# STANDARDS OF CARE

## HIV AMBULATORY OUTPATIENT MEDICAL CARE

### DEFINITIONS OF SERVICES

**Health Resources and Service Administration (HRSA)**

***Outpatient/ambulatory medical care*** includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in their jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history assessment, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical sub-specialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service (PHS) guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies. *Outpatient/Ambulatory Medical Care* includes specialty ophthalmic and optometric services rendered by licensed providers. Ryan White HIV/AIDS Program funds also may be used for *Rehabilitation Services* that includes low-vision training by licensed providers or authorized professionals.

**Services**

Eligible services include the provision of comprehensive accessible health care services in an office or clinic setting under the direction of licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or other provider that can diagnose, treat and prescribed ARVs. Services include primary medical care and all other services associated with the HIV diagnosis such as laboratory, diagnostic testing, specialty care (e.g., infectious disease, dermatology, oncology), outpatient rehabilitation, physical therapy, and vision.

**Purpose of Services**

To improve health outcomes and quality of life for HIV infected clients residing in Kentucky.

### GOALS OF SERVICES

Provide access to and facilitate maintenance in high quality primary care for HIVinfected clients.

# STANDARDS OF CARE

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Maintain a current and valid M.D., D.O., P.A., or N.P. Kentucky license. | Annual credentialing of providers and active licensure in credentialing file.<br>Provided direct, continuous ongoing care for at least 20 HIV infect clients in the past two years.<br><br>Complete at least 30 hours of HIV related training in CME Category.<br><br>Successfully completed the American Academy of HIV Medicine Credentialing examination.<br><br>Mid-level practitioner have HIV experience and protocols must be in place describing the supervisory relationship between the mid-level practitioner and the physician. |
| Each agency shall employ non-provider clinical staff that is knowledgeable and experienced in their area of clinical practice as well as in the area of HIV/AIDS (RN, LPN, etc.). | Staff meets the minimum qualifications detailed in the job description and standards of care.<br><br>Personnel records, resume, application for employment, experience and education. |
| Each agency will ensure that appropriate staffing levels are reached and maintained to provide contracted services. | Full or part time positions funded under contract are filled or appropriate actions are taken to fill positions. |

## CLIENT CHARACTERISTIC

Individuals living with HIV/AIDS in the Commonwealth of Kentucky.

| Staff Qualification | Expected Practice |
|---|---|
| Agencies providing Ambulatory/Outpatient Medical Care must document client eligibility upon enrollment into services. | Documentation of HIV status –initial visit.<br>Residence verification—annually.<br>Income under 400% of poverty. Income documentation within 30 days of initiation of service or self-declaration as stated in KHCCP manual.<br>Insurance verification.<br>Re-certification at the six month period. Statement of no change can be used for re-certification once a year.<br>Citizenship is not a requirement to access services.<br>Ryan White HIV/AIDS Program grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for Ryan White HIV/AIDS Program services. |

# STANDARDS OF CARE

## UNITS OF SERVICE

- Face-to-face clinic visit recorded in CAREWare with a qualified provider of Medical care or appropriate credentialed vision provider.
- Laboratory and Diagnostic Services by procedure as entered in CAREWare

## ACTIVITIES

**Program Outcomes**

- Clients will show reduced rate of progression of AIDS at 6 and 12 months.
- Services address client goals (self-managed protocol).

**Indicators**

- The number of clients with CD4 counts <200 on ARVs.
- The number of clients with viral load (HIV RNA) <5000 copies/ml if eligible for antiretroviral therapy according to current national treatment guidelines.
- The number of clients with no additional new AIDS-defining condition (OI or CD4<200).
- The number of clients that achieve undetectable levels of viral load.
- The number of clients in the Ryan White delivery system with an AIDS diagnosis at entry.

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data/Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| Service providers shall have an established quality assurance performance improvement plan. | QA Performance Improvement Plan on record with met or exceeding performance goals. | Number of care process measures in which goal is met or exceeded. | Number of process measures tracked during the year. | Chart audit report (can be all HIV clients, not just Part B funded). | Two (2) measures where performance meets or exceeds service provider(s) targets. |
| All HIV infected patients receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination in accordance with professional and established HIV practice guidelines within 4 weeks of initial contact with the patient. (www.hivatis.org) | Clients have CD4 counts and HIV viral loads monitored every 3-6 months.<br><br>Clients will receive a health assessment and comprehensive physical exam including an oral exam on initial visit and then annually, and will include mental health and substance use/abuse histories. | Number of clients with CD4 counts and viral loads every 3-6 months.<br><br>Number of clients with assessment and physical exam.<br><br>Number of clients offered &/or | Number of clients.<br><br>Number of clients.<br><br>Number of clients who | CAREWare or chart audits. | 75% of clients have two or more CD4 counts and HIV viral loads annually.<br><br>80% of clients will receive a health assessment and comprehensive physical exam |

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| Treatment shall be offered and delivered according to most recent United States Public Health Service (USPHS) guidelines for the treatment of people with HIV/AIDS. | Clients who meet current guidelines for ART are offered &/or prescribed ART.<br><br>Clients who have medical visits with an HIV medical provider every 3-6 months.<br><br>Clients with a CD4 count below 200 who are recommended &/or prescribed PCP prophylaxis.<br><br>Clients with a CD4 count below 50 are recommended &/or prescribed MAC prophylaxis. | prescribed ART.<br><br>Number of clients with medical visits every 3-6 months.<br><br>Number of clients with CD4 counts <200 who are recommended &/or prescribed PCP prophylaxis.<br><br>Number of clients with CD4 counts <50 who are recommended &/or prescribed MAC prophylaxis. | meet guidelines.<br><br>Number of clients.<br><br>Number of clients with CD4 counts <200.<br><br>Number of clients with CD4 counts <50. | | including an oral exam, mental health. and substance use abuse histories.<br><br>100% of clients who meet current guidelines for ART are offered &/or prescribed ART.<br><br>75% of clients who have two or more medical visits in an HIV care setting at least three months apart every year.<br><br>100% of clients with a CD4 count below 200 who are recommended &/or prescribed PCP prophylaxis.<br><br>100% of clients with a CD4 count below 50 are prescribed MAC prophylaxis. |
| Basic laboratory tests are ordered per USPHS guidelines. | Clients' medical record document the following screenings; | Number of clients on ART with annual lipid screen, | Number of clients on ART. | CAREWare or chart audits. | 75% of clients on ART receive lipid screens annually. |

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|---|---|---|---|---|---|
| | Clients on ART receive lipid screens annually. | Number of clients with annual syphilis screen. | Number of clients. | | 75% of clients receive syphilis screens annually. |
| | Clients receive syphilis screens annually. | Number of clients with annual Chlamydia screening. | Number of clients. | | 75% of clients receive Chlamydia screens annually. |
| | Clients receive Chlamydia screening annually. | Number of clients with annual gonorrhea screening. | Number of clients. | | 75% of clients receive gonorrhea screens annually. |
| | Clients receive gonorrhea screening annually. | Number of clients with Hepatitis screens as indicated. | Number of clients needing Hepatitis screens as indicated. | | 75% of clients receive hepatitis A, B & C screens, if not immune, and then annually for high-risk individuals. |
| | Clients receive hepatitis A, B & C screens, if not immune, and then annually for high-risk individuals; | Number of clients with annual TB screen. | Number of clients. | | 75% of clients receive TB screens annually. |
| | Clients receive TB screens annually.<br><br>Female clients receive Pap smears annually. | Number of female clients with annual pap. | Number of female clients. | | 75% of female clients receive Pap smears annually. |
| An Hepatitis C (HCV) protocol is in place for clients testing positive for Hepatitis C. | Clients newly diagnosed with Hepatitis C will be tested for HCV viral load and genotype. | Number of clients newly diagnosed with Hepatitis C has HCV viral load and genotype. | Number of clients newly diagnosed with HCV. | CAREWare, lab values, client charts. | 75% of clients newly diagnosed with Hepatitis C will be tested for HCV viral load and genotype. |

# STANDARDS OF CARE

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| | All clients with Hepatitis C will be evaluated or referred for evaluation of treatment suitability. | Number of Hepatitis C clients evaluated for treatment. | Number of clients with Hepatitis C. | Client charts. | |
| Clients with HIV and Hepatitis B (HBV) and/or Hepatitis C receive alcohol counseling annually. | Documentation that clients with HIV and Hepatitis B &/or C receive alcohol counseling annually. | Number of clients with dual diagnosis of HIV &/or Hepatitis B/C. | Number of clients. | CAREWare and Client charts. | 75% of clients with HIV and Hepatitis B (HBV) and/or Hepatitis C receive alcohol counseling annually. |
| Clients are offered immunizations or have documentation of decline of immunizations. | Documentation that clients receive vaccinations according to current standards (or document decline):<br>• Influenza<br>• Pneumococcal as appropriate<br>• Initiation of hepatitis A/B vaccines series if not immune<br>• Tetanus<br>• HPV as appropriate | Number of clients with influenza vaccine.<br><br>Number of clients with pneumococcal vaccine.<br><br>Number of clients with HepatitisA/B vaccine series initiated if not immune.<br><br>Number of clients with tetanus vaccine.<br><br>Number of clients with HPV vaccine. | Number of clients.<br><br>Number of clients needing pnemococcocal vaccine.<br><br>Number of non-immune clients.<br><br>Number of clients.<br><br>Number of clients needing HPV vaccine. | CAREWare or client charts. | 75% of clients receive vaccinations according to current standards (or document decline):<br>• Influenza<br>• Pneumococcal as appropriate<br>• Initiation of Hepatitis A/B vaccines series if not immune<br>• Tetanus<br>• HPV as appropriate |
| Assessment of treatment adherence and counseling, which adhere to current USPHS guidelines. | Documentation that clients' are assessed for treatment adherence and counseling at a minimum of twice a year. | Number of clients on ART with treatment assessment minimum of twice a year. | Number of clients on ART. | Client charts | 75% of charts with assessment of treatment adherence documented at a minimum of twice a year.<br><br>75% of charts |

| | | | | | |
|---|---|---|---|---|---|
| | If adherence issue is identified, follow-up action is documented.<br><br>Documentation of missed clients appointments and efforts to bring the client into care. | Number of clients with adherence issues have follow-up.<br><br>Number of charts with documented missed appointments and efforts to bring clients into care. | Number of clients with adherence issues.<br><br>Number of clients with missed appointments. | | document follow-up action if adherence issue is identified.<br><br>75% of charts document missed client appointments and efforts to bring the client into care. |
| Clients are assessed for risk behaviors and receive risk reduction counseling to reduce secondary transmission of HIV. | Charts document a risk behavior assessment and clients receive risk reduction counseling. | Number of clients with risk reduction counseling. | Number of clients. | Client charts | 75% of charts document a risk behavior assessment and clients receive risk reduction counseling. |
| Clients are screened and receive tobacco cessation counseling annually (or document decline of tobacco use). | Charts document screening for tobacco use and cessation counseling (or document decline). | Number of clients with tobacco cessation counseling. | Number of clients. | Client charts | 75% of clients are screened and receive tobacco cessation counseling annually (or document decline of tobacco use). |
| Clients receive referrals for Oral Health Care annually. | Client charts document referrals for a dental oral exam annually. | Number of clients with dental referral. | Number of clients. | Client charts and/or CAREWare | 75% of client charts document referrals for a dental oral exam annually. |
| Female clients are assessed for pregnancy and are prescribed antiretroviral therapy during 2nd and 3rd trimester. | Charts document screen for pregnancy where indicated for female clients and if pregnant, prescribed ART therapy. | Number of pregnant female clients. | Number of female clients. | Client charts. | 60% of female clients are assessed for pregnancy and are prescribed antiretroviral therapy during 2nd and 3rd trimester. |

# STANDARDS OF CARE

## EARLY INTERVENTION SERVICES

### DEFINITIONS OF SERVICE

**Health Resources and Service Administration HRSA**

***Early Intervention Services (EIS)*** for Part B include counseling individuals with respect to HIV/AIDS, testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, and tests to provide information on appropriate therapeutic measures), referrals, other clinical and diagnostic services regarding HIV/AIDS, periodic medical evaluations for individuals with HIV/AIDS, and provision of therapeutic measures.

**Services**

**Early Intervention Services (EIS)** are the provision of a combination of services that include the following as they relate to HIV/AIDS: counseling, testing, health education, referrals, and other clinical and diagnostic services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care. These services must focus on expanding key points of entry and documented tracking of referrals. EIS activities are designed to bring HIV positive individuals into Ambulatory/Outpatient Medical Care.

**Purpose of Services**

To identify individuals who are unaware of their HIV/AIDS status and link them into medical care.

### GOALS OF SERVICES

The goals of this initiative are to increase: 1) the number of individuals who are aware of their HIV status; 2) the number of HIV-positive individuals who are in medical care; and 3) the number of HIV-negative individuals referred to services that contribute to keeping them HIV-negative.

**Qualifications**

| Staff Qualifications | Expected Practice |
|---|---|
| Staff providing EIS services must be adequately trained to provide these services to persons who have been recently diagnosed or who know their status but are not in care. They also must receive supervision by a senior member with experience and skill in the field.<br><br>All agency staff that provide direct-care services shall possess:<br>Required certification as an HIV Prevention counselor; | Personnel files/resumes/applications for employment reflect requisite experience and education. |
| When funding outreach in support of the EIIHA initiative, grantees must structure outreach activities targeting specific at risk populations in accordance with their EIIHA strategy and plan. | EIIHA strategy and plan |
| Staff skilled in counseling and testing for HIV | Personnel records. |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

Persons with HIV infection who are not aware of their status.

## UNITS OF SERVICE

Face to face visits and/or phone conversations documented in quarter-hour increments in CAREWare.

## ACTIVITIES

**Program Outcome**

The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. Increase the percentage of individuals with HIV-infection who are aware of their status and seeking care.

**Indicators**

- Number of persons testing positive;
- Number of clients testing positive and brought into care;
- Number of clients returned to care.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| EIS activities ensure that clients are connected to Primary Medical Care within 30 Days of initial intake. | Documentation of first medical visit within 30 days of EIS intake in client files. | Number of newly enrolled clients. | Number of EIS clients. | Client Charts<br><br>CARE Ware | 75% of newly enrolled EIS clients will have their first medical visit within 30 days of their EIS intake in their client files. |

# STANDARDS OF CARE

## ORAL HEALTH

### DEFINITIONS OF SERVICES

***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists, auxiliaries, and other trained primary care providers.

**Services**

Services will include routine dental examinations, prophylaxis, x-rays, fillings, endodentistry, and basic oral surgery (simple extractions). Emergency procedures will be treated on a walk-in basis as availability and provisions allow. If the provider cannot provide adequate services for emergency care, the patient will be referred to a hospital emergency room. Cosmetic dentistry for cosmetic purposes only is prohibited.

**Purpose of Services**

Provide access to routine and emergency dental care for eligible persons living with HIV/AIDS, who reside within the Commonwealth of Kentucky.

### GOALS OF SERVICE

1. To maintain the oral health of consumers with HIV/AIDS to sustain proper nutrition.
2. To maintain and improve the oral health of persons living with HIV/AIDS.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Dentists must be licensed and accredited as specified by the Kentucky State Board of Dentistry (KSBD). | Personnel files/resumes/applications for employment reflect requisite licensing and accreditation. |
| Dental hygienists must be licensed and accredited as specified by the KSBD. | Personnel files/resumes/applications for employment reflect requisite licensing and accreditation. |
| Dental assistants must register with the KSBD within one year if they administer x-rays. | Personnel files/resumes/applications for employment reflect requisite SBDE registration. |
| ***Staff Vaccinations:***<br>Hepatitis B, required as defined by the<br>Tuberculosis tests at least every 12 months for all staff is strongly recommended;<br>OSHA guidelines must be met to ensure staff and patient safety. | Staff health records will be maintained at each agency to ensure that all vaccinations are obtained and precautions are met. |
| Service providers shall employ staff (i.e., receptionists, schedulers, file clerks, etc.) that is knowledgeable and experienced regarding their area of practice as well as in the area of HIV/AIDS. All staff without direct experience with HIV/AIDS shall be supervised by a staff person who has such experience. | Agency will maintain documentation of unconditional staff certification and licensure in their particular area of practice, and will monitor the activities of staff to ensure that only qualified employees administer services. |
| Dental hygienists and assistants must perform all services to patients under supervision of a licensed dentist. | Copy of supervising dentist license on file. |

# STANDARDS OF CARE

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|---|---|
| Provider/Agency shall be accredited and/or licensed to deliver dental services. | Documentation of current unconditional license and/or certification is on file for each provider and for organization as a whole, where applicable. |

## CLIENT CHARACTERISTIC

Kentucky residents with HIV disease who are enrolled in the Kentucky HIV Care Coordinator Program and require oral health services.

## UNITS OF SERVICE

- Face to face encounter between a patient and a qualified dentist or dental hygienist occurring during a single visit as entered in CAREWare.
- Dental procedure as entered in CAREWare.

## ACTIVITIES

Program Outcomes

- Clients receiving Oral Health Care services will show decrease in the number of caries.
- Clients with Phase 1 treatment plans will complete those plans within 12 months of initial exam. Phase I treatment plans include: prevention, maintenance and/or elimination of oral pathology that results from dental or periodontal disease. This includes: restorative treatment; basic periodontal therapy (non-surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition.

**Indicators:**

- Number of clients receiving Oral Health Care services.
- Number of clients with completed Phase 1 of treatment plan.

**Quality**

| Quality Standard | Outcome Measure | Numerator | Denominator | Data Source | Goal/ Benchmark |
|---|---|---|---|---|---|
| Provider obtains and documents referral from HIV primary care provider contact. | Documentation of HIV primary care provider information in the patient's chart/file. | Number of clients with documented primary care provider in chart. | Number of clients. | Client Files<br><br>CAREWare | 75% of client charts have documentation of HIV primary care provider contact information. |

# STANDARDS OF CARE

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|---|---|---|---|---|---|
| Provider collects and documents health history information for each patient. This information should include, but not be limited to:<br>Current (within the last 6 months) Viral Load and CD4;<br>Current Medications;<br>Allergies and drug-sensitivities;<br>Hepatitis;<br>Usual oral hygiene;<br>Date of last dental examination. | Documentation of health history information in patient's chart/file. | Number of clients with health history. | Number of clients. | Client Files<br><br>CAREWare | 75% of client charts have documentation of health history. |
| A comprehensive, multi-disciplinary Oral Health treatment plan will be developed in conjunction with the patient within 12 months of initial intake. This information should include, but not limited to:<br>Patient's primary reason for dental visit;<br>Patient strengths and limitations will be considered in development of treatment plan;<br>Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. | Treatment plan dated and signed by both provider and patient in patient chart/file. | Number of clients with treatment plans signed and dated. | Number of clients.<br><br>Number of clients. | Client Files<br><br>CAREWare | 75% of client charts have documentation of treatment plans signed and dated. |

# STANDARDS OF CARE

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|---|---|---|---|---|---|
| The following elements are part of each patient's initial comprehensive oral and semi-annual exam hard/soft tissue examination:<br>Charting of caries;<br>X-rays;<br>Periodontal screening;<br>Written diagnoses, where applicable;<br>Treatment plan. | Documentation in patient's file/chart.<br><br>Review of Agency's Policy and Procedures. | Number of clients with comprehensive oral and semi-annual exam hard/soft tissue. | Number of clients. | Client Files<br><br>CAREWare | 75% of client charts have documentation of initial comprehensive oral and semi-annual exam hard/soft tissue examination as indicated. |
| Provider must provide patient oral health education once each year which includes the following:<br>Caries prevention:<br>Fluoride (ADA code D1310);<br>Nutritional (ADA code D1310;<br>Smoking/tobacco cessation;<br>Oral hygiene | Documentation in patient's chart/file of rate of dental disease and oral pathology.<br><br>Documentation in patient's chart/file of rate of smoking/tobacco cessation.<br>Oral hygiene. | Number of clients with documented general oral health education.<br><br>Number of clients with documented education on smoking/tobacco cessation; oral hygiene. | Number of clients.<br><br>Number of clients. | Client Files<br><br>CAREWare | 75% of client charts have documented general oral health education provided.<br><br>75% of client charts, when applicable, have documentation of smoking/tobacco cessation education provided. |

# STANDARDS OF CARE

## Home Health Care

### DEFINITIONS OF SERVICES

**Health Resources and Service Administration (HRSA)**

***Home health care*** is the provision of services in the home by licensed health care workers, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

**Services**

Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a physician. Services include skilled nursing services, home intravenous and aerosolize drug therapy, the administration of prescription drugs therapies and the administration of other medical therapies.

Durable medical equipment including oxygen, home health aide services, physical therapy, occupational therapy, and speech therapy rehabilitation services **are not** included.

**Purpose of Services**

To provide home based nursing services to eligible clients so they can safely remain in their homes and reduce hospitalization.

### GOALS OF SERVICES

Improve the quality of care of clients in need of assistance in the administration of medical therapies at home.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Must be licensed by the appropriate state and/or local authority to provide skilled nursing services.<br>Must show evidence of professional malpractice insurance in addition to insurance requirements of Shelby County | All documents on file. |
| Plan of care must be coordinated by client's clinical care team. | All documents on file. |
| Skilled nurse a registered nurse (RN) that provides appropriate skilled nursing care to client in their place of residence in accordance with state/federal regulations. Provides services required in the treatment plan of care; performs duties consistent with the nursing practice standard of competent performance.<br>Licensed vocation nurse (LVN) is a health professional that works under the supervision of the physician or RN. LVN performs basic care services, taking vital signs, temperature, blood pressures, treating bedsores, and giving injections. | |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

Clients with chronic medical dependency due to physical or cognitive impairment from HIV infection that cannot self-administer medical therapies at home.

## UNITS OF SERVICE

Face to face encounter with the client documented in CAREWare in 30 minute increments.

## ACTIVITIES

**Program Outcome**

- Home health clients received services within 24 hours of determination of need/referral.
- Clients will be reassessed every 30 days and nurse to send report to M.D. and nurse manager.

**Indicators**

- Number of clients referred to home health services.
- Number of clients receiving home health services.
- Number of client receiving home health services and being assessed every 30 days.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| Home health care activities ensure that clients are connected to prescribe medical therapies at home within 24 hours of referral. | Documentation of first home visit in clients files. | Number of newly referred clients. | Number of home health clients. | Client Charts<br><br>CAREWare | 75% of newly referred clients will have their first home visits within 24 hours. |
| Client will be reassessed at home every 30 days and nurse will send the report to the M.D. | Documentation on client files. | Number of clients that were reassessed every 30 days. | Number of clients in home health care. | Client chars<br><br>CAREWare. | 75% of all clients will be reassessed every 30 days. 75% of the M.D. received a re-assessment report every 30 days. |

# STANDARDS OF CARE

## HOSPICE

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Hospice Services*** are an allowable Ryan White HIV/AIDS Program core medical service. Funds may be used to pay for hospice care by providers licensed in the State in which services are delivered. Hospice services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice care to terminal patients. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.

**Services**

Hospice care is provided to terminally ill persons with HIV/AIDS who have voluntarily chosen to receive such care instead of curative treatment. Such services include:

- Nursing services
- Medical supplies and equipment
- Medical social services under the direction of a licensed physician
- Medications
- Physician services
- Counseling including bereavement (both individual and family)
- Dietary counseling
- Spiritual counseling

**Purpose of Services**

To provide culturally competent care, supervision, and assistance for persons living with HIV/AIDS who have been certified by a licensed physician to be terminally ill.

### GOALS OF SERVICES

Improve the quality of care for clients who have been determined to have less than 6 months to live.

# STANDARDS OF CARE

**Qualification**

| Staff Qualification | Expected Practice |
|---|---|
| All direct -care staff who require licensure or certification must be licensed by the Commonwealth of Kentucky or certified by their respective professional organizations | Copies of licenses and certifications on file at provider agency. |
| Periodic staff training is required - quarterly training on palliative/terminal care is required | Copies of licenses and certifications on file at provider agency, including documentation of training. |

## CLIENT CHARACTERISTIC

Client is HIV-infected and terminally ill.

## UNITS OF SERVICE

- Home care = number of services (per service)
- Residential = resident days (per day)

## ACTIVITIES

**Program Outcomes**

Terminally ill clients are given the opportunity to choose palliative rather than curative therapies.

**Indicators**

- Percentage reporting improvement in control of pain;
- Percentage of clients reporting control of the symptoms noted on intake;
- Percentage of clients leaving program for reasons other than death.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| In an 8 day, 4 hour period per day, using the patient's own assessment rate from 0 to 10 for the following symptoms: Fatigue; Depression; Anxiety; Shortness of breath; Appetite; Feeling of well being. | Symptoms control. | Number of patients assessed and average rating. | Number to total patients in the eight day study. | Number of hospice patients discharged in reporting month period included in sample. | 75% reported control of symptoms noted on intake. |

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|---|---|---|---|---|---|
| In an 8 day have patient assess pain and rate from 0 to 10.<br><br>Percentage of new ratings of pain =>4 with treatment (or satisfied) w/in 4 hours. | Pain medication and palliative methods effective in controlling pain. | Total number of new pain ratings =>4 in sample, where within 4 hours of the assessment:<br>• treatment was initiated/modified (including patient-initiated use of PRN meds);<br>**OR**<br>there is documentation that the patient is satisfied w/level >3 or current treatment – does not want a change *(may include when worst level occurred in past 24 hours but treated w/PRN meds and under control at time of assessment).* | Total number of new pain ratings =>4 for all hospice patients discharged in reporting period included in sample. | Data as recorded patient chart. | 65% of the patient reported improvement in the control of pain. |
| Conduct exit interview for patients leaving the program. | Patient leaving program is decreased to less than one percent. | Number of patients leaving the program for reasons other than death. | Total number of clients in program. | Exit interviews in clients' files. | Ten percent of patients left the program for reasons other than death. |

# STANDARDS OF CARE

## MENTAL HEALTH

### DEFINITIONS OF SERVICES

**Health Resources and Service Administration (HRSA)**

***Mental health services*** are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

**Services**

Mental health counseling services includes intensive mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the Commonwealth of Kentucky. Counseling services may include general mental health therapy, counseling, and bereavement support for clients as well as non-HIV infected family members or significant others. Crisis counseling and referral will be available to clients and care givers. Medical services are provided by a licensed medical, board certified psychiatrist.

**Purpose of Services**

To assist HIV-positive clients and their significant others, which may include family, significant others, and friends, to cope with the emotional and psychological aspects of living with HIV disease.

### GOALS OF SERVICES

To have services available to minimize crisis situations and stabilize clients' mental health status in order to promote health care maintenance and positive health outcomes.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| All staff providing direct mental health services to clients must be licensed and qualified within the laws of the Commonwealth of Kentucky to provide mental health services in one of the following professions:<br>a. Licensed Clinical Social Worker;<br>b. Licensed Master Social Worker (LMSW) (is under a clinical supervision plan);<br>c. Marriage and family therapist;<br>d. Licensed professional counselor;<br>e. Psychologist;<br>f. Psychiatrist;<br>g. Psychiatric nurse;<br>h. Psychotherapist. | Current License/Certification will be maintained on file.<br><br>Personnel records/resumes/applications for employment reflect requisite experience/education. |

# STANDARDS OF CARE

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| At least two years of experience in HIV or another catastrophic illness preferred. | Documentation of experience on file. |
| A mental health supervisor must be a licensed clinical mental health practitioner. | Current License/Certification will be maintained on file. |
| Provider shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to patients within thirty (30) working days of employment, including at a minimum:<br>a. Crisis intervention procedures;<br>b. Standards of Care;<br>c. Confidentiality;<br>d. Documentation in case records; (CAREWare training);<br>e. Consumer rights and responsibilities;<br>f. Consumer abuse and neglect reporting policies and procedures;<br>g. Professional ethics;<br>h. Emergency and safety procedures;<br>i. Data management and record keeping;<br>j. Review of job description;<br>k. Occupational Safety and Health Administration (OSHA) regulations pertaining to substance abuse in the workplace; and<br>l. The Americans with Disabilities Act as Amended (ADAAA). | Personnel record reflects completion of orientation and signed job description.<br><br>Contract providers will provide documentation of receiving such training. |
| Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate CEUs based on individual licensure requirements at a minimum, as per the license requirement for each licensed mental health practitioner. | Documentation on file. |

## CLIENT CHARACTERISTIC

1. Newly diagnosed individuals with mild mental health symptoms (depressed mood and mild insomnia) or co-occurring issues (e.g. substance abuse) needing treatment follow-up appointments or referral to ongoing support.

2. Individuals with moderate to severe symptoms or moderate to severe difficulty needing an assessment for individual therapy/counseling, general group therapy/counseling, and/or psychotropic medication.

3. Individuals with severe symptoms referred for psychiatric assessment and treatment and/or intensive outpatient treatment.

# STANDARDS OF CARE

## UNITS OF SERVICE

1. Face to face individual level Mental Health visit.
2. Face-to-face group level Mental Health visit documented in CAREWare.

## ACTIVITIES

**Program Outcomes**

75% of clients with mental health concerns will show maintenance in mental health functioning from baseline assessment at care entry.

**Indicators**

- Number of clients attending Mental Health Services who are engaged in treatment.*
- Number of clients who have addressed at least 2 treatment goals.

**Engaged =individual invested in treatment and attends a minimum of 60% of mental health appointments.*

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| I. Process | | | | | |
| An appointment will be scheduled within three (3) working days of a client's request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner. | Documentation in patient's file. | Number of days documented between client request and appointment . | Number of clients. | Client Files<br><br>CARE Ware | 75% of clients will have an appointment scheduled within three working days of request for mental health services. |
| A comprehensive assessment including the following will be completed within 10 days of intake or no later than and prior to the third counseling session:<br>• Presenting Problem;<br>• Developmental/Social history;<br>• Social support and family relationships;<br>• Medical history; | Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. | Number of new client charts with assessment completed within 10 days of intake. | Number of new clients. | Client Files<br><br>CARE Ware | 75% of new client charts have documented comprehensive assessments completed within 10 days of intake. |

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| • Substance abuse history;<br>• Psychiatric history;<br>• Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks);<br>• Cognitive assessment (level of consciousness, orientation, memory and language);<br>• Psychosocial history (education and training, employment, military service, legal history, family history and constellation, physical, emotional and/or sexual abuse history, sexual and relationship history and status, leisure and recreational activities, general psychological functioning). | | | | | |
| A treatment plan shall be completed within 30 days that is specific to individual client needs. The treatment plan shall be prepared and documented for each client. Individual, and family case records will include documentation of the following:<br>• Eligibility;<br>• Psychosocial assessment;<br>• Goals and objectives;<br>• Progress notes;<br>• Referrals;<br>• Discharge summary. | Documentation in client's file. | Number of client charts with treatment plans within 30 days of first visit. | Number of clients | Client Files<br><br>CARE Ware | 75% of client charts will have documentation of a treatment plan within 30 days of first visit. |
| Progress notes are completed for every professional counseling session. | Legible, signed and dated documentation in client record. | Number of client charts with progress notes. | Number of clients. | Client Files CARE Ware | 80% of client charts will have documented legible, signed and dated progress notes. |

# STANDARDS OF CARE

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| Discharge planning is done with each client after 30 days without client contact or when treatment goals are met. | Documentation in client's record. | Number of discharged clients. | Number of clients | Client Files<br><br>CARE Ware | 75% of client charts have documentation of discharge planning within 30 days of treatment goals being met or no client contact. |
| Clients accessing psychiatric care are medically adherent and are engaged in their psychiatric treatment plans. | Clients are assessed for psychiatric care and when engaged in psychiatric care, are medically adherent. | Number of psychiatric clients | Number of clients. | Client Files Care Ware Agency Policy and Procedure Manual | 75% of clients accessing psychiatric care are medically adherent and are engaged in their psychiatric treatment plans. |
| Access to and maintenance in Medical Care: RW clients' ongoing participation in primary HIV medical care | Each client is assessed and verified for engagement in HIV medical care and assisted with establishing linkages to care if not currently receiving care. Assessed initially, then re-assessed and documented every 3 months. | Number of clients assessed/verified for medical care initially and every 3 months | Number of clients. | Client Files<br><br>CARE Ware | 90% of clients are assessed and verified for engagement in medical care. This is assessed initially, then re-assessed and documented every 3 months. |

# STANDARDS OF CARE

## MEDICAL NUTRITION THERAPY

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Medical Nutrition Therapy Services,*** including nutritional supplements provided by a licensed registered dietitian outside of a primary care visit, is an allowable core medical service under the Ryan White HIV/AIDS Program. The provision of food may be an eligible service pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician.

Nutritional services and nutritional supplements not provided by a licensed, registered dietician shall be considered a support service under the Ryan White HIV/AIDS Program. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.

**Services**

Medical nutrition therapy is the provision of specific nutrition counseling and interventions to help treat HIV disease, including screening, referral, assessment, intervention, and communication. Medical nutrition therapy involves both assessment and appropriate treatments to maintain and optimize nutrition status.

*Medical Nutrition services include:*

- An evaluation and plan;
- A nutrition care plan;
- Nutrition counseling and medical nutrition therapy;
- The distribution of nutrition supplements or food when appropriate;
- The provision of Nutrition and HIV trainings to clients and their providers; and
- The distribution of nutrition related educational materials to clients.

### GOALS OF SERVICES

The goals of medical nutrition therapy for people living with HIV include:

- Optimizing nutrition status and immunity;
- Preventing the development of nutrient deficiencies;
- Promoting the attainment and maintenance of optimal body weight and composition; and
- Maximizing the effectiveness of antiretroviral agents.

# STANDARDS OF CARE

**Qualification**

| Staff Qualification | Expected Practice |
|---|---|
| A. Registered dietitian with a Bachelors, Masters and/or Doctorate degree in nutrition and related sciences, or a supervised dietetic internship or equivalent and a national exam which credentials her/him as a Registered Dietitian by the Commission on Dietetic Registration. | • Resume in personnel file;<br>• Credential verification in personnel file;<br>• Training records; |
| B. Registered Dietician licensed in the Commonwealth of Kentucky, maintain professional education (CPE) units/hours, primarily in HIV nutrition and other related medical care. | • Personnel record verification; |
| C. Medical Nutrition Therapy staff has a clear understanding of their job description and responsibilities as well as agency policies and procedures. | • Written job descriptions that include roles and responsibilities;<br>• Personnel records include signed statement from each staff member and supervisor confirming that the staff member has been informed of agency policies and procedures and commits to following them; |

## CLIENT CHARACTERISTIC

An HIV infected client referred by physicians and surgeons, osteopaths, physician's assistants, or dentists for the following reasons:

- Physical changes and weight concerns;
- Oral/GI symptoms;
- Metabolic complications and other medical conditions including diabetes, hyperlipidemia, hypertension, etc.;
- Barriers to nutrition, living environment, functional status;
- Behavioral concerns or unusual eating behaviors;
- Changes in diagnosis requiring nutrition intervention.

# STANDARDS OF CARE

## UNITS OF SERVICE

Number of nutrition assessments, counseling sessions and seminars provided to eligible clients.

## ACTIVITES

**Program Outcome**

Improvement in the client medication side effect, absorption of medication, and body weight.

**Indicators**

- Percent of patients who maintain goal weight or make at least *5%* progress toward goal after 3 months of care;
- Percent of patients that have enough of the appropriate food to have food security;

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| Agencies providing Medical Nutrition Therapy will have written guidelines to generate automatic referrals for this service in addition to direct consults from medical providers. | Providers of Medical Nutrition Therapy shall, in conjunction with the client, develop goals and interventions strategies to determine progress made in desired outcomes or nutrition care that will be reviewed and updated as conditions warrant or at a minimum of every six months; | Number of clients with a nutrition treatment plan; | Number of clients referred to nutrition services; | Client files Care WARE | 75% of the clients referred to nutritional services will have a treatment plan that is reviewed periodically; |
| Client receiving medical nutrition therapy in need of a secure food source. | Those in need of a food source have secure food stamps, or monthly vouchers or other means of securing a food source; | Number of clients in nutritional therapy that secure a food source; | Number of clients in need of a secure food source; | Client files Care WARE | 80%receiving nutritional therapy and in need of food secure a food source; |

| | | | | | |
|---|---|---|---|---|---|
| The client nutrition treatment plan has been effective in maintaining health among PLWH/A. | Clients receiving ongoing nutritional therapy show improvement in:<br>CD4 counts;<br>adherence to medical treatment;<br>reduced medication side effect;<br>maintenance of body weight; | Number of clients keeping medical appointment;<br><br>Number of clients with increasing CD4 Counts;<br><br>Number of clients increasing or maintaining weight;<br><br>Number of clients experiencing no medication side effects; | Number of clients; | Client files<br>Care WARE | 75% of the clients are adherent to medical treatment;<br><br>65% of clients show an improvement on CD4 counts;<br><br>65% of clients increasing or maintaining body weight;<br><br>65% of clients show a decline in medication side effects; |

# STANDARDS OF CARE

## MEDICAL CASE MANAGEMENT

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Medical case management service*** (MCM) must be provided by trained professionals, including both medically credentialed and other health care staff that provides a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems. Medical case management may also include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic re-evaluation and adaptation of the care plan, at least every 6 months, and as necessary during the enrollment of the client.

**Services**

The MCM provision of services is focused on maintaining HIV-infected persons in systems of primary medical care to improve HIV-related health outcomes. Medical case managers act as part of a multidisciplinary medical team, with a specific role of assisting clients in following their medical treatment plan. Medical case managers should not serve as gatekeepers or access points into medical care, as the goal of this service is the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the medical case manager. The medical case manager should be a licensed professional (e.g., RN, LMSW). Programs providing MCM that meets the requirements of this definition with experienced unlicensed staff may apply for a limited waiver of this provision.

The MCM must include a comprehensive assessment of need, the development of a service plan to address client needs, client referral to appropriate providers based on need and service plan, interventions to address client issues such as medication compliance, adherence and risk reduction, as well as patient education.

Active, intensive medical case management services are home and community based. Medical case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the medical case management service provider agency.

The MCM can refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, ADAP Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services when appropriate.

# STANDARDS OF CARE

**Purpose of Services**
To facilitate recommended treatment plan to assure appropriate medical care is provided to HIV infected persons in Kentucky.

## GOALS OF SERVICES

Retaining clients in medical care and achieving positive health outcomes.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. They will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are:<br>A bachelor's (required) or master's degree (preferred) in social work from a program accredited by the Kentucky State Board of Social Work Examiners; OR<br>A bachelor's (required) or master's degree (preferred) in nursing (RN) currently licensed in Kentucky;<br>A licensed practical nurse licensed in Kentucky; OR<br>Case managers employed prior to the approval of these standards and who did not meet the minimum qualifications listed above may be granted a waiver from these qualifications by the Administrative Agency, as approved by the Grantee. | Personnel files/resumes/applications for employment reflect requisite experience and education. |
| Twenty-four (24) hours of annual training are required for all employees. The 24 hours shall include fifteen (15) hours of medical training, six (6) hours of psychosocial training, and three (3) hours of quality management training.<br><br>The medical training shall cover the topics of Medical Adherence, HIV Disease Process, Oral Health, Risk Reduction/Prevention Strategies (including Substance Abuse Treatment), and Nutrition. A suggested additional topic may be End-of-Life issues. Medical training shall also include training on documentation.<br><br>The psychosocial training shall include the topics of AIDS and the law, and medically related federal and state benefits programs (e.g. Social Security, Medicare, Medicaid). | Personnel files reflect training log with documentation of subject matter and attendance at twenty-four (24) hours of annual training. |

## UNITS OF SERVICE

- Face to Face Clinic (office) visit;
- Face-to-Face (home) visit;
- Phone contact of minutes or more of duration.

## ACTIVITIES

**Program Outcomes**

- 75% of clients will maintain medical care after accessing MCM services as reported every 6 months, or as determined through use of an Acuity Scale;
- % of clients retained in care (total number of clients retained/total number of clients);
- % of clients entering care (total number of new clients/total number of clients).

**Indicators**

- Care plan details client's short and long-term goals with associated tasks to achieve them. Care plan is updated every 6 months;
- Clients are successfully linked to Primary Medical Care as evidenced by initial visit and then documentation of visit every 6 months;
- The number of client charts with accurate risk/exposure group via documentation of updated risk factors twice a year.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| A client may be discharged from medical case management services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include: a reason for the discharge/closure; a transition plan to other services or other provider agencies, if applicable; ally case managers should check in with their clients monthly as determined by client need, but at a minimum of every three (3) months. | Documentation of case closure and reason in client's record. | Number of clients discharged from MCM | Number of clients. | Client Files<br><br>CARE Ware | 75% of discharged clients have documentation of case closure and reason in client files. |

# STANDARDS OF CARE

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| Medical case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. | Documentation in client's record indicating referrals or transition plan to other providers or agencies. | Number of clients leaving MCM. | Number of clients. | Client Files<br><br>CARE Ware | 75% of clients leaving MCM have documentation or referrals or transition plan to other providers/agencies in their file. |
| The medical case manager conducts a face-to-face assessment of the client's needs. | Documentation of needs assessment in client chart. | Number of MCM clients. | Number of clients. | Client Files<br><br>CARE Ware | 80% of all MCM client files have documentation of face-to-face assessment completed. |
| Within three (3) working days of enrollment, an intake shall be completed to evaluate the client's needs, including, but not limited to the following:<br>Medical history;<br>Income;<br>Insurance status;<br>Availability of food, shelter, and transportation;<br>Available support system;<br>Need for legal assistance;<br>Substance abuse history and status;<br>Emotional/mental health history and status. | Client's chart contains documentation of each client's need for (or problems with) current medical status, financial resources, food, transportation, support system, substance abuse status. and mental health status. | Number of MCM clients with intake. | Number of clients. | Client Files<br><br>CARE Ware | 80% of all MCM client files have documentation of an intake. |
| The intake should be reviewed with the client as evidenced by the completed service plan. | Documentation of service plan signed by client and case manager when reviewed in client file. | Number of MCM clients with signed plan. | Number of clients. | Client Files | 80% of all MCM clients have documentation of a signed service plan by both client and case manager. |
| Care Plans are re-assessed every 4-6 months for full eligibility, financial, and support services every 6 months. | Documentation of reassessment of care plan in client files. | Number of clients documenting review every 4-6 months of eligibility, and support services every 6 months. | Number of clients. | Client Files<br><br>CARE Ware | 75% of client files document Care Plan review every 4-6 months for eligibility and support services every 6 months. |

# STANDARDS OF CARE

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| An individual care plan will be completed within ten (10) working days of the first face-to-face meeting with the client. | Documentation of care plan in client file. | Number of clients with Care Plan. | Number of clients | Client Files<br><br>CARE Ware | 80% of clients have a comprehensive Care Plan within 10 days of the first face-to-face meeting. |
| The individual care plan will be a written comprehensive plan of intervention comprised of goals and measurable objectives, and prepared with the participation of the client, with the primary objective of including provider identified barriers to adherence to antiretrovirals, or other therapies, and continued medical follow-up[1]. | Documentation shall include client's problems and needs with treatment and medications, attempts made to solve the problems (including a timeframe and names of providers involved), and follow-up items to relay to the primary care provider. | Number of clients with Care Plan. | Number of clients. | Client Files<br><br>CARE Ware | 75% of clients have a comprehensive Care Plan with documented needs of clients in client file. |
| Medical case managers ensure that all client needs are identified by assessment and acuity, and prioritized so that the most important services for clients are made available as soon as possible. | Documentation in client file. | Number of assessments that identify and prioritize client needs. | Number of clients. | Client Files<br><br>CARE Ware | 80% of client assessments show documentation of clients' needs identified and prioritized. |
| Care Plans are signed and dated by the Medical Case Manager that developed the Plan and by the client. | Documentation of signature of the MCM and client in client files. | Number of Care Plans signed and dated by MCM and client. | Number of clients. | Client Files<br><br>CARE Ware | 80% of Care Plans are signed and dated by MCM and clients. |
| Medical Case Managers will refer clients for necessary services in a timely manner. | Documented in client's file. Failure to follow-up on completion of a referral for any service will be documented in the progress notes of client file. | Number of clients with referrals. | Number of clients. | Client Files<br><br>CARE Ware | 80% of clients have documentation on file of referrals for necessary services. |

# STANDARDS OF CARE

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| Medical Case Managers will monitor client's progress to meeting established goals of care. | Documentation in client files. | Number of client records with goals and updated care plans. | Number of clients. | Client Files<br><br>CARE Ware | 75% of client records contain established goals and updated care plans. |
| Medical Case Managers have documentation in client file of two (2) or more medical visits in the assessment year. | Documentation in client files. | Number of clients with 2 or more medical visits by prescribing provider at least three months apart. | Number of clients. | Client Files<br><br>CARE Ware | 75% of clients accessing Medical Case Management have documentation of 2 or more medical visits by a prescribing provider at least three months apart in client file. |
| Clients with high acuity scores at initial intake show a reduced acuity score at 6-month care plan review. | Documentation in client files of reduced acuity score at 6-month care plan review. | Number of clients with care plan review at 6 months. | Number of clients. | Client Files<br><br>CARE Ware | 75% of client files in high acuity show a reduced acuity score at the 6-month care plan review. |

[1] *Data collected regarding clients' treatment adherence is for information gathering only and will not be used to deny services to clients for non-adherence issues.*

# STANDARDS OF CARE

## SUBSTANCE ABUSE OUTPATIENT

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Substance Abuse Treatment Services-Outpatient*** is an allowable core medical service. Funds used for outpatient drug or alcohol substance abuse treatment, including expanded HIV-specific capacity of programs, if timely access to treatment and counseling is not available, must be rendered by a physician or provided under the supervision of a physician or other qualified/licensed personnel. Such services should be limited to the following:

- Pre-treatment/recovery readiness programs;
- Harm reduction mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
- Outpatient drug-free treatment and counseling;
- Opiate Assisted Therapy;
- Neuro-psychiatric pharmaceuticals;
- Relapse prevention; and
- Acupuncture Therapy. (*Funds awarded under the Ryan White HIV/AIDS Program may only be used to support limited acupuncture services for HIV-positive clients as part of Ryan White HIV/AIDS Program funded Substance Abuse Treatment Services (outpatient or residential), provided the client has received a written referral from his/her primary health care provider. All acupuncture therapy must be provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists).*

**Services**

Substance abuse services may involve a variety of cognitive, emotional, spiritual, and practical skills to deal with addictions, and ongoing recovery, as well as clinical treatments and interventions that address the physical sources of symptoms of addiction.

Examples of services include regular ongoing substance abuse treatment and counseling on an individual and/or group basis by a state licensed provider. Services must include provision of, or links to, the following: social and/or medical detoxification when necessary, recovery readiness, harm reduction, 12 step model, rational recovery approach model, aftercare, mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse, medical treatment for addiction, and drug-free treatment and counseling. These services will include women with children and persons with disabilities.
Referring provider will ensure collaboration across the various groups that work with the substance abuse population and those at risk, and that share the best practices to overcoming philosophical barriers.

**Purpose of Services**

To assist HIV positive client and their significant others, which may include family and friends, to cope with the physical and psychological manifestations of addiction to alcohol, tobacco, and other drugs. To assist HIV positive clients in abstaining from substance use or reducing use through harm reductions strategies.

# STANDARDS OF CARE

## GOALS OF SERVICES

1. To have services available throughout Kentucky to minimize crisis situations and stabilize client substance use, in order to maintain their participation in primary care and support services;

2. To sustain and stabilize life, motivating toward self-management especially by addressing self-destructive attitudes, activities, and behaviors; and

3. To see a reduction in the transmission of HIV through drug use in the Commonwealth of Kentucky.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| All staff providing direct substance abuse counseling or treatment services to clients will meet the qualifications for the position as outlined in the agency's job description and shall include the following:<br>Licensed by the Commonwealth of Kentucky to provide substance abuse counseling (e.g., LPC, LCSW, LMSW, LMFT, LCDC, CDAC, licensed clinical psychologist), and<br>Two years' experience in HIV or other catastrophic illness and continuing education in HIV; and<br>One year experience in family counseling as pertaining to substance abuse; and<br>Non-violent crisis intervention training; and<br>Professional liability coverage for individuals and for the agency; and<br>At least three (3) hours annually of cultural competency training as required in the Universal Standards of Care regarding populations who have an incidence of HIV infection in Kentucky (e.g., ethnic, gay/lesbian/bisexual/transgender, women, homeless, adolescents, sex trade workers, deaf/hard of hearing, drug cultures); and<br>Training in mental health issues and with capability of assessing when to refer a client to a mental health program/counselor; and<br>Supervision as required by licensure. | Personnel files/resumes/applications for employment reflect requisite licenses, certifications, experience, and training.<br><br>Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the State of Kentucky. |
| Continuing education/in-service training. In accordance with state licensing and credentialing boards, all direct care staff must satisfactorily complete the required hours in continuing education training. | Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training, and signature of employee. |
| Each substance abuse treatment provider must have and implement a written plan for regular supervision | Agency has written plan for supervision of all staff on site. |

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| of all staff by a licensed supervisor/Qualified Credentialed Counselor (QCC) in accordance with all applicable laws and regulations. | |
| Notes of weekly supervisory conferences shall be maintained for such staff. | Supervisor's files reflect notes of weekly supervisory conferences. |
| Staff must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals. | Personnel files contain annual performance evaluations. |
| The provider agency must be a licensed hospital or a licensed facility with outpatient treatment designation and must comply with the rules and standards established by the Commonwealth of Kentucky. | Documentation of current facility licensing on site. |
| Provider agency must be in compliance with the Americans with Disabilities Act as Amended ADAAA to indicate full accessibility by all clients. If not in compliance at the time of funding, agency must demonstrate a plan, including timeline, to become compliant within the funding period. | Evidence of ADAAA compliance or plan and timeline for compliance on file at provider agency. |
| Provider agency must have at least one person on staff with current certification in CPR and first aid on the premises at all times services are rendered (RN and MD can be substituted for first aid). | Documentation of CPR-certified staff and evidence of first aid capability at site. |
| Provider agency must develop and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following:<br>Verbal Intervention;<br>Non-violent physical intervention;<br>Emergency medical contact information;<br>Incident reporting;<br>Voluntary and involuntary patient admission;<br>Follow-up contacts;<br>Continuity of services in the event of a facility emergency. | Documentation of client and staff safety policies and procedures on site. |

## CLIENT CHARACTERISTIC

HIV infected individuals diagnosed with substance abuse issues and who need referral and treatment including follow up appointments or referral to ongoing support.

## UNITS OF SERVICE

- Treatment Visit- A visit that is not a counseling session or a dosing visit. (ex: visit for random drug screen);
- Individual Level Treatment Session - An individual visit where the Treatment Plan is discussed;
- Group Level Treatment Session- A group counseling session

## ACTIVITIES

# STANDARDS OF CARE

**Program Outcomes**

75% of clients enrolled in Substance Abuse Services-Outpatient who decrease substance use or maintain sobriety under treatment after accessing Substance Abuse Services-Outpatient

**Indicators**

Number of clients attending Substance Abuse services who are engaged in treatment.*
Number of clients who have addressed at least 2 treatment goals.

**Engaged=individual invested in treatment and attends a minimum of 50% of substance abuse services appointments*

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| Case conferences with members of the client's multi-disciplinary team shall be held as appropriate. | Client records include documentation of multi-disciplinary case conferences, as appropriate; | Number of client records with case conference documentation ; | Number of clients; | Client Files; CARE Ware | 75% of client records have documentation of case conferences with members of the client's multi-disciplinary team; |
| An appointment will be scheduled within three (3) working days of a client requesting substance abuse treatment services. In emergency circumstances, appointments will be scheduled within one (1) working day. If time limitation cannot be met, refer patients. | Client chart contains documentation of each item listed above. | Number of clients with appointments scheduled | Number of clients | Client Files; CARE Ware | 75% of client charts will have documentation of an appointment scheduled within three (3) working days of request for substance abuse treatment services. |
| Initial assessment protocols shall provide for screening individuals to determine level of need and appropriate service plan. The initial assessment shall include, but not be limited to the following: The presenting problem; | Client's chart contains documentation of each assessment item listed and documentation that a copy was given to the client; | Number of clients with initial assessments; | Number of clients; | Client Files; CARE Ware | 75% of client charts will have documentation of initial assessments as indicated. |

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| Substance abuse history;<br>Medical and psychiatric history;<br>Treatment history;<br>Psychological history and current status;<br>Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks);<br>Cognitive assessment (level of consciousness, orientation, memory and language);<br>Social support and family relationships;<br>Strengths and Weaknesses.<br><br>Specific assessment tools such as the Addiction Severity Index (ASI) could be used for substance abuse and sexual history, the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) for substance abuse and mental illness symptoms and the Mini Mental State Examination (MMSE) for cognitive assessment. A copy of the assessment(s) will be provided to the client. | | | | | |
| A psychosocial history will be completed and must include: | Client's chart contains documentation. | Number of clients with psychosocial | Number of clients | Client Files | 75% of client charts have documentation of completed psychosocial |

| | | | | | |
|---|---|---|---|---|---|
| Education and Training;<br>Employment;<br>Military Service;<br>Legal History;<br>Family history and constellation;<br>Physical, emotional and/or sexual abuse history;<br>Sexual and relationship history and status;<br>Leisure and recreational activities;<br>General psychological functioning. | | histories completed | | CARE Ware | history as indicated. |
| Treatment plans are developed jointly with the counselor and client and must contain:Statement of the goal(s) of counseling;<br>The plan of approach;<br>Mechanism for review. The plan must also address the full range of substances the client is abusing. Treatment plans must be completed no later than five (5) working days of admission and the client must be provided a copy of the plan. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV-related risk behaviors including substance abuse as clinically indicated. | Client chart contains documentation of client's treatment plan and that client was given a copy of the plan;<br><br>For methadone treatment, client charts will document contact with the client's medical provider within 72 hours of initiation of methadone to inform the provider of the new prescription OR client refusal to authorize this communication; | Number of clients with treatment plans completed no later than 5 working days after admission;<br><br>Number of client charts with methadone treatment documentation of contact with medical provider within 72 hours of treatment initiation; | Number of clients;<br><br>Number of clients on methadone; | Client Files;<br><br>CARE Ware | 75% of client charts have documentation of treatment plans completed no later than 5 working days after admission;<br><br>75% of client charts, for client on methadone, will have documentation of contact with client's medical provider within 72 hours of treatment initiation or the client's refusal to authorize this communication; |
| Treatment plan shall be reviewed at a minimum midway | Documentation of treatment plan review in | Number of clients with updated/revie | Number of clients; | Client Files; | 75% of client charts will have documentation of updated treatment plans |

| | | | | | |
|---|---|---|---|---|---|
| through treatment or at least every 12 sessions and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures. | client's file and agency treatment review policies and procedures on file at site; | wed treatment plans; | | CARE Ware | midway through treatment or at least every 12 sessions; |
| A client may be discharged from substance abuse services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include:<br>Circumstances of discharge;<br>Summary of needs at admission;<br>Summary of services provided;<br>Goals completed during counseling;<br>Counselor signature and credentials and date;<br>A transition plan to other services or provider agencies, if applicable;<br>Consent for discharge follow-up. | Documentation of case closure in client's record;<br><br>Documentation of reason for discharge/case closure (e.g., case closure summary); | Number of discharged clients; | Number of clients; | Client Files;<br><br>CARE Ware | 75% of discharged client charts have documentation of case closure or reason for discharge; |
| In all cases, providers/case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example: | Documentation in client's record indicating referrals or transition plan to other providers/ agencies; | Number of clients needing referrals to other agencies; | Number of clients; | Client Files;<br><br>CARE Ware | 80% of discharged client charts will have documentation of referrals or transition plans to other providers/agencies; |

| | | | | | |
|---|---|---|---|---|---|
| Relocation—research area services refer when necessary. | | | | | |
| Clients demonstrate decreased drug use frequency or maintenance of decreased drug use in a 6-month time frame through urine or blood drug screens or self-report. | Decreased use of drugs and alcohol frequency or maintenance of decreased drug use; | Number of clients show decreased drug use frequency or maintenance of decreased drug use in a 6 month time; | Number of clients; | Client Files;<br><br>CARE Ware | 70% of clients show decreased drug use frequency or maintenance of decreased drug use in a 6-month time frame demonstrated through urine or blood drug screens or through self-report; |

# STANDARDS OF CARE

## NON-MEDICAL CASE MANAGEMENT

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Case management services (non-medical)*** include the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.

**Services**

**Non-Medical Case Management** is a collaborative process that assesses, educates, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. Case Management is seen as an encounter that involves assessment and basic care needs planning with the goal of independence for the client.

Due to the episodic nature of HIV, it is expected that clients will have varying levels of need throughout their enrollment in services. Some clients may demonstrate a low level of need and would therefore benefit from *non-Medical Case Management*. Distinct case management categories are described in detail under separate sections (See description for Medical Case Management Services).

Enrollment in either medical case management services (active) or non-medical case management (direct services only) is not permanent; a client may move from one type of case management to the other depending on current circumstances. On-going and frequent assessment by a non-medical case manager and a medical case management supervisor should occur to ensure that clients receive the level of care that is appropriate. Routine screening tools and acuity scales should be used consistently by all case management providers. Activities in non-medical case management include, but are not limited to:

a. Providing information and assistance with linkage to medical case management and psycho-social services as needed;
b. Providing benefits and entitlement counseling, including assisting eligible clients in obtaining access to public and private programs that they may be eligible for. This includes Medicaid, Medicare Part D, KADAP, KHCIP, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State and local health care and supportive services;
c. Advocating on behalf of clients to decrease service gaps and remove barriers to services;
d. Helping and empowering clients to develop and utilize independent living skills and strategies;
e. Providing unbiased and ethical services;
f. Helping clients with applications for all other resources available for their service needs.

Activities that are not included in non-medical case management include, but are not limited to, activities that are related to medical care/treatment or adherence.

Case management services are home and community-based. Case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in

the facilities of the case management service provider agency. Case management shall provide for a face-to-face or phone contact, and a home visit, as determined by client need.
Clients with a lower level of need, requiring only the direct services offered or referred by the agency (e.g., rental assistance and monthly medication refills), would benefit from *Non-medical Case Management*.

**Purpose of Service**
The purpose of Non-Medical Case Management is to facilitate access to support services for people living with HIV/AIDS (PLWH/A).

## GOALS OF SERVICE
To enhance access to and retention in medical care for eligible people living with HIV/AIDS through a range of client centered services.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| All case managers will meet the qualifications for the position as outlined in the Agency's job description and/or contractual agreement, KHCCP manual and agency contract. The minimum requirements are:<br>A minimum of an Associate's Degree from an accredited college or university; **and**<br>A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness **preferred**; **and/or**<br>State or National certification from a recognized state/national certification organization and/or licensing organization **preferred** (i.e. LBSW, LMSW, LCSW, LPC, LMFT, LCDC, etc.,); **or**<br>Case managers employed prior to the approval of these standards, and who did not meet the minimum qualifications listed above, may be granted a waiver from these qualifications by the Administrative Agency; **and**<br>Extensive knowledge of community resources and services. | Personnel files/resumes/applications for employment reflect requisite experience and education. |
| A minimum of sixteen (16) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the service area including but not limited to:<br>The full complement of HIV/AIDS services available in the state and specifically within the service area. How to access such services [including how to ensure that particular sub-populations are able to access services (i.e., undocumented individuals)];<br>KHCCP manual;<br>Education on applications for eligibility under entitlement and benefit programs other than Ryan White services will be included and periodically updated as changes occur. | Personnel file reflects completion of orientation and signed job description. |
| Case managers and case management supervisors must satisfactorily complete continuing education as required by state licensing boards. | Documented in personnel file or training log. |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

Any HIV infected person in the Commonwealth of Kentucky in need of entering or remaining in medical care.

## UNITS OF SERVICE

Face to face visit or phone conversation with client(s) recorded in CAREWare in quarter-hour increments.

## ACTIVITIES

**Program Outcome**

- Clients will show a decrease in acuity scale scoring with an increase in self-sufficiency.
- Services address client access and adherence to medical care.

**Indicators**

- Number of self -sufficient clients.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| I. Structure | | | | | |
| **The objectives of the enrollment process are:** Inform the client of: all services available; AND all Ryan White funded case management agencies in the area; what client can expect if s/he enrolls in case management services; Establish client eligibility for services; Establish acuity score using scale to determine needs of client;Collect required state/federal client data for reporting purposes; Completion of a complete CAREWare intake. | Documentation in client's chart and in CAREWare. | Number of clients with acuity score. | Number of clients. | CARE Ware<br><br>Client charts | 80% of all clients will have a signed acknowledgement form of services available and have acuity score in CAREWare. |

| | | | | | |
|---|---|---|---|---|---|
| Funded Non-Medical Case Management agencies must be able to:<br>Make initial contact with client and/or referring agent within five (5) working days of receiving request for services;<br>Provide enrollment within ten (10) working days of initial contact;<br>Schedule an appointment at the client's convenience; | Agency policy and procedures reflect the availability of walk-in services.<br><br>Documented referral kept on file at the agency. | Number of client contacts. | Number of clients. | CARE Ware<br><br>Client charts | 90% of all agencies funded for Non-Medical Case Management will show a 10 working day enrollment process period. |
| II. Process | | | | | |
| Within ten (10) working days of enrollment, an **intake** shall be completed to evaluate the client's needs and will be reassessed annually. | Documentation of intake will include:<br>Medical history;<br>Available financial resources (including insurance status) with emphasis on Medicaid, ADAP, SSI and other resources;<br>Availability of food, shelter, and transportation;<br>Available support system;<br>Need for legal assistance;<br>Substance abuse history and status;<br>Emotional/ mental health history and status. | Number of clients enrolled. | Number of clients. | CARE Ware and/or client charts | 80% of all clients enrolled in non-medical case management will have a completed intake within 10 working days of enrollment and will be reassessed annually. |

# STANDARDS OF CARE

| | | | | | |
|---|---|---|---|---|---|
| A client should be discharged from case management services through a systematic process that includes a discharge or case closure note in the client's record. Including the reason for the discharge/closure or transition to another service. Most common reasons for discharge: death; at the request of the client; client moves out of the service area; or; inability to reach client after a minimum of three (3) attempts by case manager. | Documentation of discharge in client chart. | Number of clients discharged. | Number of clients. | CARE Ware and/or client chart | 100% of all clients discharged from non-medical case management will have documentation in chart with reasons for discharge. |
| In all cases, case managers shall ensure that, to the greatest extent possible, there is documented evidence that clients who leave care are linked with appropriate services to meet their needs. | Documentation in client's record indicating referrals or transition plan to other providers/ agencies. | Number of clients transitioning | Number of clients. | Client chart and/or CARE Ware | 80% of all clients transitioning from case management care are linked with appropriate services to meet their needs. |

# STANDARDS OF CARE

## EMERGENCY FINANCIAL ASSISTANCE

### DEFINITIONS OF SERVICES

**Health Resources and Service Administration (HRSA)**
Ryan White HIV/AIDS Program funds may be used to provide *Emergency Financial Assistance* (EFA) as an allowable support service.

- The decision-makers deliberately and clearly must set priorities, delineate, and monitor what part of the overall allocation for emergency assistance is obligated for transportation, food, essential utilities, and/or prescription assistance. Careful monitoring of expenditures within a category of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to request Ryan White Part B approval when reallocations may be necessary.
- In addition, Grantees and planning councils/consortia must develop standard limitations on the provision of Ryan White HIV/AIDS Program funded emergency assistance to eligible individuals/households and mandate their consistent application by all contractors. It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of Ryan White HIV/AIDS Program funds for these purposes will be the payer-of-last-resort and for limited amounts, use and specific periods of time.

**Services**
To provide limited financial assistance to candidates that demonstrate inability to pay their short term temporary housing, electricity, gas, water/sewerage, *prescriptions not on the ADAP formulary, and *medical bills due to a serious lack of money that prevents them for paying the bill.
**Includes co-pays*

*Proof of Hardship*

Demonstrated by:

- A significant increase in bills;
- A recent decrease in income;
- High unexpected expenses on essential items;
- The cost of shelter more than 30% of the household income;
- The cost of utility consumption more than 10% of the household income;
- Inability to obtain credit necessary to provide for basic needs and shelter; and
- A failure to provide emergency financial assistance that will result in danger to the physical health of client.

*Service Limitations*

1. *Short-term temporary housing and emergency rental* assistance will be transitional in nature, no more than 4 months or $2,500 a year per client. The purpose of assistance is to keep an individual or family in a long-term, stable living situation; therefore the approval

must be accompanied by a housing strategy plan that addresses transitioning to stable housing. Rent is limited to three months or $1,500 in assistance within a contract year. No funds may be used for any expenses associated with the ownership or maintenance housing (mortgage payment).

2. *Essential Utilities* is limited to three months and $500 within a contract year per client.
3. *Medical assistance* is limited to two months and $400.00 within a contract year per client.

**Purpose of Services**

The purpose of the service is to support, facilitate, enhance or sustain the continuity of the health services for individuals and/or their families who are HIV-positive.

## GOALS OF SERVICES

Assist client in gaining their ability to recover from setbacks and advance towards personal recovery and resiliency.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Bachelor in social work preferred.<br><br>Minimum qualifications for position as described in the Agency position description and contractual agreement with Grantee.<br><br>A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness. Knowledge of community resources and services. | Personnel files/resumes/applications for employment diplomas and certifications reflect requisite experience and education. |
| Agency providing emergency financial assistance shall have protocols in place to ensure that funds are distributed fairly consistently and in accordance with Part B service standards. | Agency written policy/protocol. |
| Use of emergency assistance funds for a purpose other than that for which the funds were requested constitutes abuse and will result in the denial of all future assistance. | Documentation of misuse in client file and monitoring report. |
| The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g., utility) is in another person's name, it directly benefits the client. | As documented in file.<br>• Copy of invoice/bill paid.<br>• Copy of check for payment. |
| The agency has a procedure to protect client confidentiality when making payments for assistance, (e.g., checks that do not identify the agency as an HIV/AIDS agency). | Agency Protocol/Policy and Procedure |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

Individuals living with HIV/AIDS in the Commonwealth of Kentucky and eligible for Part B Ryan White services and meet the hardship test.

## UNITS OF SERVICE

Individual payments processed.

## ACTIVITIES

**Program outcome**

- Clients stabilized at 3 and 6 month intervals that do NOT have future EFA requests;
- Clients will show improved and/or stabilized living situation as result of accessing EFA at 6 months and 12 months;
- Clients who report stable living arrangements reported on a quarterly basis;
- Number of referred clients into program;
- Number of people receiving housing assistance.

**Indicators**

Number of stabilized clients (determined by decreased need for EFA, stable housing, reduced number of requests).

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| Funds in this category are limited in months of assistance within a contract year. | Documentation in client's file. | Number of clients receiving housing assistance funds through EFA. | Number of clients receiving housing assistance through EFA. | Client Files<br><br>CAREWare | 90% of client charts have documentation of funds to clients upon approved request. |
| Provider will have a written plan regarding discharge and/or transition of client from services. | Written discharge/ transition plan on file | Number of clients discharged/ Transitioned from housing assistance through EFA. | Number of clients receiving housing assistance through EFA. | Client Files<br><br>CAREWare | 90% of client charts have documentation of written discharge/ Transition plan. |

# STANDARDS OF CARE

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|---|---|---|---|---|---|
| Service provider will conduct an assessment of the presenting problems/needs of the client with HIV-related emergency financial issue. | Documentation of the client's need for EFA. | Number of EFA charts with documentation of assessment. | Number of total client files for EFA. | Client Files<br><br>CAREWare | 90% of client files have documentation of need for EFA. |
| Client will be assessed for ongoing status and outcome of the emergency assistance plan. | Documentation of resolution of the emergency status and referrals made with outcome results in client files. | Number of EFA charts with documentation of assessment. | Number of total client files for EFA. | Client Files<br><br>CAREWare | 90% of client files have documentation of resolution of the emergency status and referrals made with outcome results in client files. |
| Emergency financial assistance payment is made out to the appropriate vendor in the *exact* amount listed on bill. No payment may be made directly to clients, family or household members. Check issues within 3 days. | Documentation of payment in client's file with copy of check/ voucher in client's file. | Number of EFA charts with documentation of payment. | Number of total client files for EFA. | Client Files<br><br>CAREWare | 90% of client files have documentation of payment with copy of check/voucher. |
| Care plan to reflect clear, time-measured objectives for transitioning client to a stable position, re-evaluation quarterly. | Documentation on care plan in client case management records. | Number of clients with service plans and quarterly follow up. | | Client files<br><br>CAREWare | 90% of client records have documentation of service plan and quarterly re-evaluations. |

# FOOD BANK/HOME-DELIVERED MEALS SERVICES

## DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Food bank/home-delivered meals*** are the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. Funds awarded under the Ryan White HIV/AIDS Program may be used to purchase essential non-food household products as part of a Ryan White HIV/AIDS Program funded *Food Bank* support service, including essential items such as:

- Personal hygiene products;
- Household cleaning supplies;, and/or
- Water filtration/ purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) in communities/areas where recurrent problems with water purity exist. Such devices (including their replacement filter cartridges) purchased with Ryan White HIV/AIDS Program funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron. This policy does not permit installation of permanent systems for filtration of all water entering a private residence.

Funds may NOT be used for household appliances, pet foods, or other non-essential products

**Services**

***Food Bank/Pantry.*** A food bank is a central distribution center within an agency's catchment area or home delivery service providing groceries for Part B eligible clients and their families. The food is distributed in cartons or bags consisting of assorted products needed by Ryan White clients. Non-food products, such as personal hygiene products, may also be provided to eligible individuals through food and commodity distribution programs.

***Food Vouchers.*** This service provides certificates or cards, which may be exchanged for food at cooperating supermarkets, or meals at clinics or social services agencies

***Home Delivered Meals.*** This service provides nutritionally balanced home delivered meals for clients with HIV/AIDS who are indigent, disabled or homebound, and/or who cannot shop or prepare (or have others shop for or prepare) their own food. This includes the provision of both frozen and hot meals

**Purpose of Services**

Reduce hunger, food insecurity, and improve the health measures of people living with HIV/AIDS in Kentucky.

# STANDARDS OF CARE

## GOALS OF SERVICES

To promote better health outcomes for People Living with HIV/AIDS through the provision of caloric and nutritionally appropriate foods.

**Qualifications**

| Staff Qualifications | Expected Practice |
|---|---|
| The agency shall adhere to all federal, state, and local public health food safety regulations (handling and storage). | Policy and documentation on file. |
| The agency shall maintain evidence that all required inspections are current and resulted in acceptable findings. | Policy and documentation on file. |
| The agency shall ensure that access to the food storage area is limited, and that it is locked outside of food handling or distribution hours. | Policy and documentation on file. |
| The agency shall consult with a registered and/or licensed dietician regarding the nutrition, caloric needs, and other dietary requirements of HIV-positive persons and has incorporated that guidance into food bank or home delivered meals programs. | Policy and documentation on file. |
| The agency shall ensure that perishable foods are stored and disposed of in accordance with applicable State Department for Public Health guidelines. Nonperishable foods should be disposed of if there is evidence of spoilage or damage to package. | Policy and documentation on file. |
| Staff is knowledgeable about available community food resources. | Policies and procedures on file.<br>Documentation in personnel files. |
| **Vouchers** | |
| Procedures are in place regarding use and distribution of food.<br><br>A system is in place to account for the purchase and distribution of food vouchers.<br><br>A security system is in place for storage of and access to vouchers.<br><br>A limitation of no more than a 3 month supply on hand of food vouchers is required as part of the policy. | Agency Policies and Procedures.<br><br>Distribution logs, client records, and financial documentation. |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

HIV infected clients in need of food services.

## UNITS OF SERVICE

- Meals prepared in a contract period;
- Number of bags of food distributed in a contract period;
- Unduplicated clients within a contract period.

## ACTIVITIES

**Program Outcomes**

- Consumers who are referred to the food program will have a unit of service that is within 3 days of the initial referral;
- Consumers will report satisfaction with the program;
- Consumers will report a reduction in the need for food services.

**Indicators**

- Client satisfaction survey
- Distribution logs
- Delivery logs
- Referral logs
- Clients care plan and reason(s) for dropping out of services

**Quality**

Develop a quality management plan and seek Ryan White Part B approval.

1. *Measurement of Outcome Indicators*-collection and analysis of data measures for specific selected indicators. In addition, agency shall measure other aspects of care and services as needed.

2. *Development of Data Collection Method*-to include sampling strategy (e.g. frequency, percentage of sample size), collection method (chart abstraction, interviews, surveys, etc.), a data collection tool.

3. *Collection and Analysis of Data*-results will be reviewed and discussed by the QM committee. The findings of the data analysis will be documented and communicated with all involved program staff.

4. *Identification of Improvement Strategies*—QM committee will be responsible for identifying improvement strategies and appropriateness of service. Feedback will also include progress and sustaining achieved improvement.

# STANDARDS OF CARE

## HEALTH EDUCATION RISK REDUCTION

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Health education/risk reduction*** is the provision of services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

**Services**

The provision of a set of prevention activities provided to individuals or groups to assist clients in making plans for individual behavior change; to promote and reinforce safer behaviors; and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. Activities range from individual HIV prevention counseling, to group interventions, and to broad, community-based interventions.

**Purpose of Services**

The objectives for this service are:

- To promote and reinforce safe behavior for the prevention of HIV transmission;
- To provide HIV information to clients to promote positive health outcomes;
- To promote adherence to medical care.

### GOALS OF SERVICES

To reduce HIV-risk behaviors by changing attitudes, norms, and practices through individual counseling, community mobilization and organization, and community-wide events.

# STANDARDS OF CARE

**Qualifications**

| Standard | Measure |
|---|---|
| A. Health Educators should at minimum hold a high school diploma or GED; and have one year experience with HIV. | • Documentation of education and resume in the staff file; |
| B. All Health Educators must complete minimum training requirements in the following areas within their agency probationary period as required and directed by the Ryan White Part B Program:<br>✓ HIV/AIDS: prevention and clinical issues;<br>✓ Sexually transmitted diseases: prevention and clinical issues<br>✓ CDC Fundamentals of HIV Testing and Counseling | • Documentation of the minimum training requirements is present in the Health Educator's personnel file and available for review; |
| C. All Health Educators must complete 12 hours of continuing education in HIV/AIDS annually. | • Documentation of completion of the continuing education must be kept in Health Educator's personnel file; |
| • Community or peer workers recruitment and engagement, screening, and coordination of services:<br>♦ Knowledge of target population;<br>♦ Cultural and linguistic competency;<br>♦ Knowledge of HIV/AIDS and other STDs;<br>♦ Knowledge of available community services; and<br>♦ Effective communication skills. | • Documentation in personnel file; |

## CLIENT CHARACTERISTIC

HIV-infected individuals exhibiting high risk behaviors and in need of acquiring interpersonal skills to change their behavior and to lower the risk of transmitting HIV disease.

## UNITS OF SERVICE

- Individual educational activities;
- Educational outreach activities in venues for at risk populations;
- Educational group activities;
- Referrals of consenting clients to primary medical care;
- Testing and/or referral for HIV testing.

## ACTIVITIES

**Program outcome**

To support and sustain positive health behaviors in order to reduce, limit and ultimately eliminate HIV related health risks.

**Indicators:**

- Encouraging at-risk individuals to be tested for HIV;
- Education on HIV positive strategies for decreasing transmission to others;
- Collaborating with physicians, community clinics and other sites that serve HIV positive individuals to provide appropriate prevention services for their clients who are at risk for or may be HIV positive;
- Visits to community areas where risky behaviors can be observed.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| In collaboration with the client, an individualized HE/RR plan is developed. Client is offered a copy of the plan. The HE/RR plan must contain the following:<br>A. Goal;<br>B. Expected outcome;<br>C. Actions taken to achieve each goal;<br>D. Person responsible for offering each action;<br>E. Target date for completion of each action;<br>F. Results of each action. | All clients to have a He/RR plan; | Clients with plan; | All clients; | Client record;<br>CARE Ware | 80% of client with have a plan on file; |

# STANDARDS OF CARE

| | | | | | |
|---|---|---|---|---|---|
| The Health Educator and client collaborate on a discharge plan once goals have been met and behavior maintained. The client may be discharged for the following:<br>1. Client is lost to follow up;<br>2. Client action(s) put the agency, staff and /or other clients at risk;<br>3. Client fails to maintain contact with the Health Educator for a period of three months despite three (3) documented attempts to contact client;<br>4. Client request;<br>5. Client death. | Clients have a discharge plan; | Clients with discharge plan; | All clients no longer receiving services; | Client file;<br>CARE Ware | 80% of clients no longer receiving services have discharge plan; |
| The Health Educator will evaluate client success in maintaining safer choices at least every 90 days. | Client re-evaluated on plan compliance at least every 90 days; | Number of clients sustaining positive behaviors; | Number of clients; | Client file;<br>CARE Ware | 75% of the clients with plan have main positive behaviors; |
| Monthly visits to areas of high risk behaviors for the purpose of providing a prevention message, offer HIV testing, preventing as care and a prevention to positive message to those that know their status. | | Number of those accepting prevention message; | Number of contacts; | Client file;<br>CARE Ware | 25% of those contacted had an HIV test.<br>75% accepted the prevention message and/ or material.<br>25% of those knowing their status accepted a referral medical care or a prevention specialist. |

# STANDARDS OF CARE

## HOUSING

### DEFINITION OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Housing services*** are the provision of short-term assistance for HIV positive persons to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services

**Services**

Housing services are available to persons living with HIV/AIDS and their families in the Commonwealth of Kentucky on a temporary basis to enable the individual gain or maintain medical care and/or transition to more permanent housing. Housing services can include:

- Hotel/Motel and Meal Vouchers;
- Emergency Shelter Programs;
- Transitional Housing Programs;
- Permanent Supportive Housing Programs.

HRSA limits housing assistance to a 24 month LIFETIME CAP for eligible individuals

**Purpose of Services**

The purpose of Housing Services is to provide Persons Living with HIV/AIDS (PLWHA) with safe and secure temporary housing that will enable a client to enroll in and/or maintain participation in medical care while a long-term housing placement plan is developed in collaboration with the client's medical case manager.

### GOALS OF SERVICES

To improve medical adherence through the provision of housing and housing assistance.

**Qualification**

| Staff Qualification | Expected Practice |
|---|---|
| Providers must demonstrate strong linkages with Ryan White Medical Case Managers and providers of other housing programs and services. These must be in the form of written Memorandum of Agreement (MOU). | Agency documentation of MOUs; |

| | |
|---|---|
| Non-Medical Case Management requirements in KHCCP manual and agency contract. The minimum requirements are:<br>A minimum of an Associate's Degree from an accredited college or university; **and**<br>A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness **preferred**; **and/or**<br>State or National certification from a recognized state/national certification organization and/or licensing board **preferred** (i.e. LBSW, LMSW, LCSW, LPC, LMFT, LCDC, etc.,); **or**<br>Case managers employed prior to the approval of these standards and who did not meet the minimum qualifications listed above may be granted a waiver from these qualifications by the Administrative Agency; **and**<br>e. Extensive knowledge of community resources and services. | Personnel files/resumes/applications for employment reflect requisite experience and education; |

## CLIENT CHARACTERISTIC

PLWHA who are on a wait-list for other housing assistance programs, or are in an unstable housing situation that is preventing them from obtaining medical care or staying in medical care.

## UNITS OF SERVICE

- Face to face with a case manager or other provider of housing services, recorded in CAREWare in quarter-hour increments;
- Number of units of vouchers provided to unduplicated client;
- Number of transitional housing days for unduplicated client ;
- Number of permanent supportive housing;
- Number of days in an emergency shelter for unduplicated client;
- Number of primary care/HIV care visits.

## ACTIVITIES

**Program Outcome**

Client to obtain or remain in permanent, safe housing.

**Indicators**

- Percentage of clients assessed for long term or permanent housing assistance;
- Percentage of clients with a housing plan that includes both short term and long term goals;
- Percentage of clients engaged in HIV care as evidenced by attendance of a minimum of two primary/HIV care office visits in a year;
- Percentage of clients moving to long term or permanent housing.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| An assessment must be completed within 10 days of intake and include the following information:<br>1. Client's financial resources including employment, income, and access to entitlement or public assistance programs;<br>2. Client's housing history, and specific housing needs;<br>3. Client's eligibility or ineligibility for other housing assistance programs;<br>4. Client's health status, with specific documentation of physical limitations and/or disabilities;<br>5. Client's social functioning and support systems; and<br>6. Client's emotional, substance use/abuse and mental health issues that impact their ability to obtain and maintain stable housing. | Assessment of client needs especially short term, long term and permanent housing needs; | Clients with assessment on file; | Number of clients receiving housing assistance; | Client file;<br><br>CARE Ware | 75% of client have an assessment within a week of referral; |
| Agency may use information from other assessments (e.g., medical case management or EIS, medical visits) in determining client needs (if) applicable. | Record of clients linked and retained in care; | Number of clients with medical information or referral on file; | Total number of clients; | Client file;<br><br>CARE Ware | 75% of clients have remained in or accessed primary/HIV care; |

# STANDARDS OF CARE

| | | | | | |
|---|---|---|---|---|---|
| Clients must have a care plan within 1 month of assessment. Information to be documented in the plan of care includes:<br>1. List of client service needs;<br>2. Establishment of short and long-term objectives for housing assistance;<br>3. Establishment of objectives to secure employment and/or public benefits and for financial planning;<br>4. Establishment of objectives for obtaining/staying in medical care;<br>5. Establishment of objectives to address other issues identified in the assessment as barriers to stable housing;<br>6. Objectives and action steps to meet short and long-term goals;<br>7. Schedule of medical and supportive service appointments that client must keep in order to continue receiving housing services;<br>8. Resources to be used to meet client goals;<br>9. Documentation of client's participation in planning process and;<br>10. Criteria for determination of completion of goals. | Clients receiving housing assistance have a plan in place to obtain permanent or long term housing; | Number of clients with a care plan and proof of client participation on file; | Number of clients receiving housing services; | Client file;<br><br>CARE Ware | 74% of clients have a care plan with all the prescribed components; |
| The needs and status of each client receiving Housing services will be assessed at least once a month to assure compliance with care plan and service requirements. | Assure that clients are eligible for the service, are receiving care and are meeting care plan goals; | Clients receiving a monthly review of care plan; | Total clients receiving service; | Client File;<br><br>CARE Ware | 75% of the clients are still eligible for the service; |

# OUTREACH

## DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Outreach services*** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in, care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

***In 2012 HRSA issued PIN 12-01 that limited Part B outreach to the*** *Early Identification of Individuals with HIV/AIDS (EIIHA). Thus outreach is for the identification, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care and medications. ****HIV counseling and testing cannot be a stand-alone service under Part B—it needs to be part of Early Intervention Services, which requires that all 4 components are in place (targeted testing & counseling, linkages, referral services and health education). This service shall not supplant but may supplement Prevention activities in specificied circumstances as approved by Ryan White staff.***

**Services**

The principal purpose of Outreach is the identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in, care and treatment services (KADAP). Outreach services do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

***Services include:***

- identification;
- providing information/education;
- *maintaining contact;*

- linked referral;
- *engagement and retention activities; and*
- When appropriate, outreach workers should accompany clients to initial visits to primary care and/or case management services for access to medications.

**Purpose of Services**
To identify those with undiagnosed HIV disease and link them to care.

## GOALS OF SERVICES

To structure outreach activities targeting specific at risk population to increase:

1. The number of individuals who are aware of their HIV status;
2. The number of HIV positive individuals who are in medical care and treatment medications; and
3. The number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Staff has appropriate skills, relevant experience, cultural and linguistic competency, and relevant licensure to provide services and/or care to people living with HIV. | Written description of staffing requirements by position;<br>Staff résumés in personnel files;<br>Personnel and training records; |
| Staff is trained and knowledgeable about HIV/AIDS, the affected communities, and available resources. Training specific to outreach activities should include (but not limited to) the following:<br>HIV/AIDS Counseling (and testing when applicable);<br>referral to medical care;<br>personal safety;<br>adherence counseling;<br>non-violent crisis intervention;<br>cultural diversity; and<br>psychosocial issues specific to HIV/AIDS. | Documentation of training on these topics;<br>Documentation of participation of all staff involved in delivering Part A services; |

## CLIENT CHARACTERISTIC

People living with HIV who are self-managed, do not utilize the HIV services available, have fallen out or care, at risk falling out of care, or know their status but are not in care.

## UNITS OF SERVICE

1. Outreach Linkage Units – Number of single events or activities to link a client to care;
2. Client Identification Units – Number of hours at an outreach event held to identify those out of care and/or those that do not know their status;
3. Information/Education Units - Number of educational hours provided
4. Linked Referral Units - Number of referral provided to link client to medical care

# STANDARDS OF CARE

## ACTIVITIES

**Program outcome**

- Engagement in Medical and Psychosocial Care;
- Satisfaction with Care;

**Indicators**

- Percent of clients who are successfully linked to medical care within 90 days of initial contact with outreach services;
- Average number of encounters required to link a client to medical care or case management;
- Percent of clients who report satisfaction with outreach services they received.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| All clients identified through Outreach Services who are out of medical care or newly diagnosed will be referred to a medical case manager to initiate or re-initiate medical care. | Engagement in medical and psychosocial services; | Those escorted or having proof of making to a medical appointment and in medication; | Those contacted in outreach session; | Medical appointment;<br><br>Outreach log; | 60% of those contacted and follow up will make an appointment with a medical and/or psychosocial provider; |
| Outreach staff will make strong effort to follow up with all clients referred to a medical care manager. Follow up should happen within 2 weeks of initial referral. | Those out of care or newly diagnosed are linked to care; | All follow up by call, visit, transported, or escorted to care; | All those link into care; | Client logs or file;<br><br>CARE Ware | 60% of those linked to care will have follow up by outreach worker; |
| Contacted clients are offered testing in the field or referred to testing site | Those in communities at risk or exhibiting risky behaviors agree to have HIV test; | Number tested; | Number contacted; | Logs and number of test provided; | 50% of those contacted have an HIV test; |
| Client satisfaction surveys are conducted on a regular basis, at least annually, and the results of customer surveys are incorporated into the provider's plans and objectives. | Those receiving outreach are satisfied with outreach services; | Client expressed satisfaction with services | Completed surveys; | Client satisfaction surveys; Survey results; and client recommendations. | 75% of those engaged into care through outreach report satisfaction with the service. |

# STANDARDS OF CARE

## TREATMENT ADHERENCE

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Treatment adherence counseling*** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

**Services**

***Treatment Adherence Counseling*** is the provision of services and supports designed to help people living with HIV or AIDS make informed decisions about their treatment and — when the decision is to take HAART — to help them follow the prescribed treatment regimen. Because difficulty following a HAART regimen can be tied to many life circumstances, addressing both medical and non-medical needs is key to adherence support. Treatment Adherence Counseling is considered a service when offered as a stand-alone service. However, when Treatment Adherence Counseling occurs within the context of case management or outpatient/ambulatory care, the essential elements of these standards should still be followed.

### GOALS OF SERVICES

To ensure HIV infected persons in care take their medications in the manner in which they are prescribed.

**Qualification**

| Staff Qualification | Expected Practice |
|---|---|
| Staff providing treatment adherence will be trained in core competencies such as:<br>Client assessment skills;<br>HIV co-morbidities, symptoms, medications, interactions, and side effects;<br>Barriers to treatment adherence;<br>Drug resistance issues;<br>Harm reduction and substance abuse;<br>Pharmacology of HIV and other meds. | Personnel file; |
| Staff providing treatment adherence and agency will establish and maintain relationships with appropriate service providers as warranted to ensure continuity of care. | |

### CLIENT CHARACTERISTIC

HIV infected person not adherent to their medication regimen.

### UNITS OF SERVICE

A visit or encounter lasting 15 minutes or longer, either face to face or by telephone, and provided as a stand-alone service, outside the context of case management or outpatient/ambulatory care.

ACTIVITIES

**Program Outcome**

Lower viral load and prevent medication resistance.

**Indicators**

- Percentage experiencing declining viral load;
- Percentage adherent to medication regiment.

**Quality**

| *Quality Standards* | *Outcome* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| An Initial Adherence Assessment and plan that is systematic and evidence-based and should, at a minimum, address the following topics: Understanding of HIV medications and the importance of adherence; Readiness to take medications; Medications included in their current prescribed regimen, and the perceived complexity of this regimen; Cultural beliefs; Strength of the patient-prescriber relationship; Recent success in adherence; Side effect concerns; Substance use issues; Mental health issues; Other barriers (limited income, housing instability, domestic violence, child care); Availability of peer support. | Lower viral load; Adherence with medication regimen; | Clients meeting plan goals and following medication regimen; | Clients that received an adherence assessment and have a plan on file; | Client File; CARE ware | 75% of those with an adherence assessment and plan are following medication regimen; |
| Clients should receive treatment adherence counseling that is evidence based and suited to their situation, including linkage to substance use services, relapse prevention, mental health services, and nutrition. | Immune suppression; | Receiving treatment adherence counseling with a declining viral load; | Those receiving treatment adherence counseling; | Client file; CAREWare | 50% of those receiving treatment adherence counseling experience a reduction in viral load in the first year; |

# STANDARDS OF CARE

## RESPITE CARE

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Respite Care*** is an allowable support service under the Ryan White HIV/AIDS Program. Funds may be used for periodic respite care in community or home-based settings that include non-medical assistance designed to provide care for an HIV infected client in order to relieve the primary caregiver who is responsible for the day-to-day care of an adult or minor living with HIV/AIDS.

In those cases where funds are allocated for home-based respite care, such allocations should be carefully monitored to assure compliance with the prohibition on direct payments to eligible individuals. Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision-making process.

**Services**

Provision of community based non-medical assistance designed to relieve the primary caregiver responsible for providing day to day care of a client with HIV/AIDS.

A caregiver is defined as someone who either cares for a HIVpositive individual, or is an HIV-positive individual who is responsible for taking care of children. Available services include:

- Assisting the family members to enable a person to stay at home;
- Relieving family members for a short duration from the constantly demanding responsibility of providing care;
- Attending to basic self-help needs and other activities that would ordinarily be performed by the family member;
- Care for children during the time that the HIV positive parent or guardian or the main caregiver must go to medical appointment or be relieved from the responsibility of child care.

### GOALS OF SERVICES

To sustain family caregiver health and well-being, avoid or delay out-of-home placements, and reduce the likelihood of abuse and neglect.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Staff has the skills, experience, and qualifications appropriate to providing respite care services. When the client designates a community respite care giver who is a member of his or her natural network, this designation suffices as the qualification. | Personnel File; |
| Staff members are licensed as necessary to provide services. | Personnel File; |

| | |
|---|---|
| If a respite caregiver is from the client's network, the client signs a disclaimer acknowledging that the caregiver may not always meet all of the requirements expected of the agency's paid staff, and that the agency is not responsible for any issues that may arise as a result of this arrangement. | Disclaimer, signed by the client, and filed in client's record, including the name(s) of the respite caregiver(s); |
| Newly hired staff is oriented within 6 weeks, and begin initial training within 3 months of being hired. Ongoing training continues throughout staff's tenure. | Documentation in personnel file of completed orientation within 6 weeks of date of hire;<br>Commencement of initial training within 3 months of date of hire; and<br>Ongoing trainings; |

## CLIENT CHARACTERISTIC

The primary caregiver who is responsible for the day-to-day care of an adult or minor living with HIV/AIDS.

## UNITS OF SERVICE

The provision of one service activity per eight hour period.

## ACTIVITIES

**Program Outcome**

To help sustain family caregiver health and well-being, avoid or delay out-of-home placements, and reduce the likelihood of abuse and neglect.

**Indicators**

Percentage of caregivers that report supported by the provision of short breaks from caring.

**Quality**

| *LPAP Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| Documentation of a service plan that includes the scope of the services to be provided, the limitations, and the client/family responsibilities. | Delay out of home placement; | Those that report high satisfaction with the services provided; | All those receiving respite care services; | Client file;<br><br>Service provision documentation;<br><br>Satisfaction surveys; | % of caregivers that report being supported by breaks from caregiving; |

# STANDARDS OF CARE

## REFERRAL SERVICES

### DEFINITION OF SERVICES

**Health Resources and Services Administration (HRSA)**

*Referral for health care/supportive services* is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals for health care/supportive services that were not part of ambulatory/outpatient medical care services or case management services (medical or non-medical) should be reported under this item. Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be included under outpatient/ambulatory medical care service category. Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category, Medical Case Management or Case Management (non-medical).

**Services**

***Referral for health care/supportive services*** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

**Purpose of Services**

The purpose of Referral to Health Care/Supportive Services is to connect Persons Living with HIV/AIDS (PLWH/A) with information regarding available medical and supportive services, and to connect those PLWH/A who are unaware of their status with available HIV testing services.

### GOALS OF SERVICES

To improve the linkages from various entry points (e.g., testing activities) to the HIV care delivery system.

**Qualifications**

| Standard | Measure |
|---|---|
| All Linkage Coordinators hired by subcontractor/provider agencies that are funded in whole or part to provide referral services with Ryan White Part B funds must possess at a minimum a HS diploma or GED. | Personnel File; |
| Referral coordinators, staff and volunteers must participate in annual training for a total of five (5) hours per year on the following topics:<br>Cultural Issues / Competency; Community Resources / Services;<br>Assessment of Client Issues/Needs;<br>Appropriate referrals to meet client needs. | Documentation of attendance to training or personnel file; |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

Persons aware or unaware of their HIV status that are seeking HIV services or testing.

## UNITS OF SERVICE

A referral "**service unit**" is defined as an instance of directing a client to a service in person or through telephone, written, or other type of communication. Each instance of referral should be counted as a separate service unit

## ACTIVITIES

**Program Outcome**

Client involvement in their own care.

**Indicators**

Percentage of referred clients that were linked to care, testing, or services.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| Each client seeking care, testing or services was linked to the appropriate service within 24 of initial contact with referral coordinator, provider, staff, or volunteer. | HIV infected linked to services that are critical to achieving optimal health and well-being; | All persons that received services as a result of a referral; | All persons referred to a service or testing site. | Referral forms; Client files; Referral tracking logs; | 75% of those seeking services were linked to a medical case manager; |

# STANDARDS OF CARE

## SUBSTANCE ABUSE RESIDENTIAL

### DEFINITIONS OF SERVICES

***Substance Abuse Treatment Services-Residential*** is an allowable support service under the Ryan White HIV/AIDS Program of the **Kentucky HIV Care Coordinator Program (KHCCP)**. The following limitations apply to use of Ryan White HIV/AIDS Program funds for residential services:

- Because of the Ryan White HIV/AIDS Program limitations on inpatient hospital care (see sections 2604(c)(3)(L) and 2612(b)(3)(L) of the Public Health Service Act), Ryan White HIV/AIDS Program funds may not be used for inpatient detoxification in a hospital setting.
- However, if detoxification is offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital), Ryan White HIV/AIDS Program funds may be used for this activity.
- If the residential treatment service is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose.
- **Acupuncture Therapy** – Funds awarded under the Ryan White HIV/AIDS Program may only be used to support limited acupuncture services for HIV-positive clients as part of Ryan White HIV/AIDS Program funded *Substance Abuse Treatment Services* (outpatient or residential), provided the client has received a written referral from his/her primary health care provider. All acupuncture therapy must be provided by certified or licensed practitioners and/or programs, where State certification or licensure exists.

**Services**

HIV substance abuse residential services provided under contract with the Ryan White Treatment Services of the HIV/AIDS Branch of the Cabinet for Health and Family Services can include:

- Substance abuse residential rehabilitation
- Acupuncture
- Should transitional housing be included??

**Purpose of Services**

Substance abuse residential rehabilitation can provide detoxification and/or 24 hour residential non-medical services to individuals recovering from problems related to alcohol and/or other drug abuse and who need alcohol and/or other drug abuse treatment or detoxification services.

### GOALS OF SERVICES

The goal of HIV substance abuse residential services for people living with HIV is to assist clients to achieve and maintain a lifestyle free of substance abuse and to transition to permanent, stable housing

# STANDARDS OF CARE

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| At least 50% of program staff providing counseling services in all alcohol or other drug program shall be certified pursuant to the Commonwealth of Kentucky's policy, procedure and regulations. | Personnel file. |
| Substance abuse treatment staff will possess the ability to provide linguistically and culturally age- appropriate care and complete documentation as required by their positions. | Resumes and record of training in employee file to verify. |
| Staff will receive an agency orientation, HIV training within three months of employment, and will be oriented and trained in confidentiality and HIPAA. | Record of orientation and training in employee file. |
| Facility must be licensed for drug and alcohol treatment according to Kentucky Code of Regulations. | Certificate of Occupancy or other certificate as required and issued by the Commonwealth of Kentucky. |
| Substance abuse residential rehabilitation services provided 24 hour, residential non-medical services to individuals in recovery. | Program policy and procedure manual and schedule to verify. |
| The length of stay is as follows:<br>High level intensity-not to exceed eight weeks;<br>Medium level intensity–not to exceed 12 weeks;<br>Low level intensity-not to exceed 16 weeks. | Client file to confirm. Extensions can be made if client meets ASAM criteria |

## CLIENT CHARACTERISTIC

Chemically dependent persons living with HIV/AIDS in the Commonwealth of Kentucky that meet the KHCCP eligibility requirements.

# STANDARDS OF CARE

| Staff Qualification | Expected Practice |
|---|---|
| Residential rehabilitation programs require the following administrative staff:<br>Program administrator on-site during normal work day;<br>Registered nurse to remain on call 24 hours a day;<br>On duty resident manager;<br>On duty awake staff–<br>1-6 beds/1 awake staff;<br>7-25 beds/2 awake staff;<br>more than 25 beds/1 awake staff for each 16 beds or portion thereof;<br>Support staff to perform office work, cooking, house cleaning,<br>Laundering, and maintenance activities; | Employee records and staffing plan to verify; |
| Programs require the following direct service staff:<br>Counselor(s) to perform admission, intake, assessment; | Employee records and staffing plan to verify; |
| HIV substance abuse residential services will respect inherent dignity of clients and will be client-centered aiming to foster client self-determination. | Supervision and program review to confirm. |

## UNITS OF SERVICE

- Substance Abuse Residential Rehabilitation Service Units – Number of days within a contract year for an unduplicated client in CAREWare.
- Substance Abuse Transitional Housing Units – Number of residential days provided within a contract year for an unduplicated client in CAREWare.
- Number of unduplicated clients receiving service during a given contract period recorded in CAREWare.

## ACTIVITIES

Program Outcomes

- Completeness of Care
- Satisfaction with Care

**Indicators**

1. 100% of clients whose treatment record documents education regarding harm-reducing and risk-reducing techniques for high-risk behaviors related to HIV.
2. 100% of clients who have had at least one HIV-related medical care consultation during the substance abuse treatment period.
3. 100% of clients who stay at least 14 days in treatment who are referred to and linked with community resources as specified in the treatment plan.
4. 90% of clients receiving the number of individual counseling sessions described in the individualized treatment plan.
5. 75% clients completing the course of substance abuse treatment described in their individual plan that are successfully referred to the appropriate next level of care.
6. 90% of clients who report satisfaction with services they received.

**Quality**

All programs will implement a Quality Management (QM) Program that assesses the extent to which care and services provided are consistent with Federal (e.g. Public Health Service and CDC Guidelines), state, and local standards of HIV/AIDS care and services. The QM program will (at minimum):

- Identify the leadership and accountability of the medical director or executive director of the program.
- At a minimum, measure the outcomes and collect the data on the indicators of the KHCCP standards of care to determine progress toward established benchmarks and goals.
- Focus on linkages to care and support services.
- Track client perception of their health and effectiveness of services.
- Serve as a continuous quality improvement (CQI) process reported annually to senior leadership.

# STANDARDS OF CARE

## PSYCHOSOCIAL SUPPORT

### DEFINITION OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Psychosocial support services are*** the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietitian; it excludes the provision of nutritional supplements.

**Services**

Psychosocial Support Services include:

- Individual and group counseling, including drop-in sessions to be provided by a qualified individual (professional or peer). These counseling sessions should be structured, with a treatment plan or curriculum, to move clients toward attainable goals;
- Peer counseling or support groups offered by HIV-positive individuals or those knowledgeable about HIV and are culturally sensitive to special populations;
- HIV support groups, pastoral care groups, and bereavement counseling.

**Purpose of Services**

Systematic provision of supportive intervention to increase the skills and confidence of persons who are HIV positive in managing their health problems

### GOALS OF SERVICES

An increased ability of service recipients to self-manage their own healthcare.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Psychosocial support service providers possess the knowledge, skills, and the experience necessary to competently perform expected services. | Personnel File; |
| Staff is trained and knowledgeable about HIV/AIDS, the affected communities and available resources. Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics, and implications including generally accepted psychosocial interventions and practices. | Documentation of attendance to training on these topics; |
| Staff is knowledgeable about available resources to avoid duplication of services. | |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

HIV infected persons experiencing a high rate of psychosocial difficulties such as stigma.

## UNITS OF SERVICE

Face to face encounter with a professional or peer in an individual or group setting.

## Activities

**Outcome**

Clients are actively involved in and able to manage their own care.

**Indicators:**

- Percentage choosing healthy behaviors as a result of psychosocial interventions;
- Percentage participating in the development of a service plan;
- Percentage meeting their service plan goals.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| Review of client needs at the first meeting. | Service plan; | Clients with chronicled needs on file; | All persons having a psychosocial encounter for the first time; | Client File; | 75% of service providers will chronicle the needs of the client in the first meeting; |
| A service plan is developed and agreed-upon by the client and provider which outline service goals, objectives, and interventions. | Development of an individual service plan; | Those with an active service plan; | All persons receiving psychosocial services; | Client files;<br><br>CARE Ware | 90% of client service plans will be documented in CAREWare or client file. |
| Review of service plan Bi-monthly | Self-management | Client meeting their goals; | All clients with a service plan; | Sign in sheet<br>Client file<br>Group notes/ curricula | 75% of clients with service plans that are meeting their goals; |

# LEGAL SERVICE

## DEFINITIONS OF SERVICES

**Health Resources and Services Administration HRSA**

***Legal Services*** are an allowable support service under the Ryan White HIV/AIDS Program. Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for any criminal defense, or for class-action suits unrelated to access to services eligible for funding under the Ryan White HIV/AIDS Program. Funds may be used for legal services directly necessitated by an individual's HIV/AIDS serostatus.

These services include but are not limited to:

a. Preparation of Powers of Attorney, Living Wills
b. Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program, and
c. Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of attorney, and (2) preparation for custody options for legal dependents including standby guardianship, joint custody or adoption.

**Services**

Legal services need to be directly necessitated by an individual's HIV/AIDS serostatus and/or related to accessing core services. These services may include:

1. Preparation of powers of attorney and/or living wills;
2. Interventions necessary to ensure access to eligible benefits, (discrimination or breach of confidentiality litigation as it relates to services necessitated by the individual (Medicare disability claims); and,
3. Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS. Permanency planning includes the provision of social service counseling or legal counsel regarding: 1) drafting of wills or delegating powers of attorney; and 2) preparation of custody options for legal dependents including standby guardianships, joint custody or adoption.

Funding for **Legal services** may not be used for any criminal defense or for class-action suits unrelated to access to services eligible for funding under the Ryan White Program

**Purpose of Services**

To provide legal assistance to HIV clients with legal problems relating to discrimination, confidentiality, access to care, public benefits, and powers of attorney and wills.

# STANDARDS OF CARE

## GOALS OF SERVICES

To guarantee HIV clients with protections from discrimination, getting redress for human rights violations, and expanding access to HIV prevention and treatment.

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| All legal counsel services must be performed by trained professional staff. Attorneys must have current licensure and hold certification through the Boards and Commissions and Bar Association in the state of Kentucky. | Personnel files/resumes/applications for employment reflect requisite experience and education. |
| Paralegal staff or other employees must be qualified to hold the position in which they are employed. Non-licensed staff must be supervised by a licensed attorney. | Personnel files/resumes/applications for employment reflect requisite experience and education. Supervisory records are kept on file. |
| A minimum of sixteen (16) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the state of Kentucky. Training should include but not limited to:<br>a. Available HIV/AIDS services in the region and the state;<br>b. How to access such services, especially Ryan White Part B funded services;<br>c. Ryan White Standards of Care (Universal and Service Category Standards) | Personnel file reflects completion of orientation and signed job description. |

## CLIENT CHARACTERISTIC

HIV clients in need of legal services to access care and treatment.

## UNITS OF SERVICE

Face to face office visits of less than one hour duration.

## ACTIVITIES

**Program outcome**

- 75% of clients will maintain medical care after accessing legal services as reported every 6 months;
- % of clients retained in care (total number clients retained/total number clients);
- % of clients entering care (total number of new clients/total number clients);

**Indicators**

- Clients accessing legal services are maintained in the medical continuum of care;
- Permanency planning requires drafting of wills or delegating powers of attorney prior to deceased;
- Referrals to access services within the continuum of care of support and core medical needs of client.

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| Clients accessing legal services are medically adherent. | Documentation in client files. | Number of clients with two or more medical visits by prescribing provider at least three months apart. | Number of clients who accessed legal services. | Client Files<br><br>CAREWare | 75% of clients accessing legal services have documentation of two or more medical visits by a prescribing provider at least three months apart in client file. |
| Clients accessing legal services for pre-decease permanency planning have legal counsel or social service counseling available for drafting of wills or delegating powers of attorney. | Documentation in client files of permanency planning with plan to draft will and/or power of attorney. | Number of clients who accessed legal services with completed wills/power of attorney. | Number of clients who accessed legal services. | Client Files<br><br>CAREWare | 75% of clients accessing legal services for pre-decease permanency have a plan or drafted will and/or power of attorney in place. |
| Clients accessing legal services who are not in medical care are referred to Early Intervention Services and/or Medical Case Management agencies to link into the continuum. | Documentation of referral to continuum of care for clients who are not accessing medical care for their HIV/AIDS progression. | Number of clients referred. | Number of clients who accessed legal services (out of care population). | Client Files<br><br>CAREWare | 100% of clients accessing legal services who are NOT in medical care are referred to such services to engage in medical interventions. |

# STANDARDS OF CARE

## MEDICAL TRANSPORTATION

### DEFINITIONS OF SERVICES

**Health Resources and Services Administration (HRSA)**

***Medical Transportation*** is an allowable support service under the Ryan White HIV/AIDS Program. Funds may be used to provide transportation services for an eligible individual to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care. Transportation should be provided through:

a. A contract(s) with a provider(s) of such services;

b. Voucher or token systems;

c. Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported with Ryan White HIV/AIDS Program funds;. Mileage reimbursement should not in any case exceed the established rates for Federal Programs. Federal Joint Travel Regulations provide further guidance on this subject;

d. Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); or

e. Purchase or lease of organizational vehicles for client transportation programs. [See also No. 12 above, *Maintenance of Privately Owned Vehicles,* for further information.] ***Note: Grantees must receive prior approval for the purchase of a vehicle.***

**Services**

Activities of Medical Transportation include:

a) Agency transportation
b) Bus passes/tokens/gas cards
c) Taxi cab services (invoiced to provider at cost)
d) Mileage reimbursement for volunteer drivers
e) Referrals to Medicaid transport
f) No gift cards for transportation

**Purpose of Services**

To meet the medical transportation needs of HIV infected clients residing in Kentucky.

### GOALS OF SERVICES

To enable HIV positive clients obtain covered medical services from both local providers and from tertiary care centers at some distance from their homes. Agencies can provide the services through contracted or by referral to the Medicaid transport in the area.

# STANDARDS OF CARE

**Qualifications**

| Staff Qualification | Expected Practice |
|---|---|
| Drivers for agency conveyance will have received training in universal precautions and infection control appropriate to their duties.<br><br>All drivers have current Kentucky driver's licenses for the type of vehicle driven as well as levels of liability insurance required by state law and funding sources.<br><br>Drivers must have verified driving records, receive a drug screen, and undergo a background check.<br><br>A signed statement from the drivers agreeing to safe driving practices is on file.. | Personnel files/resumes/applications for employment reflect requisite experience, education, licensure, required testing, and background checks. |
| **Agency Vehicle Requirements** | |
| Routine maintenance records and other repair information are available.<br><br>Agency maintains documentation of current insurance coverage as required by state law and funding sources for all agency owned vehicles.<br><br>Vehicle license and inspection are current.<br><br>A log/form for collection of mileage is maintained by the driver(s) and is reviewed at least quarterly by supervisor. | Vehicle records file. |
| Procedures are in place regarding use and distribution of vouchers or bus passes.<br><br>A system is in place to account for the purchase and distribution of vouchers and bus passes.<br><br>A security system is in place for storage of, and access to, vouchers, bus passes and fees collected.<br><br>A limitation of no more than 3 months' supply of gas vouchers or tokens on hand. | Agency policies and procedures.<br><br>Distribution logs, client records, and financial documentation. |
| Agency does not provide direct transportation services to clients in need of emergency medical care and there is a policy in place to address this. | Agency policies and procedures. |

# STANDARDS OF CARE

## CLIENT CHARACTERISTIC

Individuals living with HIV/AIDS in the Commonwealth of Kentucky in need of non-emergency medical transportation.

## UNITS OF SERVICE

Completed transport to Core Services via bus pass, gas voucher, agency, or volunteer transportation.

## ACTIVITIES

**Program outcome:**

75% of clients will arrive at core services as a result of accessing transportation.

**Indicators:**

The number of clients who arrived at core service appointments as a result of Transportation Services (counted only when services are rendered).

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| The agency provides clients with information on transportation limitations, clients' responsibilities for accessing transportation, and the agency's responsibilities for providing transportation. | Documentation in client record. | Number of clients accessing medical transportation services. | Number of clients. | Client Files<br><br>CAREWare | 75% of client files have documentation of policies for accessing medical transportation as explained to the client. |
| Screening for other transportation resources are documented, i.e., Medicaid eligible clients using Medicaid transportation program, etc. | Documentation in client record. | Number of clients screened. | Number of clients | Client Files<br><br>CAREWare | 75% of clients accessing medical transportation services are screened for eligibility of other transportation services available. |

# STANDARDS OF CARE

| | | | | | |
|---|---|---|---|---|---|
| A signed statement from client agreeing to safe and proper conduct in the vehicle is on file. | Documentation in client's record. | Number of signed statements. | Number of clients. | Client Files<br><br>CAREWare | 75% of client files have documentation of signed statement from client agreeing to safe and proper conduct. |
| Agency conveyance usage shows qualifiers for clients' accessing services (clients have NO other means to access their medical care). | Documentation in client's record. | Number of acuity score and qualifiers. | Number of clients. | Client Files<br><br>CAREWare | 75% of agencies with agency conveyance will have documentation of qualifiers for client accessing services. |
| "No Shows" are documented in a Transportation log and case managers are notified. | Transportation logs document no-shows and case manager notification. | Number of "no-shows." | Number of clients. | Client Files<br><br>CAREWare | 75% of agencies have documentation of transportation log for "no shows" with case manager notification. |
| Transportation increases access and maintenance in medical care, mental health, and substance abuse services. | Maintenance in medical care and/or mental health and substance abuse services documented. | Number of clients accessing medical care, mental health, substance abuse services. | Number of clients. | Client Files<br><br>CAREWare | 75% of clients accessing medical transportation services have increase in access to medical care, mental health, and substance abuse services. |

# STANDARDS OF CARE

## LOCAL AIDS PHARMACEUTICAL ASSISTANCE

### DEFINITIONS OF SERVICES

**Health Resources and Service Administration (HRSA)**

***Local AIDS Pharmaceutical Assistance*** (LAPA, not ADAP) are local pharmacy assistance programs implemented by a Part A, B, or C Grantee or a Part B Grantee consortium to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care or case management) to the clients that they serve through a Ryan White HIV/AIDS Program contract with their grantee.

Programs are considered LAPAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defined as a single occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Local APAs are similar to AIDS Drug Assistance Programs (ADAPs) in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds "earmarked" for ADAP.

**Services**

Individuals eligible for ADAP cannot receive Antiretroviral (ARV) medications under this program, EXCEPT during the ADAP application process not to exceed a period of one month (30 days). Medication must be purchased at 340 B pricing or lower. Services can be provided for uninsured persons who are in need assistance for prescribed HIV medications deemed medically necessary by Physician and who are NOT on ADAP formulary.

**Purpose of Services**

- To provide approved formulary HIV/AIDS medications during the eligibility gap period (30 days) to all eligible PLWHA to ensure access to and retention with HAART medication therapies for improved and/or sustained health.
- Medication adherence for all eligible PLWHA.
- To provide non-formulary medications that is deemed necessary for their HIV primary care.

# STANDARDS OF CARE

## GOALS OF SERVICES

The goal of the Local AIDS Pharmaceutical Assistance Program is to provide HIV medications to all eligible PLWHA to ensure access to and retention with HAART medication therapies for improved and/or sustained health.

### Qualifications

| Staff Qualification | Expected Practice |
|---|---|
| Service providers dispensing medications shall adhere to all local, state, and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Kentucky. | Pharmacy license is onsite and current. 340B certification is current and on file with Agency records. |
| Pharmacists must have evidence of licensure as required by the Commonwealth of Kentucky. Pharmacy technicians have required certifications and are under the supervision of a pharmacist as required by the Commonwealth of Kentucky. | Personnel files/resumes/applications for employment reflect requisite experience and education. |
| Each prescription is dispensed/delivered within two (2) working days (including mail orders). | Prescription log shows date and time each prescription was submitted and filled. |
| Labels are available in Spanish when necessary. | Prescription label descriptions are available in languages other than English upon request. |

## CLIENT CHARACTERISTIC

HIV infected clients with a prescription for the treatment of HIV disease or related diseases.

## UNITS OF SERVICE

- Successfully completed application request.
- Number of clients utilizing local AIDS Pharmaceutical Assistance.
- Filed prescriptions using local AIDS Pharmaceutical Assistance.

## ACTIVITIES

### Program Outcomes

Number of clients successfully transferring to a sustainable funding source as a result of accessing LAA.

### Indicators

Number of clients who report an improved health status as measured by virologic suppression (HIV RNA Viral Load).

## Quality

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| Service provider has record keeping system for distributing drugs. | Documented evidence of recordkeeping system for drug distribution. | LPAP providers with documented recordkeeping system for drug distribution. | All LPAP providers. | Agency Files. | 100% of LPAP providers have documented evidence of a recordkeeping system for drug distribution. |
| The client is assessed for eligibility for the Kentucky AIDS DRUG ASSISTANCE PROGRAM (KADAP). | No barriers to accessing and utilizing KADAP. | Number of clients screened for KADAP within first 30 days of medication assistance request. | Number of clients on LPAP | CARE Ware, Client charts, RSR report. | 90% of client charts document assessment screening for eligibility of KADAP. |
| Prescriptions are properly documented in client charts. | Prescriptions are properly stored in chart and include:<br>• Name of client;<br>• Date of birth;<br>• Medication & Dose;<br>• Prescribing Medical Provider. | Number of prescriptions with information listed as indicated. | Number of prescriptions. | Client charts. | 90% of client charts document prescriptions as indicated. |