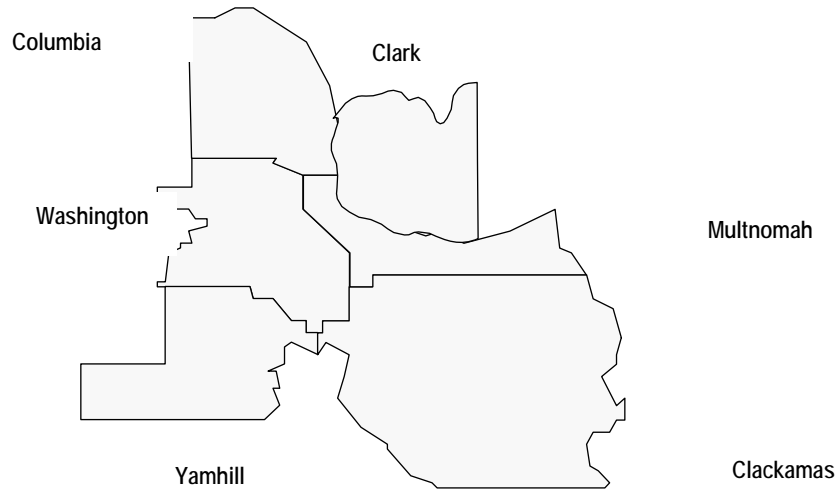


# Portland OR TGA

---



---

## Standards of Care

---

2007-2008



**Multnomah County Health Department**  
**HIV and Hepatitis C Community Programs**  
3653 SE 34<sup>th</sup> Ave.  
Portland, OR 97202-3034

## Portland TGA Standards of Care

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services funded by Portland TGA Ryan White Part A. Providers may exceed these standards.

The objectives of establishing standards of care are to provide high quality care and support to people living with HIV/AIDS by ensuring that programs:

- Have policies and procedures in place to protect clients' rights and ensure quality of care;
- Provide clients with high quality care through experienced, trained, qualified and, when appropriate, licensed staff;
- Meet federal, state and local requirements regarding safety, sanitation, access, public health and infection control;
- Guarantee client confidentiality, protect client autonomy and ensure a fair process of client grievance review and advocacy;
- Provide services that are culturally and linguistically appropriate;
- Comprehensively inform clients of services, establish client eligibility and provide equitable access to services;
- Effectively assess client needs and encourage informed and active client participation;
- Address client needs effectively through coordination of care and referrals to needed services; and
- Be accessible to all eligible people living with HIV/AIDS

### Universal Standards

All contractors should follow the minimum care standards outlined in this document. In addition, contractors shall comply with all state and local laws, ordinances, and rules governing the jurisdiction in which they practice.

#### 1. Client Eligibility

To be eligible for services funded through Part A funds, individuals, who may be self-referred or referred by case managers, outreach workers, health departments, or other community agencies, shall:

- a) Have medically verifiable HIV disease. Written verification shall be included in the client's file.
- b) Reside in the six-county Transitional Grant Area (TGA) which consists of the following counties: Clackamas, Columbia, Multnomah, Washington, and Yamhill counties in Oregon, and Clark County, Washington.

- c) Have no other source of payment for the services provided. Funds received under this Contract shall not be used to pay for any item or service to the extent that payment has been made, or can reasonably be expected to be made, by sources other than Ryan White funds.
- d) Have an income which is less than or equal to 200% of the Federal Poverty Level excluding services without income requirements, e.g. Early Intervention Services and Medical Case Management.
- e) Service providers shall have clear eligibility standards and procedures for determining a client's need for a service, based on an understanding of other resources available in the community.
- f) Providers shall update the following client data after enrollment on at least an annual basis: county of residence, household income, housing status, medical insurance, HIV status (HIV+ non-AIDS, AIDS asymptomatic etc) and client's enrollment status. Clients shall be informed that any changes must be reported to the provider.

*Indicators:*

- ◆ *Client charts shall include verification of HIV, and financial status and county of residence.*
- ◆ *Financial status and county of residence shall be updated annually.*

2. Use of Funds

- a) Providers shall make reasonable efforts to ensure that clients first use other available resources so that Ryan White Care Act funds are funds of last resort. If the provider utilizes CARE Act grant funds for client services that are eligible for third party reimbursement, they must have a system in place to bill and collect from the appropriate third party payers.
- b) Providers shall not use funds received through this Contract to make direct financial payments to clients.

*Indicators:*

- ◆ *Client charts shall document efforts made to use other available resources.*
- ◆ *Provider shall have documented system to bill and collect from appropriate third party payers.*

### 3. Client Rights and Responsibilities

- a) Providers shall have a written grievance policy and procedure in place that allows clients to express concerns and/or file complaints if they are dissatisfied with the services provided under this Contract. All providers shall submit a copy of their grievance policy and procedure to the County on an annual basis and update as appropriate. Providers shall inform clients about the grievance policy and procedure, and post it where clients can see it.
- b) Providers shall protect client confidentiality in accordance with state and federal laws and will have a system for safeguarding client information.
- c) Providers shall inform clients of their rights and responsibilities and have clear written procedures to maintain client confidentiality.
- d) Agency staff and volunteers shall receive training on confidentiality rules and procedures.
- e) Agency staff and volunteers will sign a confidentiality statement, updated annually or as necessary.
- f) Providers shall secure, and update, releases of information, in accordance with Federal and State laws, from each person enrolled to allow the provider to communicate, on a need-to-know basis, with external agencies.

#### *Indicators:*

- ◆ *Written grievance procedure is available and posted where all clients can see it.*
- ◆ *Client records shall be maintained according to all state and federal laws governing personal health information.*
- ◆ *Personnel records shall contain signed confidentiality statements, updated annually and/or as necessary.*
- ◆ *Providers shall have an established method for maintaining client confidentiality.*
- ◆ *Client records shall contain current releases of information, as appropriate.*
- ◆ *Client records shall document that clients were informed of their rights and responsibilities.*

### 4. Safety

- a) Contractors are responsible for the conduct of their staff and volunteers and shall take reasonable measures to ensure the safety of clients.
- b) Agency promotes and practices Universal Precautions.

- c) Staff are trained on personal safety issues: TB, HIV, Hepatitis infection precautions and management of potentially dangerous situations. Staff will receive blood borne pathogen training.
- d) Supervisors shall be advised when staff make home or field visits to ensure safety.

*Indicators:*

- ◆ *Personnel documents indicate that staff are trained in Universal Precautions and personal safety issues.*
- ◆ *A system of tracking staff location during home or field visits is in place.*

## 5. Staff Training

Staff and volunteer training shall include, at a minimum:

- a) General knowledge of HIV/AIDS-related conditions and diseases.
- b) HIPAA training, for those Ryan White funded agencies which are covered by HIPAA.
- c) Protection of client confidentiality.
- d) Knowledge of safer sex and risk reduction practices and appropriate referral resources.

*Indicators:*

- ◆ *Written confidentiality policy in place at provider agency.*
- ◆ *Personnel records include documentation that staff are trained to maintain appropriate client confidentiality.*
- ◆ *Staff are trained in risk reduction practices and know appropriate referral resources.*

## 6. Staff Supervision

- a) Supervision is clearly delineated in organizational chart.
- b) Staff shall be evaluated at least annually by their supervisor.

*Indicators:*

- ◆ *Organizational chart delineates staff and volunteer supervision relationships.*
- ◆ *Personnel files document completed annual employee evaluations.*

## 7. Staff Certification

Staff shall have current licenses and/or certifications required by local, state, or federal regulations to provide the program services.

*Indicators:*

- ◆ *Personnel records document that all staff providing services that require licenses or certification have licenses or certifications that are current.*

8. Quality Management Program

- a) Multnomah County HIV Care Services will work with providers to ensure compliance with these Standards of Care on an annual basis.
- b) Providers shall have a documented quality management plan to assess the quality of care provided, to ensure that deficiencies are identified and addressed, and to identify areas for improvement.
- c) Providers will provide data to the Grantee for contract monitoring, service system development and quality management.
- d) Providers shall provide a mechanism for informed community members and persons living with HIV to have meaningful input into the development and implementation of policies and programs designed to address their needs. Providers shall inform clients of opportunities for such input.

*Indicators:*

- ◆ *Client charts shall contain documentation that client was informed about the grievance policy and procedure.*
- ◆ *Provider shall have a documented quality management plan which includes quality assurance measures and quality improvement mechanisms.*
- ◆ *Provider submits accurate data in reports to the Grantee.*
- ◆ *Provider shall have a clear, documented mechanism for community members to provide input into provider policies and programs.*
- ◆ *Multnomah County works with each agency to document compliance with service standards.*

9. HIV Care Coordination

- a) Since the focus of Ryan White funds is to provide primary health care and support services which enhance access to and retention in medical care, all providers shall coordinate services with client's primary medical provider to the greatest extent possible.
- b) Providers shall screen clients for access to a primary medical care provider and to health insurance. Where indicated, providers shall link

clients with an appropriate service provider to receive medical care or to facilitate the access to insurance.

- c) Unless client declines to sign, providers shall maintain a current ROI, allowing communication among Ryan White providers to enhance coordination of care.
- d) Care shall be coordinated, when possible and with client consent, through Medical Case Management providers. This will allow for an effective and efficient flow of information that will benefit the client.
- e) Providers shall know the resources available for PLWH within the TGA. If a client presents with needs an agency is unable to meet, the provider should have the ability and the relationships necessary to link clients with other services to meet those needs, as appropriate. Multnomah County HIV Care Services shall publish *The HIV & Hepatitis C Resource Guide* to support this requirement.
- f) Providers shall inform persons living with HIV, community organizations, public health agencies, and treatment providers throughout the TGA about their services.
- g) Providers shall collaborate with other care providers to establish a coordinated and effective system of care for PLWH/A

*Indicators:*

- ◆ *Client charts shall document linkage with medical provider and insurance, or referral for access.*
- ◆ *ROIs shall be current or chart shall contain documentation that client declined to sign.*
- ◆ *Active referrals will be documented in client charts.*
- ◆ *Providers can demonstrate how they have informed other providers of their services for PLWH.*
- ◆ *Providers demonstrate knowledge of services available for PLWH within the TGA.*
- ◆ *Providers collaborate with other care providers.*

10. Culturally Competent Service Delivery

- a) Providers shall deliver services to minority populations in proportion to their representation in the local epidemic, both in number of clients and in number of service units received.

- b) Providers shall deliver services in an equitable and non-judgmental manner to potential and current clients. Cultural differences will be considered in connection with the provision of direct client services.
- c) Programs shall understand the cultural and linguistic needs, resources and assets of its service area and target populations.
- d) Programs shall recruit, retain and promote a diverse staff that reflects the cultural and linguistic diversity of the community.
- e) Staff shall receive on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.
- f) Programs must ensure access to services for clients with limited English skills.

*Indicators:*

- ◆ *Providers will document regular cultural competence training opportunities for their staff; staff will attend at least one training annually.*
- ◆ *Utilization reports document that number of clients seen and levels of service given are in proportion to their representation in the TGA's estimated prevalence, except where omitted from HIV Services Planning Council guidance.*
- ◆ *Quality improvement mechanisms to assess and address improvements in the cultural competence of staff are in place.*
- ◆ *Staffing reflects the cultural and linguistic diversity of the community, or hiring efforts have been made to do so.*

## 11. Chronic Care Model

Service delivery shall be designed in line with the Chronic Care Model which has been adopted by the Ryan White Planning Council as a means to improve medical outcomes, encourage coordination of care, and support client self management of mental health, substance abuse and HIV related symptoms and treatment (for more information on the Chronic Care Model see: <http://www.ihl.org/IHI/Topics/ChronicConditions/>).

*Indicators:*

- ◆ *Providers document their work based on the components of the Chronic Care Model in the quarterly narrative report forms.*

## **OUTPATIENT /AMBULATORY MEDICAL CARE**

### **HRSA DEFINITION:**

*Outpatient/Ambulatory medical care (health services)* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

### **TGA SERVICES PROVIDED:**

Clinic-based medical care by or under the direction of a licensed medical professional (physician, nurse practitioner, physician's assistant). Outpatient medical services also include medication management, early intervention and risk reduction, nutritional counseling, education to help understand lab results and their significance, referral to specialty services and linkage to medical case management.

### **STAFF**

#### **Staff Qualifications:**

- A. Individual clinicians shall have documented and current unconditional licensure/certification in their particular area of practice.
- B. Clinical staff shall be knowledgeable and experienced in their area of clinical practice, and in the area of HIV/AIDS clinical practice. All staff without direct experience with HIV/AIDS shall be supervised by experienced staff.

#### *Indicators:*

- ◆ *Appropriate licensure/certification is maintained.*
- ◆ *Hiring procedures require appropriate credentials. Copies of hiring procedures are available for review.*

#### **Staff Training:**

- A. Staff shall maintain up-to-date knowledge of HIV/AIDS treatment protocols and standards of care.

- B. Staff shall be trained regarding client confidentiality and HIPAA regulations.
- C. Clients will be informed of any and all treatments, medications, or protocols that are considered experimental and written consent to participate in any experimental treatment will be expressly obtained.

*Indicators:*

- ◆ *Documentation of successfully completed hours of annual job-related training to maintain knowledge of current HIV protocols, treatment.*
- ◆ *Documentation of successfully completed confidentiality and HIPAA training.*

**SERVICES STANDARDS:**

- A. Provider/agency shall be accredited/licensed to deliver clinical services.
- B. At a minimum, outpatient medical care services must be consistent with HIV clinical practice standards and Public Health Service guidelines for treatment of HIV infection including Adult, Adolescent, and Pediatric Guidelines for Antiretroviral Treatment; Opportunistic Infection Guidelines; Tuberculosis Guidelines; and Perinatal Guidelines. Current guidelines can be found at [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov)
- C. Care providers must have systems in place to link potentially eligible clients to other financial resources and programs that cover medical and supportive services, e.g., OHP, CareAssist and medical case management.
- D. Care providers must have systems in place to assist with access to drug therapies.
- E. Care providers must develop, implement and monitor strategies to support patient adherence to drug therapy regimens.
- F. Clients will be actively involved in making decisions about their medical care, having been provided education about potential side effects and benefits of any decision they make.
- G. Service provider shall collect risk behavior information at intake and make referrals to HIV prevention education as appropriate.

*Indicators:*

- ◆ *Evidence of unconditional licensure is on file.*
- ◆ *Provider has systems in place to monitor compliance with Public Health Service guidelines.*
- ◆ *System exists for linking uninsured patients with other resources to cover medical services.*
- ◆ *System exists for assisting eligible clients with drug assistance programs.*

- ◆ *Documentation of strategies used to support patient adherence to medication regimens.*
- ◆ *Client chart contains documentation of client participation and understanding of the plan for his or her medical care. (ORS 677.097 Informed consent of patient see appendix)*
- ◆ *Intake forms contain questions about sexual risk behavior. Charts document referral to HIV prevention services or onsite HIV prevention services as appropriate.*

**QUALITY MANAGEMENT:**

- A. Agency shall have a quality management team to oversee quality management activities at the clinic.
- B. Agency shall collect data to report client level outcomes.

*Indicators:*

- ◆ *Agency shall maintain a list of quality management team members and a schedule of quality management team meetings.*
- ◆ *Agency reports clinical outcomes on a regular basis.*

**CARE COORDINATION:**

- A. Providers will maintain referral relationships with programs where HIV positive individuals may be identified and referred into care (e.g., substance abuse treatment providers, emergency rooms...).

*Indicator:*

- ◆ *Referral relationships with key points of access are documented through memoranda of understanding or provider referral plan.*

- B. Outpatient medical providers shall maintain referral relationships with other Ryan White funded primary care providers to enhance client access to RW services (e.g., mental health, substance abuse, dental, complementary care). In addition, for those clients who have case managers, primary care providers should maintain communication with the case manager.

*Indicator:*

- ◆ *Other providers are listed in the client chart or computer record and communication is documented.*

**MEDICAL CASE MANAGEMENT** (see also Appendix A for more complete information)

**HRSA DEFINITION:** *Medical Case management services (including treatment adherence)* are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

**TGA SERVICES PROVIDED:** In the Portland TGA medical case management services are offered in two tiers based on client need: service access and case management. Needs will be determined by client presentation, intake interview and use of the acuity measurement tool. In all settings, the acuity score will determine the level of service provided to a client. Clients with less need will be provided a lower level of service, known as service access services. Clients with greater need will be provided more intensive medical case management services. Nursing case management is also available for clients needing home visits and/or medication management.

## **STAFF**

### **Staff Qualifications:**

#### Oregon

Service Access Specialist:

Bachelor of Social Work, or other related health or human service degree from an accredited college or university and one year relevant HIV experience.

Case Manager:

Masters of Social Work or Masters level degree in other related health or human service from an accredited college or university and one year relevant HIV experience. Strong preference for LCSW;

**OR**

Bachelor of Social Work, or other related health or human service degree from an accredited college or university and a minimum of three years relevant HIV experience.

Nurse Case Manager: An RN (with BSN preferred), one year relevant HIV experience, and currently licensed in Oregon.

#### Washington

Master's degree in behavioral or health sciences (e.g. social work, clinical psychology, sociology, guidance counseling, nursing, public health) and one year of paid social service experience;

#### **OR**

Bachelor's degree in behavioral or health sciences and two years of paid social services experience;

#### **OR**

Bachelor's degree and three years of paid social services experience.

Exceptions can be made when service population is geographically or culturally isolated or has limited English-speaking ability.

#### *Indicator:*

◆ *Personnel files and staff resumes reflect requisite experience and education.*

#### **Staff Training:**

All case managers must have a general knowledge of HIV/AIDS-related conditions and diseases. In addition, case managers shall maintain a comprehensive understanding of the treatment, financial, and support services available to meet the needs of persons living with HIV in the TGA.

- A. All staff providing case management or service access services will receive orientation and training that covers the following topics (or have documented competency in these areas):
- Understanding of motivational interviewing theory and practice and of harm reduction;
  - Legal requirements for potential child or elder abuse or neglect and how to report incidents;
  - Knowledge of home health care and long term care resources;
  - A basic understanding of benefits programs including SSA, state disability programs, ADAP (CAREAssist), and medical/insurance benefits programs.
  - A basic understanding of housing options for PLWH/A (specific case managers will be responsible for a more in-depth understanding of available housing resources).

- B. HIV/AIDS case managers shall complete TGA specific designated on-going training, when offered.

*Indicators:*

- ◆ *Personnel files document completion of staff orientation and training or documented competency.*

**Staff Supervision:**

Supervisor Qualifications:

- A. Masters of Social Work or equivalent, LCSW highly preferred.
- B. Staff supervisor must meet case manager qualifications and have three years of paid social service experience, including two years supervisory experience.
- C. In Washington, if supervisors carry case management workloads, the span of control shall allow for supervisory and medical case management duties to be performed within Title XIX standards.

Supervision Activities:

- A. Maintain regular contact with staff and meet with individual staff and with the medical case management team a minimum of once per month.
- B. Review a sample of client's care and case records at least once every 90 days.
- C. Provide and arrange for appropriate staff case consultation. Includes consultations by other professionals, as needed.

*Indicators:*

- ◆ *Personnel files document regular supervisory meetings with staff.*
- ◆ *There is documentation of supervisory review of case records every 90 days.*
- ◆ *There is documentation of appropriate consultations with other professionals.*

**SERVICES STANDARDS:**

**A. Intake**

Each prospective client who is referred to or who requests medical case management services will be properly screened and evaluated through a brief face-to-face intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs. Intake shall be scheduled within two weeks from time of first request and shall be prioritized by clients' identified problems.

*Indicator:*

- ◆ *All elements of intake listed shall be documented in the client record.*

**B. Assessment**

Each client of medical case management services will participate in at least one (1) face-to-face interview annually. The assessment should commence no later than two (2) working days following intake and should be completed within two (2) weeks from commencement. The comprehensive assessment will result in the creation of the care plan.

**C. Acuity Scale**

Based on the assessment, the client’s level of service needs will be assigned based on the System Acuity Measurement (SAM) acuity scale. The acuity scale levels of medical case management are as follows:

14-28	Service Access: Client needs access to information and possibly initial referral to service(s). Client may need education about services, health issues, medications and other topics.
29-45+	Case Management: Client needs on-going referrals and case manager follow-up; an individualized service plan will be developed with all case management clients. Case manager involvement will be determined by acuity score and client needs. Contact frequency must be sufficient to ensure implementation and ongoing maintenance of the care plan. <u>Minimum</u> contact every 90 days, (telephone or face-to-face) including evaluation of goals, activities and outcomes.

If client’s needs change, they will be reassessed and assigned to the appropriate service level.

*Indicators:*

- ◆ *Acuity scale has been used and client’s current score is documented, with date, in client chart.*
- ◆ *Reassessments, in accordance with the acuity level, are documented, with date, in client charts.*

**D. Care Planning**

**1. Service Access**

Clients who are assessed as needing service access will have their needs, services provided, and necessary follow-up documented in client charts. Each client will have a brief individualized service plan. Follow-up tasks should include identification of the issue and who (client or SAS) has responsibility. The SAS and client will work together, as needed, for the successful completion of the task/issues identified.

**2. Case Management**

Clients in Case Management will work with their case manager to develop an individualized service plan within two days of the completion of the

comprehensive assessment. The planning process includes the development of goals, assigned activities (client or CM), referrals and reporting on outcomes. The client and the case manager will sign the service plan and the client will be given a copy. Appropriate documentation of goals, assigned activities and the outcomes of each will be included in the client's file (paper or electronic), along with any other service planning documents, e.g., housing plan. The service plans will be reviewed, and revised appropriately, at least every 90 days.

In all situations, an appropriate and current release of information (ROI) for referrals will be maintained.

*Indicators:*

- ◆ *There shall be documentation of needs discussed, and services provided in service access client files.*
- ◆ *There shall be a signed copy of the individualized service plan and complete documentation of care planning and evaluation of the goals in all medical case management client files.*
- ◆ *Housing plans are included in the charts of all clients with housing needs.*
- ◆ *All referrals are appropriately documented.*
- ◆ *ROIs for all referrals are current.*
- ◆ *Charts contain documentation of re-evaluation of the care plan at appropriate intervals, at least every 90 days.*

**E. Reassessment**

Reassessment shall occur at least annually for all case management and nursing case management clients, or more often, as needed. The following information should be documented as part of the overall reassessment:

- updated demographic data,
- updated assessment data,
- updated goals and activities reflecting the above input and review.

*Indicator:*

- ◆ *All reassessments and updated acuity scores are documented in the client record.*

**F. Caseloads**

Recommended caseload size for full time provider:

- Service access only: 150-175 clients
- Case management only: 50-60 clients
- Nurse case management only: 30-35 clients
- Blended caseload (case management and service access): 75-85 clients

## **G. Transfer and Discharge**

A systematic process shall be in place to guide transfer of the client to another program, to another staff member, and/or to discharge from medical case management services. The process includes clear documentation of the reason(s) for transfer, discharge, notifying the client of case closure and the appeals process.

### *Indicator:*

- ◆ *Eligibility criteria are followed and those no longer meeting the criteria are discontinued.*
- ◆ *Discharge summary with complete documentation of reason for discharge is included in client file.*

## **ORAL HEALTH CARE**

### **HRSA DEFINITION:**

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

### **TGA SERVICES PROVIDED:**

Comprehensive dental care services are provided for persons living with HIV/AIDS who reside in the Portland TGA and have no other coverage for their dental care. Services may include diagnostic and preventative care, restorative, periodontics, prosthetics (not including orthodontics), oral surgery (to the extent it can be provided in a general practice dental office), endodontics, crown and bridge procedures, and emergency care, resulting from acute pain and infection. Emphasis is placed on early intervention to prevent occurrence of dental problems.

### **STAFF**

#### **Staff Qualifications:**

Providers will hold appropriate license, credentials and expertise.

#### *Indicator:*

- ◆ *Current licensure on file for all providers. Forms contain Board of Dentistry license number for all dentists.*

#### **Staff Training:**

Oral health care providers shall have training in providing care to patients with HIV/AIDS. They shall understand the interaction of HIV/AIDS disease and medications with oral health care. The clinician should be aware that HIV disease and its treatment may be associated with increased risk for dental caries.

#### *Indicators:*

- ◆ *All providers have documented training/experience in providing care to patients living with HIV/AIDS.*

#### **Staff Supervision:**

Supervision shall be provided at a minimum according to the Dental Practices Act.

#### *Indicator:*

- ◆ *Organizational chart will document appropriate supervision.*

### **SERVICES STANDARDS:**

Oral health care services provided shall be in accordance with the standard of care in the community. In addition, due to co-morbidity with HIV/AIDS, the following guidelines shall be followed:

- A. All people living with HIV/AIDS should have routine examinations by a dentist every six months. (from David I Rosenstein and Gary T. Chiodo "Oral Problems" Chapter 8 in A Clinical Guide to Supportive & Palliative Care for HIV/AIDS 2003 Edition)
- B. Provision of care should be coordinated between medical and oral health care providers.
- C. If a patient is not seeing a primary care physician regularly, he or she should be urged to seek care, and a referral to a primary care physician should be made.
- D. The oral health care provider should promptly communicate any clinical findings that may signify a change in the patient's systemic health, or any planned, extensive surgical procedures that may impact the patient's systemic health. A signed consent form shall be obtained from the patient to share personal health information.
- E. Every patient should receive a comprehensive initial evaluation which shall include a medical and social history and a comprehensive medical system review. The medical and social history and comprehensive medical review should be performed at each visit for unstable patients and at each recall visit for stable patients.
- F. Extra-oral head and neck examination and oral soft tissue examination should be performed at each visit. (Patients with HIV infection may develop associated skin manifestations and cervical lymphadenopathy.)
- G. The patient's oral health care provider should review all medications (including naturopathic or homeopathic remedies, or over the counter medications) being used by the patient since HIV-related medications may affect dental treatment and cause adverse effects. (adapted from Oral Health Care for people with HIV Infection, AIDS Institute, NY State Dept of Health, 2001)

*Indicator:*

- ◆ *Chart reviews document that services are being provided that meet the standard of care in the community. Procedures listed above are documented in client charts.*

**CARE COORDINATION:**

Providers shall maintain communication with client's primary care provider.

*Indicator:*

- ◆ *Release(s) of information are current and allow communication between the dental provider and other primary care providers.*

## **EARLY INTERVENTION SERVICES**

### **HRSA DEFINITION:**

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

### **TGA SERVICES PROVIDED:**

Early Intervention services (EIS) support clients who are not in care by making effective referrals with follow up until the client is engaged in HIV related medical care, case management, substance abuse or mental health treatment services. EIS prioritizes clients who have been recently diagnosed or are out of medical care for longer than six months and who experience barriers to care such as:

- Primary language other than English
- Active or recent substance abuse issue
- Active or recent mental health issue
- Recent or chronic incarceration
- Homelessness or unstable housing
- Lack of health insurance combined with no case manager
- Recent change in income

## **STAFF**

### **Staff Qualifications:**

Staff shall have documented training and/or experience in HIV/AIDS.

#### *Indicators:*

Staff has documented training and/or experience in HIV/AIDS in their personnel file

### **Staff Training:**

Staff should be trained in harm reduction, motivational interviewing, substance abuse/addiction, issues of poverty, mental illness, developmental delays, and educational disadvantages.

#### *Indicators:*

- ◆ *Staff personnel records include documentation of training in harm reduction, motivational interviewing substance abuse/addiction, issues of poverty, mental illness, developmental delays, and educational disadvantages.*

## **SERVICES STANDARDS:**

- A. Services must be provided through one of the following facilities; public health department, emergency room, substance abuse or mental health treatment program, sexually transmitted disease clinic, homeless shelter, HIV/AIDS counseling and testing program, or a federally qualified health center.
- B. EIS primarily targets newly HIV positive persons.
- C. 70% of clients in the program shall be those who need to be engaged in medical care.
- D. Program must follow up on referrals of clients who have not been engaged in medical care, case management, substance abuse (if appropriate) or mental health treatment (if appropriate) for six months or longer to support their reengagement in care.
- E. Services include engaging clients who have been identified by a provider as being at risk for substance abuse or mental health disorders and who may benefit from additional support so that they can be engaged in substance abuse and mental health treatment services.
- F. Early intervention services address HIV prevention needs of clients to support sexual health and reduce the risk of transmission of disease through referral mechanisms to HIV prevention services in the community.

*Indicators:*

- ◆ *Services are provided through one of the following facilities; public health department, emergency room, substance abuse or mental health treatment program, sexually transmitted disease clinic, homeless shelter, HIV/AIDS counseling and testing program, or a federally qualified health center.*
- ◆ *Data collected indicates that the program is primarily serving newly HIV positive persons*
- ◆ *At least 70% of clients in the program are those who need to be engaged in medical care.*
- ◆ *Program receives referrals of clients who have not been engaged in medical care, case management, substance abuse (if appropriate) or mental health treatment (if appropriate) for six months or longer to support their reengagement in care.*
- ◆ *Program data indicates that the program successfully engages clients who are in need of substance abuse and mental health treatment services.*
- ◆ *Documentation of service includes assessment for behavioral risk factors for HIV and STD transmission.*

**CARE COORDINATION:**

- A. Services must establish and maintain referral relationships with medical and social service providers including but not limited to; public health departments, emergency rooms, substance abuse and mental health

treatment programs, detoxification centers, detention facilities, sexually transmitted disease clinics, homeless shelters, HIV/AIDS counseling and testing centers, and federally qualified health centers.

- B. The role of early intervention services must diminish after three consecutive months of a client regularly attending scheduled medical or case management appointments.
- C. The program shall have a strong working relationship with case management programs for people with HIV/AIDS.

## **FOOD AND HOME DELIVERED MEALS**

### **HRSA DEFINITION:**

*Food bank/home-delivered meals* include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

### **TGA SERVICES PROVIDED:**

Prepared meals are delivered to those clients whose illness limits their ability to travel outside the home or to prepare meals.

Hot meals are provided in a group setting; occasional meals are also provided to a women and children's multi-service center. Menus that address a variety of cultural preferences are developed, as needed.

Meals shall be provided that meet the nutritional needs of PLWH/A.

### **STAFF**

#### **Staff Qualifications:**

- A. All staff and volunteers who help with food preparation shall have valid food handler cards.
- B. All volunteers delivering food by car shall have a valid driver's license and appropriate auto insurance
- C. A background check will be run on all volunteers who may enter clients' homes.

#### *Indicators:*

- ◆ *Copies of current food handler cards for all cooks are available in program files.*
- ◆ *Copies of valid driver's licenses for all drivers are available in program files.*
- ◆ *Background checks are documented in personnel/volunteer file.*

#### **Staff Training:**

- A. All staff and volunteers shall receive training on food safety issues and have current knowledge of the nutritional needs of PLWH.
- B. All staff and volunteers shall receive confidentiality training.
- C. Provider shall provide training for staff and volunteers on use of the Food Services manual (see service standards below).

#### *Indicators:*

- ◆ *Staff has maintained current knowledge of nutritional needs of PLWH.*

- ◆ *Volunteer records document that all volunteers have received training on food safety, with additional training on the food safety needs of people with HIV disease.*
- ◆ *Personnel and volunteer records document that all staff and volunteers have received confidentiality training.*
- ◆ *All staff and volunteers have been trained on use of the Food Services manual.*

**Staff Supervision:**

- A. All volunteers shall be supervised by a staff person.
- B. Supervisors shall maintain periodic checks to ensure that staff and volunteers are following the Food Services manual.
- C. All staff shall be reviewed, at least annually, by their supervisor.

*Indicators:*

- ◆ *Supervision of volunteers is assigned to a specific staff person.*
- ◆ *There is evidence that program supervisors have monitored food preparation and storage at least every three months.*
- ◆ *Personnel records document annual supervisory review.*

**SERVICES STANDARDS:**

- A. Group meals are available for clients with psychosocial needs including but not limited to: a) reducing social isolation, b) increased linkages with medical and social services, c) support for medical adherence, d) support for activities of daily living and e) peer support.
- B. Group meals shall be offered in a setting which promotes the development of a support community, where clients are able to meet with other service providers and where health education and risk reduction messages are shared. (Planning Council Guidance)
- C. Clients receiving home delivered meals with Ryan White funds shall have a documented medical necessity for receiving the service. Authorizations for the service must be conducted by a case manager by phone, fax, mail, or e-mail at least every six months.
- D. Meals should have nutritional value in compliance with HRSA's Nutritional Guide for Providers and Clients. (Planning Council Guidance)
- E. Provider shall maintain a Food Services Manual that addresses food service and preparation standards, sanitation, safety, food storage and preparation, portioning and serving meals, and volunteer and driver training.

- F. All food preparation and storage shall be provided in accordance with the Food Services Manual.
- G. Clients receiving home-delivered meals shall have documentation of need in their charts.

*Indicators:*

- ◆ *Assessment indicates need for group meals and psychosocial services.*
- ◆ *Charts for clients receiving home delivered meal must document referral by primary care physician or case manager, with reassessment of need for home-delivered meals every six months.*
- ◆ *Agency shall maintain a Release of Information (ROI) with all clients' case managers to allow communication when necessary or document that client declined signing.*
- ◆ *Meals have nutritional value in compliance with HRSA's Nutritional Guide*
- ◆ *Food Services Manual has been developed and maintained and is easily available for staff to consult.*
- ◆ *There is evidence that program supervisors have monitored food preparation and storage at least every three months.*
- ◆ *Client charts document need for home delivered meals.*

**CARE COORDINATION:**

Staff provide clients with information about other food services available in the community. At on-site programs, information about other services for PLWH is readily available. Staff from other agencies serving PLWH/A are invited to provide services at the site and training and education programs are made available to clients.

*Indicators:*

- ◆ *Clients who recover and no longer need home-delivered meals are linked with group meal services and other food programs in the community.*
- ◆ *Care system staff make presentations at program sites.*

## **HEALTH INSURANCE PREMIUM & COST SHARING ASSISTANCE**

### **HRSA DEFINITION:**

**Health Insurance Premium & Cost Sharing Assistance** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

### **TGA SERVICES PROVIDED:**

Provision of health insurance should be based on demonstrated eligibility and need of client. The service shall promote continuity of insurance coverage.

Part A funds should support the following elements within this service category:

- Insurance premiums including public and private policies
- Cost shares
- Medication co-pays
- Lab co-pays
- Other non-medication co-pays

### **STAFF**

#### **Staff Qualifications:**

Staff must be familiar with eligibility requirements for Medicaid/Medicare and other state insurance programs.

#### *Indicator:*

- ◆ *Personnel records document that staff have experience working with or have received training to provide necessary knowledge of state insurance and entitlement programs.*

#### **Staff Training:**

Staff shall receive ongoing training regarding changes in federal and state policies which impact health insurance coverage for PLWH/A in the Portland TGA.

#### *Indicators:*

- ◆ *Personnel records document that staff have received up to date training on any changes in federal or state policies which impact health insurance coverage for PLWH/A served.*

### **SERVICES STANDARDS:**

- A. The health insurance program shall provide co-payments or premium payments for insurance for low-income PLWH/A who would otherwise be unable to pay these costs to continue their medical and prescription drug needs. Focus of the program shall be on continuous coverage for the maximum number of PLWH/A.

- B. This program is exempt from the requirement of documenting geographic and/or race-ethnicity proportions within the TGA.
- C. Clear eligibility guidelines are documented, available in English and in Spanish.
- A. When changes in eligibility, program policies and/or program capacity are necessary, clients shall be given the maximum notice possible, but no less than 1 month

*Indicators:*

- ◆ *Program provides co-payments or premium payments for insurance for low-income PLWH/A*
- ◆ *Program distributes clear eligibility guidelines to clients in English and Spanish, changes to these guidelines are sent to clients within one month.*

**CARE COORDINATION:**

Changes in eligibility criteria, program policies and/or program capacity shall be shared with clients in a timely manner.

## **HOUSING SERVICES**

### **HRSA DEFINITION:**

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

### **TGA SERVICES PROVIDED:**

Housing services include financial assistance to help pay rent, move-in costs or deposits, information and referral to help clients find the most suitable housing program for which they are eligible and classes to enable clients to maintain stable housing. Housing services shall include alcohol and drug free housing resources and housing for clients who are enrolled in substance abuse treatment. Staff support for clients in housing units paid through other funding sources are also included in housing assistance.

### **STAFF**

#### **Staff Qualifications:**

Staff must be knowledgeable about HIV/AIDS and its impact upon client ability to maintain housing. They must also maintain current information about other housing programs in the Portland TGA including but not limited to HOPWA funded housing.

#### **Staff Training:**

Staff may be called upon to deal with evictions or other highly stressful situations; staff shall have experience with or receive training in dealing with clients under stress. They shall also have experience or training in dealing with clients under the influence of alcohol or other drugs, and clients with mental illness.

#### *Indicators:*

- ◆ *Site visits demonstrate that staff have adequate knowledge of housing program in the Portland TGA to assist clients.*
- ◆ *Personnel records document that staff have received training dealing with clients under stress, under the influence of alcohol or other drugs, or dealing with clients suffering from mental illness.*

### **SERVICES STANDARDS:**

- A. Agency shall document individual client's need for emergency rent assistance on a Care Services-approved "Certification of Need" form kept in the client's record. This certification shall document that the housing assistance is essential to the client's ability to gain and/or maintain access to

HIV-related medical care or treatment. This certification shall be signed by a qualified professional who coordinates care for the client. Qualified professionals may include physicians, nurses, care coordinators, case managers, program managers, team leads and housing caseworkers.

- B. The agency shall require that clients receiving emergency rent assistance have a medical care provider or accept a referral for care. Subsequent emergency housing assistance requests shall require verification of participation in medical care.
- C. Any exceptions to the financial limitations for assistance shall be approved by agency's Program Director or his/her designee.
- D. Any extension of time in transitional housing assistance must be based on documented need related to the permanent housing plan and be approved by agency's Housing Manager.
- E. Housing planning meetings shall include a short assessment and development of a housing plan that identifies strategies to secure or maintain long-term stable housing.
- F. Housing assessment shall include an in-depth assessment and development of a housing plan. The plan will address individual/family strengths and available resources. The plan will also include identification of goals, barriers to obtaining those goals, steps to overcome the barriers, progress toward achieving goals and document access to and participation in medical care.
- H. Workshops shall assist clients and their families to develop skills that will enable them to attain and maintain permanent housing.
- I. Clients in substance abuse treatment shall be provided with individual housing. Clients housed during their substance abuse treatment are able to remain in housing after treatment.
- J. Clients shall reside in substance abuse treatment housing for a maximum of six months (unless special circumstances are noted).

*Indicators:*

- ◆ *100% of participants in housing program are participating in medical care or have documented referrals.*
- ◆ *Certification of Need is included for all clients receiving emergency rent assistance.*
- ◆ *Documentation shows that no client has received more than limitations; if more assistance is provided, there is documentation signed by the Program Director or designee.*

- ◆ *Any extensions of time in Transition to Housing units are signed by the Housing Manager and a related plan for permanent housing is documented.*
- ◆ *Housing planning meetings are documented for all clients.*
- ◆ *Clients eligible for Ryan White funded housing have documentation of housing assessments, including goals, barriers, a plan to overcome the barriers and documentation of progress.*
- ◆ *Workshop curricula include information about tenant/landlord rights and responsibilities, eviction prevention, and housing discrimination.*
- ◆ *For those clients in substance abuse treatment, housing records shall indicate that clients are provided with individual housing. Housing records shall indicate that clients housed during their substance abuse treatment are able to remain in housing after treatment.*
- ◆ *Housing records shall indicate that clients are remaining in substance abuse treatment housing for a maximum of six months (unless special circumstances are noted).*

**CARE COORDINATION:**

Housing casework and medical case management services shall be coordinated; housing plans shall be included in goal planning for medical case management clients.

*Indicators:*

- ◆ *Documentation shows that housing plans have been shared with the client's case manager.*

## **MENTAL HEALTH SERVICES**

### **HRSA DEFINITION:**

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

### **TGA SERVICES PROVIDED:**

Mental health services may include a peer mentor program to support client engagement in services, mental health assessment; short-term individual, couples and family counseling; short-term group counseling for individuals, couples and families; medication evaluation and management.

Services may be provided in a variety of settings--at community mental health centers, at specialty mental health centers, or in conjunction with other Ryan White funded services, including medical case management. In certain circumstances, services can be delivered in-home when a client's mental or physical condition prevents them from going into an office for services.

Providers help clients cope with serious mental illness, issues related to living with a chronic disease, and with the effects of medication on psychological health and self-esteem. Services are designed to meet the diverse mental health needs of PLWH/A.

## **STAFF**

### **Staff Qualifications:**

- A. Mental health services are provided by a licensed mental health professional or by a qualified mental health professional as defined by Oregon Administrative Rules or Washington Administrative Code (i.e. psychologist, psychiatrist, psychiatric nurse practitioner, clinical social worker or licensed professional counselor). Peer mentor services must be provided by a Qualified Mental Health Associate as defined by Oregon Administrative Rules.
- B. Clinical staff shall be knowledgeable and experienced in working with people living with HIV/AIDS. All staff without direct experience with HIV/AIDS shall be supervised by experienced staff.

### *Indicators:*

- ◆ *Appropriate licensure/certification is maintained.*
- ◆ *Personnel files/resumes/applications for employment reflect requisite experience.*

- ◆ *Staff without direct experience with HIV/AIDS are supervised by experienced staff*

**Staff Training:**

Providers shall maintain up-to-date knowledge of HIV/AIDS treatment and the possible effects of HIV/AIDS or its treatments on clients' mental health.

*Indicators:*

- ◆ *Documentation of successfully completed hours of job-related training for all providers.*

**Staff Supervision:**

- A. Supervision of non-licensed Qualified Mental Health Professional must be twice monthly, at a minimum, by a person who is a licensed mental health professional to review the services provided by the unlicensed person.
- B. Supervision of Qualified Mental Health Associate must be twice monthly, at a minimum, by a person who is a licensed mental health professional or a licensed substance abuse treatment provider to review the services provided by the unlicensed person.
- B. Supervisor shall review a sample of each provider's charts regularly for completeness, compliance with standards, and quality of service delivery.

*Indicators*

- ◆ *Appropriate supervision of QHMP and QMHA is documented.*
- ◆ *Sample of providers' charts are reviewed regularly by supervisor.*
- ◆ *Personnel files document completed annual employee evaluations and chart review.*

**SERVICES STANDARDS:**

- A. Agencies providing mental health services funded by Ryan White Part A funds must have the ability to bill Medicaid for services to clients in the state in which services are provided.
- B. All mental health services provided in Oregon shall be provided in accordance with Oregon Administrative Rules governing provision of mental health care. Services provided in Clark County, Washington shall be provided in accordance with Washington Administrative Code.
- C. Each client receiving mental health services shall have a mental health assessment and a current treatment plan with clearly defined goals in his/her client record. Current treatment plan is defined as one which has been reviewed and updated, if necessary, at each client visit.
- D. Clients shall be assessed using the OQ 45. Such assessments will be the basis for decisions about the need for continued care.

- E. Service provider shall collect risk behavior information at intake and make referrals to HIV prevention education as appropriate.
- F. Peer mentor services shall include:
- 1) Services will be provided to PLWH/A who have indications of mental illness as determined by a medical or case management provider.
  - 2) Each client engaged will have a brief goal plan developed in conjunction with the client.
  - 3) Work with clients will be time limited and focused on identifying clients and engaging them in mental health or substance abuse treatment, as appropriate. Support to clients in the program shall be provided for up to two months after they are engaged in mental health or substance abuse treatment to allow for problem-solving and support retention in treatment.

*Indicators*

- ◆ *Ryan White providers bill Medicaid for clients with Medicaid coverage.*
- ◆ *Chart review documents that services are being provided in accordance with appropriate state rules and statutes.*
- ◆ *Charts for each individual contain a mental health assessment and current treatment plan.*
- ◆ *Clients are assessed using the OQ 45.*
- ◆ *Intake forms contain questions about sexual risk behavior. Charts document referral to HIV prevention services or onsite HIV prevention services as appropriate.*
- ◆ *Peer mentor clients shall be referred by a case manager or medical provider who has reason to believe the client has a mental health or substance abuse diagnosis.*
- ◆ *Each peer mentor client has a brief goal plan developed in conjunction with the client..*

**CARE COORDINATION:**

Services shall be coordinated with clients' primary medical providers.

*Indicator:*

- ◆ *Coordination and communication with primary medical provider shall be evident in the client's chart.*

## **PSYCHOSOCIAL SUPPORT SERVICES**

### **HRSA DEFINITION:**

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

### **TGA SERVICES PROVIDED:**

Services provided include opportunities to meet with other PLWH/A, receive information and health education, and create client support networks to improve clients' quality of life and ability to deal positively with issues of HIV disease. Psychosocial services must employ principles of harm reduction and motivational interviewing to assist clients' participation in healthy living and medical care. *From Guidance:* Programs shall facilitate entry into medical and social service delivery systems and address needs either directly or through collaboration with other Ryan White and mainstream social services. Services may include congregate meals.

### **STAFF**

#### **Staff Qualifications:**

Staff shall have documented training and/or experience in HIV/AIDS.

#### **Staff Training:**

- A. Staff must be trained to understand HIV/AIDS transmission and prevention.
- B. Staff should be trained in harm reduction and motivational interviewing.
- C. Staff shall have knowledge of HIV services.

Indicators:

- ◆ *Staff personnel records include documentation of training in HIV/AIDS transmission, harm reduction and motivational interviewing.*
- ◆ *Staff shall demonstrate knowledge of HIV services in supervision meetings.*

### **SERVICES STANDARDS:**

- A. Clients shall be PLWH who have advanced stage HIV disease, are experiencing acute changes in health, and/or have multiple diagnoses that necessitate additional support systems.
- B. Agency shall assess clients for support services needs, including support needs for adherence to antiretroviral treatment regimens, and develop an appropriate service plan for assessed needs.

- C. Agency shall provide referral to outreach, medical case management, mental health and substance abuse treatment.
- D. Agency shall provide emotional and social support services, including peer support, advocacy, informal counseling, linkage with medical case management, information and referral.
- E. Agency shall comply with federal requirements regarding use of Ryan White Part A funds for recreational and social activities for eligible individuals in adult and child day or respite care centers. Contract funds cannot be used for off-premise social/recreational activities.

*Indicators:*

- ◆ *Clients shall complete an assessment of need at intake.*
- ◆ *An appropriate service plan shall be developed for each client.*
- ◆ *Agency has established working relationships with agencies that provide outreach and advocacy, medical case management, mental health and substance abuse treatment.*
- ◆ *Information about other agencies is available to clients at the agency.*
- ◆ *Program schedule documents activities that provide support and education to PLWH/A.*

**CARE COORDINATION:**

At on-site programs, information about other services for PLWH is readily available. Care system staff serving PLWH/A are invited to provide services at the site and training and education programs are made available to clients.

*Indicators:*

- ◆ *Relevant health and services information is presented at the on-site programs.*

## **SUBSTANCE ABUSE SERVICES OUTPATIENT**

### **HRSA DEFINITION:**

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

### **TGA SERVICES PROVIDED:**

Substance abuse services include outpatient counseling to address substance abuse issues and provision of alcohol and drug-free housing to PLWH during substance abuse treatment. Services may also include a peer mentor program to support clients in substance abuse treatment

### **STAFF**

#### **Staff Qualifications:**

- A. Staff providing substance abuse treatment services must be certified Alcohol and Drug Counselors I, II, or III as outlined by the Oregon Administrative Rules or Chemical Dependency Specialists according to the Washington Administrative Code. An exception to this is made for staff providing peer mentor services, who must be Qualified Mental Health Associates per the Oregon Administrative Rules.
- B. Clinical staff shall be knowledgeable and experienced in working with people living with HIV/AIDS. All staff without direct experience with HIV/AIDS shall be supervised by experienced staff.

#### *Indicators:*

- ◆ *Appropriate licensure/certification is maintained.*
- ◆ *Personnel files/resumes/applications for employment reflect requisite experience.*
- ◆ *Staff without direct experience with HIV/AIDS are supervised by experienced staff*

#### **Staff Training:**

Providers shall maintain up-to-date knowledge of HIV/AIDS treatment and the possible effects of HIV/AIDS or its treatments on clients' health.

#### *Indicators:*

- ◆ *Documentation of successfully completed hours of job-related training for all providers.*

#### **Staff Supervision:**

- A. Supervision of Peer mentors (Qualified Mental Health Associates) must be twice monthly, at a minimum, by a person who is a certified Alcohol and Drug Counselor to review the services provided.

- B. Supervisor shall review a sample of each provider's charts regularly for completeness, compliance with standards, and quality of service delivery.

**SERVICES STANDARDS:**

- A. All substance abuse counseling shall be provided by a professional who is licensed or certified according to the state standards in which s/he provides services.
- B. Clients referred for assessment (and treatment) shall be seen for an assessment within five working days of referral.
- C. Each client admitted to the outpatient program must be assigned a primary counselor.
- D. Each client shall be given an individual evaluation for purposes of assessment and treatment planning. Evaluation shall include psychosocial evaluation, review of mental health history and any previous diagnoses, and referral to psychiatrist or psychiatric nurse practitioner, when indicated.
- E. Individual and group counseling for both substance abuse issues shall be available. The frequency and intensity of the counseling shall be determined by the initial assessment and by each client's individual needs and requests.
- F. Couples and/or family counseling shall be provided as needed and requested by clients.
- G. Alcohol and drug monitoring shall be provided, as indicated.
- H. Providers will have protocols for crisis intervention and referral to appropriate level of service.
- I. Client records must meet appropriate state standards for State of Oregon standards for Outpatient Alcohol and Drug treatment services as defined in OAR 415-51-000 through 415-51-120 and State of Washington standards as defined in WAC 388-805-325.
- J. Service provider shall collect risk behavior information at intake and make referrals to HIV prevention education as appropriate.

*Indicators:*

- ◆ *Current licenses/certificates shall be documented for all staff providing treatment.*
- ◆ *Providers will document their ability to schedule assessments within 5 days of a referral received.*
- ◆ *Client charts shall include the name of the primary substance abuse counselor.*

- ◆ *Client charts shall include an individual evaluation.*
- ◆ *Providers will provide documentation of their crisis intervention and referral protocols.*
- ◆ *Chart review shall indicate that client records meet appropriate state standards.*
- ◆ *Intake forms contain questions about sexual risk behavior. Charts document referral to HIV prevention services or onsite HIV prevention services as appropriate.*

**QUALITY MANAGEMENT:**

The agency shall monitor staff caseloads to ensure that high quality services can be uniformly provided.

*Indicators:*

- ◆ *Agency maintains records of staff caseloads.*

**CARE COORDINATION:**

Agencies will maintain communication with client's other primary care providers (medical and dental providers, and mental health counselor,) and HIV case manager.

*Indicator:*

- ◆ *Release(s) of information are current and allow communication between the substance abuse treatment provider, other primary care providers, HIV case manager and other appropriate service providers.*

## APPENDIX A – Medical case management Standards details

### **MEDICAL CASE MANAGEMENT**

#### **HRSA DEFINITION:**

Medical case management is a formal and professional service which helps to facilitate access to primary medical care, ancillary health and psychosocial services with the goal of improving health outcomes.

#### **TGA SERVICES PROVIDED:**

In the Portland TGA, medical case management services are offered in two tiers based on client need: service access and case management. Needs will be determined by client presentation, intake interview and use of the acuity measurement tool. In all settings the acuity score will determine the level of service provided to a client. Different levels of service may be provided by different staff members. For example, clients with less need will be provided a lower level of service and assigned to a service access specialist (SAS) for short-term assistance. Clients with greater need will be provided more intensive services and assigned to a case manager. The same staff member may provide both levels of service.

Service access will include:

- Access to information and referral and general information related to services linked to medical care.
- Support for clients to access and remain in healthcare, to access drug therapies and to improve their quality of life, specifically, assistance in obtaining and maintaining health insurance.
- Provide education to clients about services, health issues, medications and other topics, as needed.
- Culturally appropriate services, ensuring the availability of services for at-risk populations.
- Short-term problem-solving assistance.
- Development of an individualized service plan.
- Advocacy on behalf of the client.
- Reassessment, as necessary.

Case Management will include the above **plus**:

- Intake and assessment.
- Assignment to appropriate level of service, based on acuity measurement.
- Development of a comprehensive, individualized service plan for case management clients, in conjunction with the client.
- Coordination and linkage to services inside and outside the Ryan White system of care to implement the care plan.

- Follow up and monitoring of case management clients to assess the efficacy of the care plan.
- Re-evaluation and revision of the care plan, as necessary, at a minimum every 90 days.
- Annual Reassessment (more often as needed).

Nurse case management will include the above **plus**:

- Home visits.
- Medication Management.

**STAFF:**

**Staff Qualifications:**

Oregon

Service Access Specialist: Bachelor of Social Work, or other related health or human service degree from an accredited college or university and one year relevant HIV experience.

Case Manager\*: Masters of Social Work, or Masters level degree in other related health or human service from an accredited college or university and one year relevant HIV experience. Strong preference for LCSW;

**OR**

Bachelor of Social Work, or other related health or human service degree from an accredited college or university and a minimum of three years relevant HIV experience.

Nurse Case Manager: An RN (with BSN preferred), one year relevant HIV experience, and currently licensed in Oregon.

Washington

Master's degree in behavioral or health sciences (e.g. social work, clinical psychology, sociology, guidance counseling, nursing, public health) and one year of paid social service experience;

**OR**

Bachelor's degree in behavioral or health sciences and two years of paid social services experience;

**OR**

Bachelor's degree and three years of paid social services experience.

Exceptions can be made when service population is geographically or culturally isolated, or has limited English-speaking ability.

\*If Medicaid/Medicare systems change to allow billing for medical case management services, these qualifications may change.

*Indicator:*

- ◆ *Personnel files and staff resumes reflect requisite experience and education.*

**Training:**

All case managers must have a general knowledge of HIV/AIDS-related conditions and diseases. In addition, case managers shall maintain a comprehensive understanding of the treatment, financial, and support services available to meet the needs of persons living with HIV in the TGA.

A. All staff providing case management or service access services will receive orientation and training that covers the following topics (or have documented competency in these areas):

- Basic medical information about HIV/AIDS, including CDC classification and an overview of major illnesses associated with HIV/AIDS.
- Basic information on medications/treatments for HIV and adherence issues/strategies.
- The continuum of HIV/AIDS and mainstream resources relevant to the population.
- Personal safety issues: TB, HIV, Hepatitis infection precautions and management of potentially dangerous situations.
- Confidentiality issues and management.
- HIPAA training. (ok if repeated)
- Identification and management of culturally relevant issues.
- Understanding of motivational interviewing theory and practice and of harm reduction.
- Legal requirements for potential child or elder abuse or neglect and how to report incidents.
- Knowledge of resources for home health care and long term care.
- A basic understanding of benefits programs including SSA, state disability programs, ADAP (CAREAssist), and medical/insurance benefits programs.
- Knowledge of safer sex and risk reduction practices and appropriate referral resources.

B. HIV/AIDS case managers shall complete TGA specific designated on-going training, when offered.

*Indicators:*

- ◆ *Personnel files document HIPAA training for all staff.*
- ◆ *Personnel files document completion of staff orientation and training or documented competency on all topics listed above.*

**Staff Supervision:**

Supervisor Qualifications:

- A. Masters of Social Work or equivalent, LCSW highly preferred.
- B. Staff supervisor must meet case manager qualifications and have three years of paid social service experience, including two years supervisory experience.
- C. In Washington, if supervisors carry medical case management workloads, the span of control shall allow for supervisory and medical case management duties to be performed within Title XIX standards.

Supervision Activities:

- A. Maintain regular contact with staff and site teams (if applicable); meet with individual staff and with the medical case management team a minimum of once per month.
- B. Review a sample of client's care and case records with staff to determine effectiveness of actions taken, as well as accuracy and completeness of records, at least once every 90 days.
- C. Provide and arrange field and formal training for case managers.
- G. Provide and arrange for appropriate staff case consultation. Includes consultations by other professionals, as needed.
- H. Conduct a formal evaluation of each staff person. For new employees an evaluation will be completed at six months and at one year, and yearly from that point forward. For established staff, evaluation will be at least once a year.

*Indicators:*

- ◆ *Personnel files document completed annual employee evaluations and new employee evaluation after six months.*
- ◆ *There is documentation of supervisory review of case records every 90 days.*

**SERVICES STANDARDS:**

**A. Intake:**

Each prospective client who is referred to or who requests medical case management services will be properly screened and evaluated through a brief face-to-face intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs. Intake shall be scheduled within two weeks from time of first request and shall be prioritized by clients' identified problems.

Client charts shall include:

1. Name, address, mailing address (if different), phone, and message phone
2. Permission to be contacted by mail
3. Location where client prefers/declines to be contacted

4. Emergency contact information
5. Age/Date of Birth
6. Gender
7. Racial and/or ethnic identification
8. Documentation of HIV status (verified within 30 days, see clarification below)\*
9. Primary Care Physician/clinic/address/phone
10. Other health care providers (past and present), address, phone
11. Release of Information
12. Documentation of financial information/verification/proof of income
13. Documentation of health insurance (if applicable)
14. Date/source of referral, date of intake
15. Photo ID (if available)
16. Social Security Number (if available)
17. Signed Client Rights and Responsibility
18. Signed Informed Consent
19. Signed Client grievance procedures
20. In Washington - Documentation showing that the client is voluntarily requesting and receiving HIV/AIDS medical case management services shall be maintained in the client's case record.

*Indicator:*

- ◆ *All elements of intake listed shall be documented in the client record.*

**B. Assessment:**

Each client of medical case management services will participate in at least one (1) face-to-face interview to assess their medical and psychosocial needs on an

---

\*Client self report of HIV status is documented at intake. Within **30** working days from the date of Intake, verification of HIV status **must** be obtained. Acceptable verification includes at least one of the following:

- 1) A copy of the client's seropositive test results from the test provider.
- 2) A signed document from a physician or his/her designee, verifying that the client is HIV positive.
- 3) Lab results at any time during the client's lifetime that show the presence of the human immunodeficiency virus.
- 4) Written verification from another case manager or provider who has one of the above documents in the client's file.

Exemption from the requirement to secure verification of HIV status is granted when a person who is affected, but not infected, is determined to be appropriate for case management services. However, as per HRSA guidelines, **if case management services are provided to a client who is affected, but not infected, there must be clear rationale documented in the client file that the services offered will directly benefit a person living with HIV/AIDS.** Specifically, the rationale will address one or more of the following:

- 1) How the delivery of case management services to the affected client will allow him/her to participate in the care of someone with HIV disease or AIDS.
- 2) How case management of the affected client will enable an infected individual to receive needed medical, support or housing-related services by removing identified barriers to care.
- 3) How case management of the affected client will promote family stability in coping with the unique challenges posed by HIV/AIDS

annual basis. The assessment should commence no later than two (2) working days following intake and should be completed within two (2) weeks from commencement. However, there may be factors which require a longer period of time to begin and complete the assessment and these should be documented in the client record. In addition to providing services at the agency sites, if a case manager finds it in the best interest of the client, s/he shall schedule client visits at a provider's office or clinic, in the client's home, or at another mutually agreed upon location.

The assessment will include information on the client's presenting needs, psychosocial and medical status, ability to perform activities of daily living, support system, legal information and/or history, risk assessment, available resources, and any projected barriers to services. The comprehensive assessment will result in the creation of the care plan.

**C. Acuity Scale:**

Based on the assessment, the client's level of service needs will be assigned based on the System Acuity Measurement (SAM) acuity scale. The acuity scale levels of medical case management are as follows:

14-28	Service Access: Client needs access to information and possibly initial referral to service(s) if needed. Client may need education about services, health issues, medications and other topics, provided as appropriate. Individualized service plan is developed for outlining the steps necessary to secure needed services.
29-45+	Case Management: Client needs on-going referrals and case manager follow-up; a care plan will be developed with all case management clients. Case manager involvement will be determined by acuity score and client need. Contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individualized service plan. <u>Minimum</u> contact every 90 days, (telephone or face-to-face) including evaluation of goals, activities and outcomes.

If client's needs change, they will be reassessed and assigned to the appropriate service level.

*Indicators:*

- ◆ *Acuity scale has been used and client's current score is documented, with date, in client chart.*
- ◆ *Reassessments, in accordance with the acuity level, are documented, with date, in client charts.*

#### **D. Care Planning:**

##### **Service Access:**

Clients who are assessed as needing service access will have their needs and services provided documented in client charts. Charts may contain a specific task list outlining the steps necessary to secure needed services and resolve short-term issues. The task list should include identification of the issue and who has responsibility (client or SAS) for the steps necessary to resolve the issue. If created, this task list will be appropriately documented in the client record. The SAS and client will work together as needed for the successful completion of the task/issues identified.

##### **Case Management:**

Clients in Case Management will work with their case manager to develop an individualized service plan within two days of the completion of the comprehensive assessment. If this is not possible, the case manager shall document the reason(s) for the delay. The care plan will identify client needs for accessing and maintaining medical care, and may address other unmet needs as they relate to accessing health care. The service plan will identify the resources needed to assist in meeting the client's needs. The planning process includes the development of goals, assigned activities (client or CM) and reporting on outcomes. Once developed, the client and the case manager will sign the service plan and the client will be given a copy. Appropriate documentation of goals, assigned activities and the outcomes of each will be included in the client's file (paper or electronic).

Any referrals should be appropriately documented in the client record, and the case manager will follow up with the client or the referral source to determine if referrals are successful. If not successful, the service plan shall be revised. The care plans will be reviewed at least every 90 days.

If a housing plan for the client has been created by the appropriate agency or staff, a copy of that plan will be included in each client's file, and the goals and objectives identified in that plan should be supported in the case management care planning process.

In all situations, an appropriate and current release of information (ROI) for referrals will be maintained.

##### *Indicators:*

- ◆ *There shall be documentation of needs discussed, and services provided in service access client files.*
- ◆ *There shall be a signed copy of the service plan and complete documentation of care planning and evaluation of the goals in case management client files.*
- ◆ *Housing plans are included in the charts of all clients with housing needs.*
- ◆ *All referrals are appropriately documented.*
- ◆ *ROIs for all referrals are current.*

- ◆ *Charts contain documentation of re-evaluation of the service plan at appropriate intervals, at least every 90 days.*

#### **E. Reassessment:**

1. Reassessment shall occur at least annually or as needed. The following information should be documented as part of the overall reassessment:
  - updated demographic data,
  - updated assessment data,
  - updated goals and activities reflecting the above input and review.
2. For service access clients, reassessment will occur if and when the client identifies a significant change or life event. At that time, a new acuity score will be calculated, and, if necessary, the client will be moved to the appropriate level of service.
3. For case management clients, reassessment should naturally occur with the review of the care plan, and/or in the event of significant changes in the client's life. A new acuity score will be calculated, and, if necessary, the client will be moved to the appropriate level of service.

#### *Indicator:*

- ◆ *All reassessments and updated acuity scores are documented in the client record.*

#### **F. Caseloads:**

1. Recommended caseload size for full time provider:
  - Service access only: 150-175 clients
  - Case management only: 50-60 clients
  - Nurse case management only: 30-35 clients
  - Blended caseload (case management and service access): 75-85 clients
2. All providers are using common service unit definitions as below:

#### **Contact Types:**

Face to Face: Any time the case manager meets directly with the client or his/her representative\*

Telephone: Any telephone encounter the case manager has with the client or his/her representative\*.

On Behalf of: Any contact the case manager makes on behalf of the client.

\*A representative is a spouse, partner, family member or Designated Power of Attorney (DPOA) representing a client who is too sick to meet or talk with the

case manager directly. The reason for meeting with the representative instead of the client must be documented in the client's chart.

**Unit of Service:**

Services will be documented in units of fifteen (15) minutes (includes time required by the case manager for documentation, consultation, and/or travel.)

*Indicator:*

- ◆ *Agencies will have caseloads within recommended range and be able to demonstrate staff to client ratio including information on case acuity.*
- ◆ *Client contacts will be documented in the client record, identifying the mode of contact and issues addressed.*

**G. Transfer and Discharge:**

A systematic process shall be in place to guide transfer of the client to another program, to another staff member, and/or to discharge from case management services. The process includes clear documentation of the reason(s) for transfer, discharge, notifying the client of case closure and the appeals process.

A client may be discharged from the case management system or transferred to another service provider in the following conditions:

1. Death of the client.
2. The client and/or the client's legal guardian requests that the case be closed.
3. Client makes fraudulent claims about their HIV diagnosis or falsifies documentation.
4. Client enters prison.
5. Client moves into a system of care that offers case management.
6. Client moves out of the geographic area.
7. Client becomes self-sufficient.
8. Client is unwilling to participate in care planning.
9. Client exhibits a pattern of abuse of agency staff, property or services.
10. Client needs are more appropriately addressed in other programs.
11. Client no longer meets eligibility requirements.
12. Client is "lost to follow-up":

For service access clients: if there has been no contact from the client for 6 months, a file may be inactivated without notifying the client. Any future service request initiated by the client would reactivate the file providing the client meets any eligibility standards in place at the time of the request.

For case management clients: a case may be closed if the chart contains documentation of a minimum of 3 good faith attempts within a six (6) month period to contact the client, with no response. Contact may be attempted through phone, letter, provider contacts, or home visits. After the three attempts, a letter indicating a change to inactive

status should be mailed to last known address. The letter should state that the client may reactivate their status at any time by contacting the program (providing eligibility criteria are met).

A discharge summary, including complete documentation of reason(s) for discharge, and a service transition plan as appropriate, shall be included in the client's record.

*Indicator:*

- ◆ *Eligibility criteria are followed, and those no longer meeting the criteria are discontinued.*
- ◆ *Discharge summary with complete documentation of reason for discharge is included in client file.*

For more information or copies of these standards, please contact:

Margy Robinson, MPH

Phone: (503) 988-3030 x 25681

Fax: (503) 988-3035

Email: [margaret.l.robinson@co.multnomah.or.us](mailto:margaret.l.robinson@co.multnomah.or.us)