of HIV status of children and family members is in client file, with consent of the individuals and the client. (Verbal verification for child(ren) status is acceptable. Written documentation preferable.) Documentation of family member(s) in medical care.

2.0 Assessment/Reassessment

Standard	Measure
1.1 With client consent and proper releases, case managers should, as appropriate, conduct a biopsychosocial assessment that includes an assessment of the pregnant client's safety and the safety of her children and the need for assistance with disclosure to family members.	1.1 There is documentation in the client chart that the assessment included a safety assessment and that the client was offered assistance with disclosure.

3.0 Service Plan Development

Standard	Measure
1.1 Signed release of information forms will be obtained for all appropriate family members.	1.1 There are signed and dated release of information forms in file.

4.0 Coordination, Follow-up, and Monitoring of Medical Treatment and Other Services

Standard	Measure
1.1 The case manager should, as appropriate and needed, and agreed to by client and with proper consent: • Assess client's insurance status. If the client has no insurance, begin Medicaid enrollment process as part of the Department of Human Services paperwork for mother and baby as early as possible. • Assist client in finding prenatal care provider, if needed. • Confirm client is attending scheduled prenatal care and other appointments related to her pregnancy (ultrasounds, nutritional, etc.). • Address any barriers that are inhibiting her from attending appointments, including transportation, lack of insurance, inability to pay, etc. • Confirm client is attending scheduled infectious disease care appointments. • Coordinate prenatal care and infectious disease care appointments as needed. Schedule clinic appointments on the same day, if possible. • Coordinate client's care and the care of any infected or affected children. (Scheduling clinic appointments for mom and baby/child should be on the same day, if possible.) • Coordinate transportation between clinics if they are at separate locations.	1.1 Documentation of coordination, follow-up and monitoring is in the client file.

- Coordinate services with outside agencies, such as WIC, Healthy Start, parenting classes, etc.

- Work with the hospital discharge planner and/or nurse to ensure client is discharged with adequate ZDV (AZT) for the baby and that client understands medication administration to her newborn.

- Prior to hospital discharge, case manager should confirm with hospital social worker that the child is being enrolled into Children's Special Health Care Services. (All HIV-exposed children are eligible for CSHCS.)

- Confirming insurance for the baby prior to hospital discharge is in place to ensure there is no lag time between discharge from the hospital and the baby being seen at a pediatric infectious disease clinic.

- Identify an experienced pediatric infectious disease physician or pediatricians.

- Confirm that the clinic accepts child's insurance, obtaining any necessary referrals, etc.

- Contact the practice and if needed attend the first appointment with the client.

- Seek well-baby items for when the client delivers. (Car seats, crib, strollers, etc).

Post Partum:

- Confirm client has attended her 6-week post partum check up.

- Confirm that the client is taking her child to all necessary medical appointments and receiving the necessary immunizations.

• Confirm client is attending her infectious disease care appointments. • Confirm the child's serostatus at the end of six (6) months and confirm the child is engaged in appropriate medical care based on the child's serostatus. • Address the possible need for mental health care.	
1.2 Client's needs are discussed with client at least every month.	1.2 Client contact and needs are documented monthly.