# STANDARDS OF CARE

Reviewed & Updated Oct 2022

# EARLY INTERVENTION SERVICES

## DEFINITIONS OF SERVICE

**Health Resources and Service Administration HRSA**

RWHAP Parts A and B EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV- infected
  - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

## PURPOSE SERVICE

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.

## 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**

Reviewed & Updated Oct 2022

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. |

Reviewed & Updated Oct 2022

# HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

## DEFINITIONS OF SERVICES

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

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits thatprovide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one
- U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental

insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

## PURPOSE OF SERVICES

To receive medical, pharmacy and dental benefits under a health care and/or dental insurance.

## GOALS OF SERVICES

The goals of Health Insurance Premium and Cost Sharing Assistance for eligible people living with HIV include:

- Paying on behalf of the client for health and dental insurance premiums; and
- Paying for co-pays, deductibles and co-insurance.

## CLIENT CHARACTERISTIC

HIV clients in need of assistance to pay its health and dental insurance premiums, copays, deductible and coinsurance.

## UNITS OF SERVICE

- Number of successful monthly premiums to insurance companies.
- Number of successful co-payments and deductibles billed by physician offices or pharmacies.

## ACTIVITIES

**Program Outcomes**

- Medically related health insurance premiums, co-pays, and deductibles completed on behalf of the HIV infected persons.

**Indicators**

100% of clients access HIV-related PMC or HIV medications supported by premiums, deductibles, and co-payment assistance.

**Quality**

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

| *Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| Provider agency has clearly stated written guidelines that list all criteria, including review of eligibility criteria and if a client is eligible for health insurance premium or cost sharing.assistanc | Agency has documented criteria to determine eligibility for health insurance premium and cost sharing assistance; | Number of agencies with written guidelines for the payment of health insurance on behalf of client; | Number of contracted agencies for the payment of insurance, copay and deductible; | Agency files Policy & Procedure Manual; | 100% of agencies have written guidelines for payment of health insurance premiums and/or cost sharing assistance; |
| Agency provides comprehensive orientation for new staff members that include LALAP written guidelines; | Client charts document adherence to guidelines; | Number of new staff with documente d orientation; | Number of new staff; | Personnel file | 100% of new staff receive orientation on guidelines; |
| Services are made available to all individuals who meet TGA program eligibility requirements; | Eligibility application and documents | Number of clients eligible for the service; | Number of clients requesting the service; | Client Chart Log | 100% of charts documents client eligibility for Part A assistance; |
| Agency follows written guidelines, without exception, for all requests | Providers of service knowledgeable of guidelines; | Instances for which guidelines were not followed; | Number of clients; | Client chart | 100% charts document adherence to written guidelines; |

| Provider agency pays routine requests for payment within 7 days; | Client insurances not to be cancelled as a result of non-payment of premium; | Number of clients for which a cancellation notice was received; | Number of clients paid; | Client chart Payment logs | 100% of client charts document payment within 14 days; |
|---|---|---|---|---|---|
| Provider agency pays emergency requests for payment within 48 hours; | 100% of charts documents client eligibility for Part A assistance; | Number of clients with no eligibility documentation on record; | Number of eligible clients; | Client chart Payment logs | 100% of client charts document emergency payment within 48 hours; |
| Agency payable journal/logs document payment of insurance; | Number of clients for which the agency has received a insurance cancellation notice; | Client with insurance cancellation notice | Number of clients requesting premium payments | Client chart Log journals | 90% of client case managers receive notice of payment within 5 days after check is sent; |

Reviewed & Updated Oct 2022

# HOME AND COMMUNITY-BASED HEALH SERVICES

## DEFINITIONS OF SERVICES

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

Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

## PURPOSE OF SERVICE

To provide opportunities for RWHAP-eligible clients to receive services in their own home or community rather than institutions or other isolated settings.

## GOALS OF SERVICES

To enable HIV/AIDS clients to: 1) reasonability attend health care services; 2) to access indicted skilled care and 3) to receive services that perform for them house and personal care activities

## CLIENT CHARACTERISTIC

Clients with chronic medical dependency due to physical or cognitive impairment from HIV infection.

## UNITS OF SERVICE

Face to face encounter with a professional or personal aide.

## ACTIVITIES

### Program Outcomes

Clients that are incapacitated or otherwise home bound can receive medical, and personal home services in the home and community that they live.

### Indicators

- % of referrals with the appropriately signed referral care plan.

**Quality**

| *Performance Measure* | *Outcome* | *Numerator* | *Denominator* | *Data Source* | *Goal/ Benchmark* |
|---|---|---|---|---|---|
| The referring care plan must have: Physician order; Home visit with a nursing and/or medical case management assessment; A written care plan signed by physician; and appropriate referrals to meet needs identified in nursing assessment. | Evidence in consumer records of physician order, home visit and nursing assessment, signed care plan, and referrals | A documented care plan signed by a physician and that includes a nursing and medical case management assessment. | . All referrals made for home and community base service | Client record. | 85% of those in service have a documented care plan. |
| The following therapies Nursing, speech, physical, and occupational must be reauthorized by a physician every 60 days. All other services (e.g., home health aide) must be reauthorized every 120 days. Reauthorization decisions must be made in conjunction with the nurse, physician, and other staff (e.g., medical case manager) as appropriate. | Current physician authorization (every 60 days) in file for those clients receiving one or more of the following therapies: nursing, speech physical or occupational therapy<br><br>120 day physician authorization for all other services. | Client receiving home health and related therapies that have documented physician re-authorization s on file. | All clients receiving home and community health care services. | Evidence in client records of reauthorizati on | 80% of the clients receiving home and community health care services have current physician re-authorizations for treatment. |
| The provider must complete a discharge summary that indicates services have been completed and consumer progress. | Evidence in consumer records of completed discharge summary | Clients with a discharge summary on file. | All client no longer on care. | Client record | 75% of clients no longer in service have a discharge summary in record. |

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

Reviewed & Updated Oct 2022

# Home Health Care

## DEFINITIONS OF SERVICES

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

Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

## PURPOSE SERVICES

Improve the quality of care

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.

## 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. |

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# STANDARDS OF CARE

Reviewed & Updated Oct 2022

# MEDICAL CASE MANAGEMENT

## DEFINITIONS OF SERVICES

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

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

## PURPOSE 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**.**

## 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. |

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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. |

| | | | | | |
|---|---|---|---|---|---|
| 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 assessment s 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. |

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|---|---|---|---|---|---|
| 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. |
| 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

Reviewed & Updated Oct 2022

# MEDICAL NUTRITION THERAPY

## DEFINITIONS OF SERVICES

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

Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

## PURPOSE OF SERVICE

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

## 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.

## 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.

## 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 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; |

Reviewed & Updated Oct 2022

# MENTAL HEALTH

## DEFINITIONS OF SERVICES

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

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

## PURPOSE OF SERVICE

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.

## 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.

## 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; | 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. |

| | | | | | |
|---|---|---|---|---|---|
| • Medical history;<br>• 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 | Number of clients. | Client Files CARE Ware | 80% of client charts will have documented legible, signed |

| | | | | | |
|---|---|---|---|---|---|
| | | progress notes. | | | and dated progress notes. |
| 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

Reviewed & Updated Oct 2022

## ORAL HEALTH

### DEFINITIONS OF SERVICES

***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental

### PURPOSE SERVICE

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.

### 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. |
| 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 | 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.<br><br>. |

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| 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. | | | | | |
| 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; | 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 |

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| | | oral hygiene. | | | education provided. |

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

# OUTPATIENT/AMBULATORY HEALTH SERVICES

## DEFINITIONS OF SERVICES

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

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

**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.

## CLIENT CHARACTERISTIC

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

## UNITS OF SERVICE

- Face-to-face or telehealth 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).

Reviewed & Updated Oct 2022

**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)<br><br>Treatment shall be offered and delivered according to most recent United States Public Health Service (USPHS) guidelines for | 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.<br>Clients who meet current guidelines for ART are offered &/or prescribed ART.<br><br>Clients who have medical visits with an HIV medical | 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 prescribed ART.<br><br>Number of clients with medical visits every 3-6 months. | Number of clients.<br><br>Number of clients.<br><br>Number of clients who meet guidelines.<br><br>Number of clients. | 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 including an oral exam, mental health. and substance use abuse histories.<br><br>100% of clients who meet current |

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| the treatment of people with HIV/AIDS. | 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. | Number of clients with CD4 counts <200 who are recommende d &/or prescribed PCP prophylaxis.<br><br>Number of clients with CD4 counts <50 who are recommende d &/or prescribed MAC prophylaxis. | Number of clients with CD4 counts <200.<br><br>Number of clients with CD4 counts <50. | | 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;<br><br>Clients on ART receive lipid screens annually. | Number of clients on ART with annual lipid screen,<br><br>Number of clients with annual syphilis screen.<br><br>Number of clients with | Number of clients on ART.<br><br>Number of clients.<br><br>Number of clients. | CAREWare or chart audits. | 75% of clients on ART receive lipid screens annually.<br><br>75% of clients receive syphilis screens annually.<br><br>75% of clients receive |

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| | Clients receive syphilis screens annually.<br><br>Clients receive Chlamydia screening annually.<br><br>Clients receive gonorrhea screening annually.<br><br>Clients receive hepatitis A, B & C screens, if not immune, and then annually for high-risk individuals;<br><br>Clients receive TB screens annually.<br><br>Female clients receive Pap smears annually. | annual Chlamydia screening.<br><br>Number of clients with annual gonorrhea screening.<br><br>Number of clients with Hepatitis screens as indicated.<br><br>Number of clients with annual TB screen.<br><br>Number of female clients with annual pap. | Number of clients.<br><br>Number of clients needing Hepatitis screens as indicated.<br><br>Number of clients.<br><br>Number of female clients. | | Chlamydia screens annually.<br><br>75% of clients receive gonorrhea screens annually.<br><br>75% of clients receive hepatitis A, B & C screens, if not immune, and then annually for high-risk individuals.<br><br>75% of clients receive TB screens annually.<br><br>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.<br><br>All clients with Hepatitis C will be evaluated or referred | Number of clients newly diagnosed with Hepatitis C has HCV viral load and genotype.<br><br>Number of Hepatitis C clients | Number of clients newly diagnosed with HCV.<br><br>Number of clients with Hepatitis C. | CAREWare, lab values, client charts.<br><br>Client charts. | 75% of clients newly diagnosed with Hepatitis C will be tested for HCV viral load and genotype. |

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| | for evaluation of treatment suitability. | evaluated for treatment. | | | |
| 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 document |

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| | 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 appointment s. | | 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 $2^{nd}$ and $3^{rd}$ 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 $2^{nd}$ and $3^{rd}$ trimester. |

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

Reviewed & Updated Oct 2022

# SUBSTANCE ABUSE OUTPATIENT

## DEFINITIONS OF SERVICES

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

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

## PURPOSE OF SERVICE

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.

## 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.

## 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

**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;<br><br>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 | Client chart contains documentation of each item listed above. | Number of clients with appointments scheduled | Number of clients | Client Files;<br><br>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. |

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| time limitation cannot be met, refer patients. | | | | | |
| 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:<br>The presenting problem;<br>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 | 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;<br><br>CARE Ware | 75% of client charts will have documentation of initial assessments as indicated. |

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| 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:<br>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. | Client's chart contains documentation. | Number of clients with psychosocial histories completed | Number of clients | Client Files<br><br>CARE Ware | 75% of client charts have documentation of completed psychosocial history as indicated. |

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| 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; 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 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. | Documentation of treatment plan review in client's file and agency treatment review policies and procedures on file at site; | Number of clients with updated/reviewed treatment plans; | Number of clients; | Client Files;<br><br>CARE Ware | 75% of client charts will have documentation of updated treatment plans midway through treatment or at least every 12 sessions; |

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| 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: Relocation—research area services refer when necessary. | 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; |
| Clients demonstrate decreased drug use frequency or maintenance of decreased drug use in a 6-month time frame | Decreased use of drugs and alcohol frequency or maintenance of | Number of clients show decreased drug use frequency or maintenance | 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 |

| | | | | | |
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| through urine or blood drug screens or self-report. | decreased drug use; | of decreased drug use in a 6 month time; | | | demonstrated through urine or blood drug screens or through self-report; |

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

# CHILD CARE

## DEFINITIONS OF SERVICES

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

The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered childcare provider to deliver intermittent care
- Informal childcare provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

## PURPOSE OF SERVICES

To enable clients with children to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

## GOALS OF SERVICES

To promote better health outcomes for People Living with HIV/AIDS by providing for their children Child Care services to enable the infected parent and/or caregiver receive Ryan White core and support services.

## CLIENT CHARACTERISTIC

HIV infected clients with children in need of child care.

## UNITS OF SERVICE

- Number of hours provided
- Number of children receiving childcare services

## ACTIVITIES

**Program Outcomes**

- HIV positive parents able to secure needed medical and support services

- Compliance with medication regimens.

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**Indicators**

- Accessibility
- Comprehensive child care services
- Satisfaction with service

**Quality**

| ***Performance measure*** | ***Outcome Measure*** | ***Numerator*** | ***Denominator*** | ***Data Source*** | ***Goal/Benchmark*** |
|---|---|---|---|---|---|
| | | | | | |
| Number of families using the service | Families assessed as needing the service have child care for their children | Children receiving child care services | Families assess and refer to agency for child care. | | 95% of those in need of childcare have access to service. |
| Documented assessment of childcare needs and eligibility to childcare services. | Children receiving intermittent child care are eligible for the service and have a need assessment on file | Client with documented need and eligibility assessment on file | All clients receiving Ryan White Part A childcare services at the facility | Client record | 100% children will have a childcare need assessment on file. |
| | | | | | |

# EMERGENCY FINANCIAL ASSISTANCE

## DEFINITIONS OF SERVICES

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

Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

## 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.

## 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 6 and 12 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. |
| 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. |

Reviewed & Updated Oct 2022

# FOOD BANK/HOME-DELIVERED MEALS SERVICES

## DEFINITIONS OF SERVICES

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

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

## PURPOSE OF SERVICES

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

## GOALS OF SERVICES

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

## 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

Reviewed & Updated Oct 2022

# HEALTH EDUCATION RISK REDUCTION

## DEFINITIONS OF SERVICES

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

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre- exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

## GOALS 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.

## 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; |
| 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 | 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; |

| | | | | | |
|---|---|---|---|---|---|
| (3) documented attempts to contact client;<br>4. Client request;<br>5. Client death. | | | | | |
| 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

Reviewed & Updated Oct 2022

## HOUSING

### DEFINITION OF SERVICES

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

Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation.

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

### PURPOSEOF 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.

### 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; | 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; |

| | | | | | |
|---|---|---|---|---|---|
| 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. | | | | | |
| 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; |
| 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; | 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 participatio n 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; |

| | | | | | |
|---|---|---|---|---|---|
| 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. | | | | | |
| 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; |

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

# LINGUISTIC

## DEFINITIONS OF SERVICES

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

Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

## PURPOSE OF SERVICES

To facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

## GOALS OF SERVICES

To enable eligible HIV/Aids clients interact with their provider by providing:

- Interpreter Services:
- Translation Services:
- *Sign Language Interpretation Services*:

## CLIENT CHARACTERISTIC

HIV infected clients in need of linguistic service.

## UNITS OF SERVICE

1. Number of unduplicated clients receiving linguistic services annually
2. Number of service hours provided in language interpretation or translation services.
3. Number of service hours providing ASL interpretation.

## ACTIVITIES

**Program Outcomes**

Percent of client's reporting satisfaction with availability and quality of interpreter services they received.

**Indicators**

Number of non-English speaking and/or hearing or visually impaired persons who report being able to communicate effectively with health providers one on one.

Reviewed & Updated Oct 2022

**Quality**

| *Performance measure* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Benchmark* |
|---|---|---|---|---|---|
| | | | | | |
| Non-English speaking and hearing impaired clients can communicate effectively with health providers | Client surveys document using interpretation and ALS services and receiving translated material. | Client reporting using linguistic services | Non-English speaking or hearing impaired clients in need of linguistic services. | Surveys Focus groups Client interviews | 90% of clients report using available linguistic services |
| Availability of translation and interpretation services | Service provider has contracts with translators that reflect the language and hearing disabilities of the client population | | | Contracts | Contracts on file |

Reviewed & Updated Oct 2022

# MEDICAL TRANSPORTATION

## DEFINITIONS OF SERVICES

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

Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

## PURPOSE OF SERVICES

To facilitate the access to core and support services to eligible HIV infected in need of transportation.

## GOALS OF SERVICES

To enable HIV positive client's obtain covered core and support service from both local providers and from tertiary care center at some distance from their homes.

## CLIENT CHARACTERISTIC

Individuals living with HIV/AIDS in the Commonwealth of Kentucky in need to core and support services.

## UNITS OF SERVICE

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

## ACTIVITIES

**Program Outcomes**

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 | Documentation in client record. | Number of clients | Number of clients. | Client Files | 75% of client files have |

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| information on transportation limitations, clients' responsibilities for accessing transportation, and the agency's responsibilities for providing the transportation. | | accessing medical transportation services. | | ECompas | 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>ECompas | 75% of clients accessing medical transportation services are screened for eligibility of other transportation services available. |
| "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>ECompas | 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>ECompas | 75% of clients accessing medical transportation services have increase in access to medical care, mental health, and substance abuse services. |

# STANDARDS OF CARE

Reviewed & Updated Oct 2022

## NON-MEDICAL CASE MANAGEMENT

### DEFINITIONS OF SERVICES

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

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans.

NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

### 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.

### 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 | Agency policy and procedures reflect the | Number of client contacts. | Number of clients. | CARE Ware | 90% of all agencies funded for Non- |

| | | | | | |
|---|---|---|---|---|---|
| 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; | availability of walk-in services.<br><br>Documented referral kept on file at the agency. | | | Client charts | 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. |

| | | | | | |
|---|---|---|---|---|---|
| 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;<br>at the request of the client;<br>client moves out of the service area; or;<br>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. |

Reviewed & Updated Oct 2022

# PROFESSIONAL SERVICE

## DEFINITIONS OF SERVICES

**Health Resources and Services Administration HRSA**

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - 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 RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits

## 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.

## 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.

## CLIENT CHARACTERISTIC

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

Reviewed & Updated Oct 2022

## 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. |

Reviewed & Updated Oct 2022

# OUTREACH

## DEFINITIONS OF SERVICES

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

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities.

When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

## PURPOSE OF SERVICES

To identify those with undiagnosed HIV disease and link them to care.

## GOALS OF SERVICES

To structure out services 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 numbers of HIV negative individuals referred to services that contribute to keeping them HIV positive.

## CLIENT CHARACTERISTIC

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

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## 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.

## ACTIVITIES

**Program Outcomes**

- 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.

Reviewed & Updated Oct 2022

**Quality**

| *Quality Standard* | *Outcome Measure* | *Numerator* | *Denominator* | *Data Source* | *Goal/Bench mark* |
|---|---|---|---|---|---|
| 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 attendance at a medical appointment and/or receiving medication; | Those contacted in outreach session; | Medical appointment;<br><br>Outreach log; | 60% of those contacted 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 receiving follow- up by call, visit, transported, or escorted to care; | All those link into care; | Client logs or file;<br><br>ECompas | 60% of those linked to care will have follow up by outreach worker; |
| 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;<br>Survey results; and client recommendations. | 75% of those engaged into care through outreach report satisfaction with the service. |

Reviewed & Updated Oct 2022

# PSYCHOSOCIAL SUPPORT

## DEFINITION OF SERVICES

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

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support (RWHAP Part D)
- Child abuse and neglect counseling
- HIV support group

## 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.

## 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><br>Client file<br><br>Group notes/ curricula | 75% of clients with service plans that are meeting their goals; |

Reviewed & Updated Oct 2022

# REFERRAL SERVICES

## DEFINITION OF SERVICES

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

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

## 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.

## 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.

Reviewed & Updated Oct 2022

**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

Reviewed & Updated Oct 2022

# SUBSTANCE ABUSE RESIDENTIAL

## DEFINITIONS OF SERVICES

Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

## 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

## CLIENT CHARACTERISTIC

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

## 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.