

Dutchess County HIV Health Services Planning Council

Standards of Care

I. Introduction

Standards of Care are principles and practices for the delivery of HIV/AIDS related health and support services based on specific research when available. Standards of Care are established by the Planning Council for determining core standards for HIV/AIDS related services funded by Ryan White, setting a minimum service level regardless of setting, size or target population. According to Health Resources Service Administration (HRSA) guidelines, these Standards of Care were created for the Dutchess County Transitional Grant Area (TGA).

II. Generic Standards. Every contracted agency will abide by the generic standards listed below:

A. Licensing

1. The agency/organization will show evidence of being a licensed body when applicable.
2. Show evidence that the license of the organization is current and available, if necessary.

B. Knowledge, Skills and Experience

1. Staff will possess necessary current organizational and professional licensure.
2. Staff will receive programmatic supervision.
3. Staff will have experience in caring for HIV/AIDS-infected clients or receive appropriate training.

C. Client Rights and Confidentiality

Contractor will:

1. Provide assurances and a method of protection of patient rights in the process of care provision.
2. Provide assurances and a method of protection of client confidentiality [in accordance with New York State Confidentiality Law, article 27f, Section 2782.5(a)] with regard to medical information transmission, maintenance and security.
3. Adhere to HIPAA regulations.
4. Provide assurances regarding the provision of culturally appropriate care to clients. Respect, confidentiality and equal access will be assured.
5. If a client cannot participate in his or her own treatment plan, documentation explaining the circumstances must be recorded in the progress plan.
6. Establish a grievance procedure for clients.

D. Access, Care and Provider Continuity

1. Provide services in a timely fashion to all eligible clients, including verification of HIV/AIDS status and that Ryan White funded services are the payer of last resort.
2. Develop and maintain linkages with other service providers, to maintain care continuity for clients.
3. Develop and maintain a system that ensures continuity of services to their clients in all settings in which they may receive care.
4. Establish a mechanism for the termination of a client's enrollment in the program.

E. Quality Assurance

1. Maintain methods to monitor areas in need of improvement.
2. Maintain a mechanism of corrective action including assessment and response.
3. Review of decisions will be clinically based on best practice and consistent with emerging national standards.
4. Documentation that Ryan White funds are the payer of last resort.
5. Reflect competence and experience in evaluation, formulation and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available, including treatment readiness and relapse prevention.

F. Training and Education

1. Program staff of Ryan White Part A funded services will attend a minimum of one professional development training course or seminar yearly.
2. The training for staff development must be in one or more of the following service areas:

Substance abuse and drug treatment services, mental health, domestic violence, clinical trials/protocols/vaccines (with attention to 076), tuberculosis, sexually transmitted diseases, partner notification, bereavement, cultural competence, nutrition, housing services, mental health, adolescent health issues, communication, opportunistic infections, commercial sex work, gay/bisexual and transgender concerns, HIV/AIDS updates, HIV/AIDS medication updates, as well as other related topics.

3. Information on recommended training can be obtained by contacting the Dutchess County Department of Health (DCDOH) Ryan White Part A Program Administration and the Planning Council office.

III. Service Category Specific Standards

1. Ambulatory/Outpatient Medical Care Specific Standards of Care

Primary Care for people living with HIV/AIDS (PLWH/A) should reflect competence and experience in both primary care and therapeutics known to be effective in the management of persons with HIV/AIDS infection.

- A. Providers are requested to follow NYS DOH AIDS Institute treatment guidelines, and minimally must meet the Public Health Standards for ambulatory care.
- B. The following components of care should be demonstrated in the clinical record:
 - 1. Problems list and HIV/AIDS status are updated as medical conditions change.
 - 2. Risks and benefits of antiretroviral therapy shall be reviewed. Adherence issues shall be addressed with appropriate interventions documented.
 - 3. Each clinical monitoring and follow-up.
 - 4. All laboratory tests.
 - 5. Risk reduction for HIV/AIDS transmission should be addressed and documented
 - 6. Advanced directives should be addressed at initial visit and annually.
 - 7. History and activity of mental health and substance abuse disorders.
- C. Primary Care Medical Case Management:
 - 1. Identify location/provider of ancillary continuing healthcare (e.g. mental health or substance abuse provider, or other continuing specialty service).
 - 2. Bio-psychosocial assessment and appropriate referrals are made if necessary.
 - 3. Specialty care services are provided as needed, documented and tracked for follow up.
 - 4. Access, coordinate, and monitor patients' medical needs as per medical providers' treatment plan.
- D. Demonstrate:
 - 1. Services are delivered, including initial appointment, within ten days of request.
 - 2. Mechanisms for urgent care evaluation and/or triage are maintained.
 - 3. Mechanisms for in-patient care (or referral) and return to ambulatory care are maintained.
 - 4. Continuation of coordination with Social Work, Case Management services and other providers.
 - 5. Education of the client and affected collaterals regarding HIV/AIDS disease and treatment options.
 - 6. Facilitate access to clinical studies and trials.

2. Medical Case Management Specific Standards of Care

Medical Case Management is a process of assessing, planning, coordinating, and monitoring a patient's HIV/AIDS care and other health care needs. Case management must ensure access to and maintenance in medical care. Provide supervised, treatment adherence support to PLWH/A with the goal of optimizing benefits of ARVT and other therapies and supporting participation in HIV/AIDS primary care services.

A. In general, case management provides the following functions:

1. Intake into care;
2. Bio-psychosocial assessment of client needs; assessments will be updated on a continuous basis, but no less than once every six months;
3. On-going service planning;
4. Referral to and coordination of primary care;
5. Assisting patients with case coordination and referral to other medical and support services, including public entitlements;
6. Providing monitoring and follow-up; including assisting with discharge planning from medical facilities.

B. Comprehensive medical information will be included in the assessment:

1. Client's medical status, including a health systems review to gather history of HIV/AIDS disease and other related illnesses, relevant medical and psychosocial information
2. Current medical care, including names of treating physicians, eligibility and participation in other HIV/AIDS related services
3. Prescribed tests and treatment regimens
4. Assessment of successes and barriers in adhering to medical treatment
5. Client's level of understanding and educational needs related to diagnosis, treatment options, prognosis, and health insurance coverage.
6. Client's risks for HIV/AIDS transmission need for health education, and support
7. Consultation with patient's health care and social service providers to gather additional data necessary for assessment

C. Medical case management plans will include:

1. Description of flexible short- and long-term patient goals, desired outcomes and dates of goal establishment
2. Steps to be taken by patient, medical case manager and others to accomplish goals
3. Timeframe by which goals are expected to be met
4. Contingencies for anticipated problems or complications
5. The client will actively participate in developing the medical case management plan.

D. Referral and coordination of care:

1. Programs providing medical case management will demonstrate active collaboration with other agencies to provide referral to the full spectrum of HIV/AIDS-related services. Medical case managers will maintain knowledge of local, state and federal services available for people living with HIV/AIDS.
2. Referrals to services including, but not limited to, mental health treatment, community case management, treatment adherence, peer support, dental treatment, substance abuse treatment, and transportation will also be made as appropriate. Because public/private benefits issues change frequently and are especially complex, special attention must be given to appropriate referral or coordination of public/private benefits specialty services.
3. Referral systems must include a process for tracking and monitoring referrals and their results.

E. Treatment Adherence:

1. Counselors and staff will possess the knowledge, skills, and experience necessary to competently perform expected services.
2. Services are monitored for professional accountability through the following: ongoing training, regular and ongoing team meetings, and formal supervision.
3. Provide and document a quantitative assessment of medication and medical adherence for each client at initial and quarterly visits.

3. Substance Abuse Specific Standards of Care

Substance abuse services for PLWH/A is the provision of medical or other treatment and/or counseling to address substance abuse problems in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

- A. The following components of assessment, evaluation and treatment should be standard practice with all PLWH/A and be reflected in medical record documentation:
 1. Provision of group psychotherapy or group psycho-educational counseling as indicated by the clinical situation based on practice guideline recommendations and linked to treatment goals.
 2. Provision of supportive and educational counseling at visits as indicated. This includes counseling regarding the risk and harm reduction methods.
 3. Monitoring of medications and/or alternative therapies, as indicated by the clinical situation and linked to specific treatment goals.
 4. Follow-up visits to provide or monitor treatments and to assess progress toward meeting goals.
- B. Clinical services are provided in a timely fashion to all PLWH/A. New patient/client evaluations are conducted within 5 business days of referral to the provider.
- C. Mechanisms for urgent care evaluation or triage are provided

- D. As clinically indicated, the provider facilitates the access to the full range of substance abuse treatment including detoxification, twelve-step programs, and long-term structured treatment programs (e.g. halfway houses).
- E. Development and maintenance of a system that ensures continuity of substance abuse treatment to their PLWH/A in all settings in which they may receive care, including but not limited to: day programs, day hospitals, mental health programs, inpatient psychiatric units, inpatient medical units, and chronic care units (nursing homes).
- F. Development and maintenance of linkages with treatment service providers, to maintain care continuity for patients with dual diagnosis of substance abuse and mental health disorders.

4. Health Insurance Premium and Cost Sharing Assistance Specific Standards of Care

Provide financial payments for PLWH/A directly to health insurance companies for initial health insurance premiums to address the goal of access to comprehensive health care.

- A. Assessment
 - 1. Assess the ability of the client to access health care.
 - 2. Assess client financial eligibility for comprehensive health care entitlement programs and refer as appropriate.
 - 3. Assess client eligibility for HIV Uninsured Care Programs (ADAP/ADAP Plus/APIC).
- B. Staff will gather supporting documentation from client for completion of appropriate health care funding source.
- C. Assist client in completion and submission of appropriate application.
- D. Follow-up to insure continued health payment source is acquired.

6. Early Intervention Specific Standards of Care

Provide counseling to individuals with respect to HIV/AIDS, including HIV testing.

- A. Establish and maintain referral and linkage relationships with other Ryan White funded providers as well as key providers to PLWH/A.
- B. Provide HIV/AIDS counseling and testing, consistent with NYS guidelines for HIV/AIDS counseling, including an emphasis on risk and harm reduction and NYS Partner Notification processes.
- C. Provide services which engage PLWH/A with unmet need and document efforts in linking them with care.
- D. EIS activities are supervised and monitored for appropriateness, accountability and effectiveness.

7. Emergency Financial Service Specific Standards

Provide financial payments for PLWH/A directly to utility (i.e. telephone, electric & gas) companies and pharmacy providers to address emergency needs with the goal of maintaining primary medical care.

- A. Development and maintenance of a system to process requests and stabilize the situation within 72 hours.
- B. Policies/procedures exist for equity and distribution of available funds among all eligible applicants, and that provider is tracking annual individual disbursements.
- C. Development and maintenance of a system with each request that other resources (such as pharmaceutical assistance programs, public entitlements and other financial assistance programs) have been investigated and exhausted, so that Ryan White funds are used as a payment of last resort.
- D. Development and maintenance of the application and assessment process including: written criteria for eligibility for the program, criteria for acceptance/denial, formal grievance procedures and assessment of economic and other immediate needs.
- E. Provide mechanism through which payments can be made on behalf of the client.
- F. Assistance is made directly on client's behalf to pharmacies or utility companies.
- G. Under extreme circumstances an individual's maximum benefit can be reviewed and raised, in consultation with the Grantee.

8. Home Delivered Meals Specific Standards

Provide nutritionally balanced home delivered meals to PLWH/A and their dependent children under 18 years of age when medically necessary as indicated by a clinician.

- A. In accordance to NY State Sanitary Code Subpart 14-1 for Food Service Establishments from the Public Health Law 225:
 - 1. Licensed drivers and or delivery providers are used to deliver meals.
 - 2. Menus are reviewed by a registered dietician once yearly. Menus based on clinical recommendations are available.
 - 3. The preparation and delivery of meals meets sanitary and safety code standards.
 - 4. Appropriate packaging and reheating instructions are provided with each delivery.
 - 5. When possible, provider is responsive to client's food preferences.
 - 6. Clients are re-assessed to ensure they meet eligibility criteria quarterly.

9. Medical Transportation Specific Standards of Care

Provide transportation services to PLWH/A in order to access primary medical care and the following core medical services: mental health, substance abuse, treatment adherence, and oral health care.

- A. The provider must submit evidence that:
 - 1. Vehicles to be used are licensed and insured.
 - 2. Drivers are appropriately screened and offered training.
- B. Transportation services are arranged for, coordinated and/or delivered in a timely and safe manner.
- C. Application and assessment process includes, but is not limited to: written applications, criteria for acceptance/rejection, ranking criteria utilized for eligible applications when waiting lists exist.
- D. Appropriate referrals are made if clients require assistance with other services.
- E. Development and maintenance of the most cost-effective mode of transportation for the geographic area while safe and effective services are maintained.
- F. Documentation that other transportation resources have been exhausted and that Ryan White funds are last resort.

10. Outreach Services Specific Standards of Care

Identify people with unknown HIV/AIDS disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment service.

- A. Establish and maintain referral and linkage relationships with HRSA identified points of entry, providing service to identified populations: jails or prisons, alcohol and drug rehabilitation or treatment centers, youth facilities, group homes, and homeless shelters.
- B. Implement community outreach with consistency to ensure client access to medical services.
- C. Refer clients of unknown HIV status for testing.
- D. Identify HIV positive clients.
- E. Refer consenting clients to Primary Medical Care and Medical Case Management services.
- F. Follow-up on referrals made on behalf of clients.