

## **Evaluation for Infectious Disease Case Management and Referral Protocol**

### **Referrals**

Normally, women who receive OB/GYN services via Sacred Heart Hospital Seton Center that have been identified as HIV positive or “High Risk” will be offered a referral to Children’s Medical Services.

- At the time of the referral, the Seton Nurse will obtain a signed medical Release of Information form prior to contact with the CMS ID Team Social Services Counselor.
- Referrals are normally made over the telephone from the Seton Center Nurse to the CMS ID team Social Services Counselor.
- The CMS ID Team Social Services Counselor then records referrals in a tracking/information log that is maintained by the CMS Social Worker in an approved locked security area.
- The Seton Nurse will inform the CMS Social Services Counselor of the client’s first appointment time and date.
- The CMS Social Services Counselor will see the mother on an as needed basis and create a separate record in order to initiate any services and/or care that CMS can offer. This will also facilitate a smooth transition for the child upon birth.

Note: there may be times when the above cannot be accomplished because the patient may not be referred until close to the time of delivery. There are times when CMS is not notified until after delivery. During these occasions, adjustments have to be made in the process in order to ensure proper protocol has been followed as closely as possible.

### **Assessment**

The CMS Social Services Counselor will call Seton Center and ask to be contacted when the client arrives for their appointment. After notification of the mother’s arrival, the Social Services Counselor will go to the Seton Center and check in with the Seton Nurse who will find a private space for the client and Social Services Counselor to meet. The initial assessment will include:

- A short introduction and explanation of services provided by CMS to HIV positive mothers.
- If the mother agrees that she is interested in receiving CMS services, the mother will receive guidance through the enrollment process.
- The mother will sign a Non Routine Disclosure form and CMS Medical Release of Information form.
- Demographic information will be collected and pamphlets will be provided to the mother.
- The counselor will assess any immediate needs of the mother and begin to plan for interventions. In an effort to provide a well-coordinated transition during the pre/post natal process, contact information will be provided and communication will be supportive.
- The counselor will schedule a follow-up home visit (or office visit to CMS) at which time a complete Psycho-Social Assessment will be conducted privately. Consultation with the RN Care Coordinator will be as needed for medical concerns.

- If the mother desires CMS transition services the CMS RNS will review the mother's chart or request records on an as needed basis to collect information pertinent to managing the care of the infant upon birth.

### **Intake**

At the time of delivery, a referral from Sacred Heart Hospital is made to the CMS ID Team RN Care Coordinator or Social Services Counselor. The CMS ID Team RN Care Coordinator or Social Services Counselor will enroll the infant in CMSN while the mother is still in the hospital. It is crucial that the enrollment be done at the hospital within 48 hours to ensure that medication prophylaxis protocols are implemented.

- If the mother has been discharged before the enrollment can be done, CMS ID Team RN Care Coordinator or Social Services Counselor will arrange a home visit.
- At the time of enrollment, the infant is scheduled to attend the CMS Infectious Disease Clinic or Exposed Baby clinic within 6 weeks. It is here that the Pediatric Infectious Disease Specialist and/or ARNP will see the infant.
- The mother will be referred to the Center for Prevention and Treatment of Infections or the Ryan White Case Manager at Sacred Heart Hospital for follow-up; however, this may be followed initially postpartum at Seton Center.

### **Clinic Follow-Up**

During the initial visit, the child will be seen by the Infectious Disease Team, which includes an Infectious Disease M.D. Specialist, ARNP; CMS ID Team RN Care Coordinator, Sacred Heart Hospital Ryan White Case Manager, Social Services Counselor and Nutritionist. The Infectious Disease Team will determine a Plan of Care that will meet the individual needs of the child. Upon the initial visit, the mother will meet with the enrollment clerk to update any necessary information, and releases enrollment.

- Upon each clinic visit, blood will be drawn (as directed) to determine disease progression. The Infectious Disease MD Specialist will evaluate the lab report from the last visit, discuss any concerns that the parent/guardian may have and will make his recommendations as to the appropriate steps in assuring the best possible care.
- The Social Services Counselor will also see the child at each clinic visit and document each session in the client's record. During these visits, the Counselor has the opportunity to keep in touch with the family.
- A Team staffing is held before each clinic to evaluate the progress of the child. During the staffing, the team has the ability to discuss any concerns that they may have. If any lab work, x-rays etc. are needed, it will be documented in the child's chart. The staff assistant will then request these items so that they are available for the next clinic visit.
- In addition, The Infectious Disease Physician and or CMS ID Team RN Care Coordinator will determine when the child should be rescheduled for a follow-up visit.