

Introduction

The AIDS Institute has developed standards by which contractor program performance will be measured. The enclosed workplan is based upon those standards. The standards have been updated to reflect changing models based on recommendations from the Centers for Disease Control and Prevention (CDC), Provider Quality Committee meetings and other public health entities.

The AIDS Institute developed these standards to provide guidance on what is expected of contractors. Moreover, the standards promote program models that are flexible to meet the needs of targeted populations; they encourage models that are dynamic and provide comprehensive and integrated HIV prevention and care services.

The Primary Care Section asks its contractors to view these standards as tools for quality management of HIV programming and service coordination. The standards also encourage the Primary Care Section and contract agencies to develop a common language for effective contract administration.

The expectation is that contractors will meet all workplan standards. Grant funded agencies must agree to ensure that they will have the capacity to meet the standards as put forth in the workplan. The workplan also requires that agencies provide projections of standard-related activity levels.

We are stressing the need for thorough, ongoing outcome evaluation of each component of your HIV program. We require ongoing and meaningful participation by consumers in program evaluation through the use of consumer boards, client or consumer satisfaction surveys, focus groups and through inclusion in quality improvement activities wherever possible. Program evaluations must measure the effectiveness of funded services. If needed, we will work with you to access additional training on evaluation techniques.

Reporting and data collection requirements have increased as the AIDS Institute is being held to higher standards of accountability by Federal and State governments. Therefore, adequate resources must be allocated for data entry, data collection and reporting. The requirements of the AIDS Institute for data are extensive and, therefore, positions dedicated to support data collection for the HIV program are justifiable as part of your personnel expenses. Agencies must ensure that AIRS accurately reflects program activity levels.

When preparing the budget for this contract period, we want to stress that budgets, in general, should support positions that are not reimbursable under Medicaid, ADAP or other third-party payers. Throughout the year we will be requesting reports, plans and policies/procedures that are requirements of workplan standards. It is expected that each document is reviewed and revised at least annually and reflects current practices of the HIV program at your agency. Contract managers are available for assistance in reviewing a draft or beginning work on required plans.

On-site evaluations, such as site visits and comprehensive program monitorings, monthly reports, quality results and voucher review are the instruments used by the Primary Care Section to ensure that workplan performance standards are being met. Technical assistance is available from the Primary Care Section and other AIDS Institute staff to support providers' efforts to meet performance standards. We encourage you to speak with your contract manager about your agency's technical assistance needs.

Introduction - RW

The AIDS Institute has developed standards by which contractor program performance will be measured. The enclosed workplan is based upon those standards. The standards have been updated to reflect changing models based on recommendations from Health Resources Services Administration (HRSA), Provider Quality Committee meetings and other public health entities.

The Primary Care Section expects its contractors to view these standards as tools for quality management of HIV programming and service coordination. The standards also encourage the Primary Care Section and contract agencies to develop a common language for effective contract administration.

The expectation is that contractors will meet all workplan standards. Grant funded agencies must agree to ensure that they will have the capacity to meet the standards as put forth in the workplan. The workplan also requires that agencies provide projections of standard-related activity levels.

We are stressing the need for thorough, ongoing outcome evaluation of each component of your HIV program. We require ongoing and meaningful participation by consumers in program evaluation through the use of consumer boards, client or consumer satisfaction surveys, focus groups and through inclusion in quality improvement activities wherever possible. Program evaluations must measure the effectiveness of funded services and should focus on clinical outcomes for HIV-infected patients. If needed, we will work with you to access additional training on evaluation techniques.

The reauthorized Ryan White HIV/AIDS Treatment Modernization Act (RWHATMA) has "medicalized" Ryan White services. The law limits the services that are allowable under Ryan White and the persons eligible for services. The AIDS Institute has been advised by HRSA that we must comply with all RWHATMA requirements immediately. Specifically, we must ensure that all funded services are either "core" medical services, or support services that are required to achieve medical outcomes associated with the HIV-related clinical status of persons with HIV/AIDS.

When preparing the budget for this contract period, we want to stress that budgets should support positions that are not reimbursable under Medicaid, ADAP or other third-party payers. Throughout the year we will be requesting reports, plans and policies/procedures that are requirements of workplan standards. It is expected that each document is reviewed and revised at least annually and reflects current practices of the HIV program at your agency. Contract managers are available for assistance in reviewing a draft or beginning work on required plans.

In order to ensure that Ryan White funds are payer of last resort, contractors must screen clients for eligibility to receive services through other programs (e.g., Medicaid, Medicare, VA benefits, private health insurance), periodically reassess client eligibility for Ryan White services, and document client eligibility. Contractors must have policies and procedures in place addressing these screening requirements. Contract managers will review these policies and procedures as well as documentation of screening activities and client eligibility during contract monitoring.

On-site evaluations, such as site visits and comprehensive program monitorings, monthly reports, quality results and voucher review are the instruments used by the Primary Care Section to ensure that workplan performance standards are being met. Technical assistance is available from the Primary Care Section and other AIDS Institute staff to support providers' efforts to meet performance standards. We encourage you to speak with your contract manager about your agency's technical assistance needs.

Reporting and data collection requirements have increased as the AIDS Institute is being held to higher standards of accountability by Federal and State governments. Therefore adequate resources must be allocated for data entry, data collection and reporting. The requirements of the AIDS Institute for data are extensive and, therefore, positions dedicated to support data collection for the HIV program are justifiable as part of your personnel expenses. Agencies must ensure that AIRS accurately reflects program activity levels. For that reason, we are stressing the need for adequate staffing to support data collection and reporting. Contractors can use Ryan White funds to meet reporting requirements.

Program Administration

An HIV program administrative structure is in place to ensure that the program is organized equipped and staffed to fulfill the scope of services and meet patient care needs.

Agency administrative commitment is adequate to support the HIV program. The HIV program director and executive staff conduct formal and routine meetings.

Executive staff are familiar with workplan standards and actively support program efforts to achieve program goals and objectives.

Agency administration shares workplan standards and progress in meeting those standards with the Board of Directors, County Commissioner or Hospital Administration.

Executive staff participate in site monitoring reviews.

Agency administration pursues HIV funding opportunities to ensure sustained support for existing and newly identified needs.

The organization has established and implemented policies and procedures for all components of the HIV program. Policies and procedures are reviewed no less than annually and updated, with dates of revision and administrative sign-off.

The agency promotes and markets the full spectrum of available HIV services. Methods of promotion and marketing include:

- ◆ Use of written materials and other forms of media
- ◆ Participation in regional Ryan White CARE network activities and other community planning body activities
- ◆ Regular contact with informal and formal community leaders
- ◆ Linkages with agencies providing HIV services, working with high risk and/or persons with HIV

Agency administration ensures that a process is in place to review educational materials developed in-house or purchased/obtained from outside sources per AIDS Institute requirements.

Comprehensive personnel policies and procedures are in place.

Systems are in place to minimize staff vacancies, including reducing staff turnover and expediting recruitment.

The agency has policies to ensure hiring of staff that represents the community being served, both culturally and linguistically.

The agency assesses the need for training and ensures that staff receives ongoing training and updates on HIV related issues.

Job descriptions are available for all positions and are accessible to all employees.

Timely staff performance evaluations are conducted with supervisory input.

Administration ensures that all staff is familiar with workplan standards that pertain to their duties and responsibilities.

Personnel files are in place that includes all transactions regarding grant-funded employees and position information. Individual personnel files include:

- ◆ Copy of licenses
- ◆ Signed HIV confidentiality statement
- ◆ Documentation of annual HIV confidentially training
- ◆ Certificates of training and/or proof of attendance
- ◆ Employee resume and job description
- ◆ Annual performance evaluation

A system is in place to promote the efficient and effective expenditure of grant funds.

- ◆ Program and fiscal staff regularly and systematically review the status of grant spending.
- ◆ The HIV program director and fiscal staff are responsible for timely submission of vouchers to the AIDS Institute.
- ◆ Internal controls allow program and fiscal staff to identify the need for budget modifications throughout the year and to process them in a timely manner. Final budget modifications must be submitted at least 30 days prior to the end of the contract period.
- ◆ Both HIV program and fiscal staff maintain copies of all vouchers and budget modifications.
- ◆ Budget allocations are reviewed regularly to ensure that they are consistent with program needs and activities, and workplan standards.
- ◆ An annual review identifies which HIV program costs are most appropriately budgeted to grants and which should be supported through third party revenue and agency “in kind” contributions.

A system is in place for maximizing third party revenue.

- ◆ The agency participates in the HIV Primary Care Medicaid Program.
- ◆ Systems are in place to review eligibility and enroll/dis-enroll clients in Medicaid/ADAP.
- ◆ The agency periodically reviews the billable encounter reporting system to ensure that it includes and correctly codes all billable services.
- ◆ Periodic training is provided for medical, program and support staff on appropriate coding, and completion of encounter forms.
- ◆ A system exists for ensuring that the agency is accurately and reliably billing Medicaid and ADAP through the enhanced HIV rate structure, as well as private insurers, for HIV related services.
- ◆ A quality review process exists to ensure integration between fiscal, management information systems, and program operations. At a minimum, this will consist of routine formal meetings between fiscal and program staff to review third party revenue generated as a result of program services.
- ◆ Feedback on third party revenue reimbursement provided by the AIDS Institute is shared with all staff involved in maximizing third party revenue.

All third party revenue generated through grant-funded activities is directed toward enhancing the HIV program.

- ◆ An accounting system identifies revenue generated through grant-funded HIV services.
- ◆ A budgeting system ensures the allocation of this revenue to HIV program- related expenses.
- ◆ Allocation of third party revenue is reported to the AIDS Institute on an annual basis.

Data Collection and Reporting

In order to accurately report contract deliverables and other relevant data through the AIDS Institute Reporting System (AIRS), adequate staff resources, policies, procedures, and systems exist which include:

- ◆ System administration
- ◆ Staff training
- ◆ Complete and timely data collection and input
- ◆ Report and extract generation and timely submission
- ◆ Security and confidentiality
- ◆ Quality control
- ◆ Technical support

Monthly Reports consisting of the following components are due by the 30th of the following month:

- ◆ Hard copies of AIRS aggregate reports and manual reports must be submitted to the AIDS Institute contract manager, if required.
- ◆ AIDS Institute extracts (generated in AIRS) must be submitted either by e-mail or zip drive to the AIDS Institute's Information Systems Office.
- ◆ Monthly narrative reports must be submitted to the Contract Manager. Narratives should include:
 - Significant program highlights
 - Data reporting issues
 - Fiscal issues
 - HIV Program quality improvement activities during the month
 - Staff changes during the month
 - Update on the educational materials review process
 - Update on applications for new HIV grant funds

Prior to purchasing computer equipment with grant funds, the agency must submit a completed "Checklist for Agency Proposed Computer Purchases" along with a copy of the vendor's specifications and price quote for the proposed equipment. All new computers purchased with grant funds must meet the AIDS Institute's minimum standards for AIRS reporting. Up-to-date standards may be found on the AIDS Institute's AIRS website: www.AIRSNY.org under the "about AIRS" tab.

The agency must have an effective back-up staffing plan in place to ensure uninterrupted AIRS data collection, entry, and reporting in the event of staff absences or vacancies.

Any agency staff using AIRS must receive the appropriate AIRS training from Defran (the AIDS Institute's AIRS vendor) or from authorized AIDS Institute Office of Systems Development (OSD) staff.

For all agencies receiving Ryan White funds, submission of Ryan White CARE Act Program Data Report (PDR) is completed electronically on an annual basis and includes all Ryan White eligible activities.

All agencies that provide grant-funded HIV clinical care must participate in the HIVQUAL Project, and meet the submission requirements of the Office of the Medical Director. A copy of each annual HIVQUAL report to the AIDS Institute is also submitted to the Primary Care Section Contract Manager.

Failure to meet reporting requirements will result in withholding of payment on contract vouchers.

Communication with Agency Boards of Directors, County Commissioners and Hospital Administration

The governing body of the agency (Board of Directors, County Health Commissioner, or hospital administration) receives timely and regular updates on the status of the grant-funded HIV program.

- ◆ Governing body members are provided with information related to service activity levels, staffing, fiscal issues, site visit findings, quality review results, and significant issues affecting the agency's ability to meet program standards.
- ◆ Governing body receives regular feedback from consumers and formally responds to consumer input.
- ◆ Governing body members are informed of upcoming AIDS Institute site visits, given the opportunity to participate, and receive copies of site visit reports.
- ◆ A Board representative is available for meeting with AIDS Institute staff when requested.
- ◆ Board members are reflective of communities most impacted by the epidemic.

Each member of a community-based agency's Board of Directors is provided with current information on available Board training offered by the New York State Department of Health through the State Board Training Consortium.

Culturally and Linguistically Appropriate Services¹

The HIV program ensures that patients/consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language. Services are responsive to the needs of gay, lesbian, bisexual and transgender populations, deaf and hard of hearing, racial and ethnic minorities, and individuals with diverse religious beliefs and practices.

The HIV program implements strategies to recruit, retain and promote at all levels of the program a staff and leadership that are representative of the demographic characteristics of the service area.

The agency ensures that staff at all levels of the HIV program and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

The agency offers and provides language assistance services, including bilingual staff, interpreter services, and access to language phone lines, at no cost to patients/consumers with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.

Family and friends are not used to provide interpretation services except on request by the patient/consumer.

The HIV program makes available easily understood patient-related materials and posts signage in the languages of the commonly encountered groups and or groups represented in the service area.²

The HIV program maintains a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

¹ These standards are adapted from the HRSA Office of Minority Health CLAS Standards

² All materials should be reviewed through the materials preview process required by the AIDS Institute

Consumer Involvement

A written plan is in place to ensure active consumer involvement in the continuous development and improvement of the HIV/AIDS program through advisory groups, focus groups, consumer satisfaction surveys and other mechanisms.

- ◆ Consumer input is used for program evaluation, and to modify the program to meet changing needs of consumers.
- ◆ The plan includes strategies to ensure ongoing and meaningful participation of clients in the development and improvement of the HIV/AIDS program.
- ◆ Staff at all levels, receive training on consumer involvement and strategies to encourage and support meaningful consumer participation.
- ◆ A Consumer Advisory Board (CAB) for the HIV/AIDS program has been established and meets preferably monthly but at least quarterly. Minutes are documented for all meetings.
- ◆ The majority of the CAB or focus group is composed of consumers who are receiving services from the HIV program.
- ◆ The CAB or focus group reflects the diversity of the client population of the program.
- ◆ The CAB reports on the progress of the HIV program to the program director and to the Board of Directors.
- ◆ Focus groups, consumer satisfaction surveys and the consumer advisory committees have sufficient participation by consumers (the agency has a target of at least 8 consumers for the CAB, 8 for focus groups, and 33 - 50% of consumers for client satisfaction surveys, based on caseload).
- ◆ Results of surveys and recommendations for improvements and changes to the HIV program by the CAB or focus groups are submitted to the HIV program director and to agency administration.
- ◆ Agency administration's response to the results/recommendations from the CAB is documented and provided to staff, CAB, and other consumers.
- ◆ Changes in the program that result from consumer input are formally documented and publicized.
- ◆ Staff is encouraged to develop innovative strategies to engage consumers and solicit their feedback.
- ◆ Consumers are actively involved in the materials review process as required by the AIDS Institute.
- ◆ Consumers participate in the Quality Improvement Program and their input is an integral part of ongoing performance improvement activities.
- ◆ The hiring of consumers with minimum and preferred qualifications for vacant positions is encouraged.
- ◆ Consumer Involvement plans are reviewed and updated at least annually.

Consumers are informed of and encouraged to participate actively in city/county/regional/ statewide AIDS planning groups.

- ◆ The agency encourages client involvement in planning groups.
- ◆ Consumers are informed of opportunities for orientation and training for active participation in planning groups, such as the AIDS Institute-sponsored Leadership Training Institute (LTI).
- ◆ Consumers are encouraged to participate in RFP/RFA reviews.

The agency fosters consumer participation in AIDS conferences and other related meetings outside the agency.

- ◆ Consumers are encouraged to apply for scholarships or agency aid to attend relevant area, statewide or national conferences. Contract manager approval must be obtained for out-of-state travel using grant funds.
- ◆ Consumers are kept informed of internal and external opportunities for conferences and related meetings through publicly posted information and via staff and agency communications.

Quality Improvement

A formal quality of care program that embraces quality improvement (QI) philosophy is developed and implemented as part of the HIV service delivery program. The agency's HIV quality improvement program includes the following components.

- ◆ The infrastructure of the quality program is fully described in the quality plan, with a clear indication of responsibilities and accountability, and elaboration of processes for ongoing evaluation and assessment.
- ◆ Staff are actively involved in the HIV Quality Program, including QI activities. Participation in the quality program is part of job expectations. Provisions are made for orientation to and ongoing education of staff about quality improvement.
- ◆ Quality improvement activities are conducted as an interdisciplinary effort.
- ◆ Performance measurement includes clearly defined indicators that address clinical, case management, behavior change and other services as prioritized by the program. A plan for follow-up of results is outlined in the plan. Quality outcomes are routinely communicated to program, administration, and consumers.
- ◆ QI activities are based on performance reviews and data results. Specific QI projects are undertaken which include action steps and a mechanism for integrating change into routine activities.
- ◆ Short-term PDSA (Plan, Do, Study, Act) activities specifically aimed at evaluating and improving HIV program services are implemented.
- ◆ Consumers actively participate in quality-related activities.
- ◆ The HIV Quality Improvement Program is part of the overall agency's quality improvement activities.
- ◆ The HIV Quality Improvement Program integrates principles of patient self-management and decision support as described in the HIV/AIDS program of the Institute for Healthcare Improvement website (<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/HowToImprove/>).
- ◆ Agencies providing grant-funded HIV Clinical care collect data through HIVQUAL and participate in HIVQUAL Workshops and Learning Networks provided by the AIDS Institute.

Quality Improvement plans are updated and submitted at least annually to the Primary Care Section.

The Quality Program routinely assesses continuity of care for clients on the primary care caseload. This includes a review of clients that meet eligible caseload requirements, (at least 2 visits within the last 12 months, and at least one of those in the last 6 months during the calendar year). The standard for eligible caseload is currently being reviewed and may be amended during the contract year. It is the expectation that providers are aware of changes in eligible caseload requirements.

Health Behavior Change

Health Behavioral Change services are individualized and tailored to the client's capacity to initiate or sustain practices that reduce or prevent HIV and Sexually Transmitted Infection (STI) acquisition, transmission or re-infection.

A system exists to provide accessible, client-centered and evidence-based services for high risk persons and persons infected with HIV. These systems will be developed by implementation of DEBI's, Motivational Interviewing techniques and other behavioral science-based interventions. These protocols are divided between Prevention with Positives and High Risk individuals.

Health Behavior Change for High Risk Individuals

- ◆ Tailored HIV prevention interventions, using a risk-reduction approach should be delivered to patients at highest risk for acquiring HIV.
- ◆ After initial prevention messages are delivered, subsequent longer or more intensive interventions should be delivered if feasible.
- ◆ Individual and group level interventions will be used to target at risk individuals, using Behavioral/Science based interventions as appropriate.
- ◆ A tool to assist in ongoing assessments of each client's ability and readiness to integrate and incorporate behavior change strategies exist. Included, as a minimum, in the assessment are:
 - Strengths clients bring to the process
 - Health status
 - Sexual history, including sexual orientation, use of the internet in finding partners, STIs, trauma, etc.
 - Substance use history and associated risk behaviors
 - Client readiness to enter into recovery through drug or alcohol treatment or other means
 - Mental health history and mental status
 - Readiness to think about and act on changing behaviors
 - Current level of motivation to address specific sexual or drug-using behaviors
 - Specific goal-oriented and harm reduction strategies
 - Barriers and/or adverse consequences to safer behaviors, e.g., domestic violence

Health Behavior Change for HIV Infected Individuals:

- ◆ Systems for identifying and referring individuals who need or request risk/harm reduction services currently exist. These protocols should include screening for behaviors associated with HIV transmission at the initial and subsequent routine visits, as the clinician feels necessary, but annually at a minimum. Any indication of risk associated with transmission should prompt a more thorough assessment of HIV transmission risks and referral to more intensive HIV behavioral change interventions.
- ◆ Brief, general HIV prevention messages should be regularly provided to HIV infected patients at each visit, or periodically, as determined by the clinician and at a minimum of twice yearly. These messages should emphasize the need for behavior change regardless of perceived risk. Messages should be tailored to meet the patient's needs and circumstances.
 - Clinicians incorporate risk/harm reduction and behavior change strategies into routine clinical encounters with HIV-infected persons.
 - Behavioral science based interventions and DEBI's are implemented as appropriate.

- Tailored HIV prevention interventions using a risk reduction approach should be delivered to patients at highest risk for transmitting HIV.
- Post-test counseling, for the purpose of risk reduction, behavior change and partner counseling and referral services should be conducted annually, documented, and billed if appropriate for all HIV-infected patients.
- HIV infected patients should be referred to appropriate services that cannot be adequately addressed during the clinic visit.
- ◆ An updated referral list of agencies offering additional risk/harm reduction services in the community, including prevention case management, drug treatment, recovery readiness, and syringe exchange are available for program and clinical staff.
- ◆ A tool to assist in ongoing assessments of each client's ability and readiness to integrate and incorporate behavior change strategies exist. Included, as a minimum, in the assessment are:
 - Strengths clients bring to the process
 - Health status
 - Sexual history, including sexual orientation, use of the internet in finding partners, STIs, trauma, etc.
 - Substance use history and associated risk behaviors
 - Client readiness to enter into recovery through drug or alcohol treatment or other means
 - Mental health history and mental status
 - Readiness to think about and act on changing behaviors
 - Current level of motivation to address specific sexual or drug-using behaviors
 - Specific goal-oriented and harm reduction strategies
 - Barriers and/or adverse consequences to safer behaviors, e.g., domestic violence

HIV-infected clients are educated about confidential voluntary partner counseling and referral services for sex and needle sharing partners who may have been exposed to HIV. Such education includes the following elements:

- ◆ The importance of partner assistance services and related legal requirements.
- ◆ An explanation as to the available partner assistance options and a discussion about option(s) that best serve the needs of the client is provided. The options may include:
 - Referral systems to Partner Counseling and Referral Services (PCRS)
 - Staff- supported assistance
 - Peer-supported assistance
 - Coaching regarding self-disclosure
- ◆ At the initial visit, patients should be asked if all of their sex and needle-sharing partners have been informed of their exposure to HIV.
- ◆ At routine follow-up visits, patients should be asked if they have had any new sex or needle-sharing partners who have not been informed of their exposure to HIV.

Potential barriers to immediate assistance are assessed.

- ◆ A domestic violence protocol has been developed and is updated annually in accordance with partner notification laws.
- ◆ A domestic violence screening tool is made available to staff.
- ◆ Staff is trained on how to identify potential for domestic violence, the agency's protocol, and the use of the agency's domestic violence screening-assessment tool.
- ◆ Staff explore with clients any other concerns or potential barriers to partner notification.

Partner counseling and referrals services are integrated across the continuum of care.

- ◆ The entire care team is involved in educating and supporting the clients' disclosure to their partners.
- ◆ The care team is aware of other options for informing partners (Article 27F).
- ◆ Adequate space is available to ensure confidentiality during partner assistance counseling.
- ◆ Staff are trained through linkages with City and County notification services on how to provide partner assistance and referral services.

Partners of HIV + clients who seek services are provided with:

- ◆ HIV/AIDS education
- ◆ Information on the benefits of knowing one's sero-status
- ◆ Risk reduction strategies
- ◆ Referrals as needed
- ◆ HIV counseling and testing

Partner counseling and referral services are documented in client records.

Staff providing risk/harm reduction services receive adequate and ongoing training on current behavioral science based models, addressing sexual, and drug using behaviors.

A process exists to evaluate the delivery of risk/harm reduction services.

- ◆ Mechanisms to assure the quality of risk/harm reduction services include:
 - Supervision of staff
 - Chart review to ensure clear documentation of assessments and interventions
 - Multi-disciplinary case conferencing
 - Methods for obtaining client feedback (e.g., advisory communities, satisfaction surveys, interviews and focus groups)
 - The program conducts quantitative and qualitative evaluations of risk/harm reduction services.

Data is collected on Health Behavior Change and Partner Counseling and Referral activities.

- ◆ Health Behavior change activities and partner counseling and referral activities are entered into AIRS and are reported manually to the AIDS Institute monthly, as required.

Client level data will be collected on Health Behavior Change activities including:

- ◆ Interventions Delivered to Individuals (IDI) and Interventions Delivered to Groups (IDG)
- ◆ Single session structured session
- ◆ Multiple session structured sessions
- ◆ Individual/Group level risk-reduction counseling
- ◆ Peer training service
- ◆ Partner assistance and referral activities

Partner counseling and referral activities are used in planning and monitoring progress in meeting program objectives.

Complete the following services projections.

Health Behavior Change (includes risk/harm reduction and prevention w/positives & high-risk negatives)	
# Clients (unduplicated) receiving Interventions Delivered to Individuals (IDI) during the contract period.	
# Interventions Delivered to Individuals (IDI) conducted during the contract period.	
# Clients (unduplicated) participating in Interventions Delivered to Groups (IDG) during the contract period.	
# Interventions Delivered to Groups (IDG) conducted during the contract period.	

Health Behavior Change - RW

Health Behavioral Change services are individualized and tailored to the client's capacity to initiate or sustain practices that reduce or prevent HIV re-infection and Sexually Transmitted Infection (STI) acquisition, or re-infection.

A system exists to provide accessible, client-centered and evidence-based services for persons infected with HIV. These systems will be developed by implementation of DEBI's (targeted to HIV-positive persons), Motivational Interviewing techniques and other behavioral science-based interventions.

- ◆ Systems for identifying and referring HIV-infected individuals who need or request risk/harm reduction services currently exist. These protocols should include screening for behaviors associated with HIV/STI transmission at the initial and subsequent routine visits, as the clinician feels necessary, but annually at a minimum. Any indication of risk associated with transmission should prompt a more thorough assessment of HIV/STI transmission risks and referral to more intensive HIV behavioral change interventions.
- ◆ Brief, general health education and risk/harm reduction messages, should be regularly provided to HIV infected patients at each visit, or periodically, as determined by the clinician and at a minimum of twice yearly. These messages should emphasize the need for behavior change regardless of perceived risk. Messages should be tailored to meet the patient's needs and circumstances.
 - Clinicians incorporate risk/harm reduction and behavior change strategies into routine clinical encounters with HIV-infected persons.
 - Behavioral science based interventions and DEBI's (targeted to HIV-positive persons) are implemented as appropriate.
 - Tailored HIV education interventions using a risk reduction approach should be delivered to patients at highest risk for re-infection of HIV and acquisition of STIs.
 - Post-test counseling, for the purpose of risk reduction, behavior change and partner counseling and referral services should be conducted annually, documented, and billed if appropriate for all HIV-infected patients.
 - HIV infected patients should be referred to appropriate services that cannot be adequately addressed during the clinic visit.
- ◆ An updated referral list of agencies offering additional risk/harm reduction services in the community, including case management, drug treatment, recovery readiness, and syringe exchange are available for program and clinical staff.
- ◆ A tool to assist in ongoing assessments of each client's ability and readiness to integrate and incorporate behavior change strategies exist. Included, as a minimum, in the assessment are:
 - Strengths clients bring to the process
 - Health status
 - Sexual history, including, sexual orientation, use of the internet in finding partners, STIs, trauma, etc.
 - Substance use history and associated risk behaviors
 - Client readiness to enter into recovery through drug or alcohol treatment or other means
 - Mental health history and mental status
 - Readiness to think about and act on changing behaviors
 - Current level of motivation to address specific sexual or drug-using behaviors
 - Specific goal-oriented and harm reduction strategies
 - Barriers and/or adverse consequences to safer behaviors, e.g., domestic violence

Staff providing risk/harm reduction services receive adequate and ongoing training on current behavioral science based models, addressing sexual, and drug using behaviors.

A process exists to evaluate the delivery of risk/harm reduction services.

- ◆ Mechanisms to assure the quality of risk/harm reduction services include:
 - Supervision of staff
 - Chart review to ensure clear documentation of assessments and interventions
 - Multi-disciplinary case conferencing
 - Methods for obtaining client feedback (e.g., advisory communities, satisfaction surveys, interviews and focus groups)
 - The program conducts quantitative and qualitative evaluations of risk/harm reduction services.

Data is collected on Health Behavior Change activities.

- ◆ Health Behavior change activities are entered into AIRS and are reported manually to the AIDS Institute monthly.

Client level data will be collected on Health Behavior Change activities including:

- ◆ Interventions Delivered to Individuals and Interventions Delivered to Groups to improve medical outcomes and reduce further risk to HIV positive individuals
- ◆ Single session structured session
- ◆ Multiple session structured sessions

Complete the following services projections.

Health Behavior Change (includes risk/harm reduction, and health behavior change)	
# Clients (unduplicated) receiving Interventions Delivered to Individuals (IDI) during the contract period.	
# Interventions Delivered to Individuals (IDI) conducted during the contract period.	
# Clients (unduplicated) participating in Interventions Delivered to Groups (IDG) during the contract period.	
# Interventions Delivered to Groups (IDG) conducted during the contract period.	

Integrated HIV Testing

HIV counseling and testing is integrated into the provision of general primary care at the facility as per “NYS DOH 2005 Guidance for HIV Counseling and Testing and New Laboratory Reporting Requirements” and “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings” issued by CDC in the September 22, 2006 MMWR. *

- ◆ HIV testing is routinely recommended to all adults, all sexually active young people, and young people who may be using drugs.
- ◆ Screening and testing is conducted and at-risk clients are referred to dedicated counselors for intensive risk reduction and behavior change counseling and referrals.
- ◆ Pregnant women are provided with HIV counseling, with testing strongly recommended, per regulations of the New York State Department of Health.

HIV counseling and testing is available, accessible and integrated within general health care services.

- ◆ HIV counseling and testing services are available on-site, and off-site as needed, and offered at times and in locations that meet client needs.
- ◆ Services are culturally competent, linguistically specific, developmentally appropriate, and ensure client privacy and confidentiality.

Data is collected on HIV counseling and testing and referral activities. **

- ◆ Counseling and testing and referral activities are entered into AIRS through the CTS emulation utility. Prenatal counseling and testing data is excluded from this submission.
- ◆ Data on counseling and testing and referral activities are used in planning and monitoring progress in meeting program objectives.

A process exists to evaluate the quality of HIV counseling and testing services.

- ◆ Qualitative and quantitative methods are in place to evaluate and improve the quality of HIV counseling and testing.

*** Integrated HIV testing services should be provided through funding sources other than Ryan White. If there is no access to other funding sources, please contact your contact manager for guidance.**

**** Based on initial statements from the Centers for Disease Control and Prevention, it is anticipated that there will be reductions in data reporting requirements for streamlined HIV testing in the clinical setting. Until this has been finalized through guidance from CDC, providers should continue to submit HIV testing data as currently required.**

Complete the following service projections.

Integrated HIV Testing	
# HIV tests administered during the contract period.	
# Clients receiving HIV results during the contract period.	
# Post-test positive counseling encounters conducted during the contract period.	
# Clients receiving partner notification assistance during the contract period.	
# Clients referred for other services (medical, partner notification, mental health, substance use, etc.) during the contract period.	

Integrated HIV Testing - RW

Please note that while Integrated HIV Testing is an expectation for all AIDS Institute Primary Care contractors, HIV counseling and testing services cannot be funded by Ryan White contracts.

HIV counseling and testing is integrated into the provision of general primary care at the facility as per “NYS DOH 2005 Guidance for HIV Counseling and Testing and New Laboratory Reporting Requirements” and “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings” issued by CDC in the September 22, 2006 MMWR. *

- ◆ HIV testing is routinely recommended to all adults, all sexually active young people, and young people who may be using drugs.
- ◆ Screening and testing is conducted and at-risk clients are referred to dedicated counselors for intensive risk reduction and behavior change counseling and referrals.
- ◆ Pregnant women are provided with HIV counseling, with testing strongly recommended, per regulations of the New York State Department of Health.

HIV counseling and testing is available, accessible and integrated within general health care services.

- ◆ HIV counseling and testing services are available on-site, and off-site as needed, and offered at times and in locations that meet client needs.
- ◆ Services are culturally competent, linguistically specific, developmentally appropriate, and ensure client privacy and confidentiality.

Data is collected on HIV counseling and testing and referral activities. **

- ◆ Counseling and testing and referral activities are entered into URS through the CTS emulation utility. Prenatal counseling and testing data is excluded from this submission.
- ◆ Data on counseling and testing and referral activities are used in planning and monitoring progress in meeting program objectives.

A process exists to evaluate the quality of HIV counseling and testing services.

- ◆ Qualitative and quantitative methods are in place to evaluate and improve the quality of HIV counseling and testing.

*** Integrated HIV Counseling and testing services should be provided through funding sources other than Ryan White. If there is no access to other funding sources, please contact your contact manager for guidance.**

**** Based on initial statements from the Centers for Disease Control and Prevention, it is anticipated a that there will be reductions in data reporting requirements for streamlined HIV Counseling and testing in the clinical setting. Until this has been finalized through guidance from CDC, providers should continue to submit HIV Counseling and testing data as currently required.**

Enhanced Outreach and Engagement in Care

The HIV/AIDS program's enhanced outreach activities are designed to identify and engage high-risk individuals and impart the value of knowing their sero-status. These activities take place on the street, in high-risk venues and engage at-risk individuals in a series of interactive, one-on-one, in-depth encounters with the goal of gaining trust and developing helping relationships. Enhanced outreach is designed to:

- ◆ Identify and bring previously unidentified individuals into care.
- ◆ Target high-risk groups including substance users, the homeless, men-who-have sex with men, young people, and those who exchange sex for drugs or money.
- ◆ Target venues known for sexual activity and sex work, shooting galleries, sex parties, and gay bars.
- ◆ Provide at-risk individuals with effective interventions, which can lower the risk of infection, impart risk-reduction information, and develop skills to self-assess risk and support safe behaviors.
- ◆ Utilize behavioral-science based theories including behavior change models.
- ◆ Assist at-risk individuals to access HIV counseling and testing and other services.

Information from community needs assessment(s) and regional gaps analysis is used to assist in the development of a written plan for Enhanced Outreach. The written plan is submitted to the AIDS Institute each year.

Plans are developed, reviewed and updated at least annually. Plans incorporate evidence based practices for outreach to the target population and may be designed for group level or individual level interventions using models such as DEBIs.

- ◆ Plans address the following issues:
 - Target groups
 - Identification of gatekeepers
 - Target/location area
 - Appropriate times/schedules
 - Staff responsible
 - Scope of activities
 - Intensity of interventions expected in Enhanced Outreach
 - Security/safety issues
 - Review of educational information
 - Distribution of safer sex and harm reduction materials
 - Strategies to be utilized
 - Evidence-based behavior change interventions
 - Evaluation of outreach effectiveness
 - Referral procedures and follow-ups
- ◆ Plans are communicated to program staff and administration, as well as key community leaders and groups.

Training and staff development is provided to all Enhanced Outreach staff, including volunteers and peer outreach staff.

- ◆ Documentation of staff training contains the following information:
 - Training topics

- Training agency name
- Duration and date of training
- Staff attendance
- Copies of certificates
- ◆ Training topics are relevant to agency goals and the Enhanced Outreach Plan.
- ◆ All staff, volunteers, peer educators and supervisors have received training on how to integrate behavior change messages into Enhanced Outreach activities.
- ◆ Staff is trained in the protocol for enhanced outreach crisis intervention.
- ◆ Issues of sobriety and recovery are considered when identifying street outreach staff, volunteers or peers to work in the community.
- ◆ Ongoing supervision and support is provided to outreach workers to encourage maintenance of healthy behaviors and development of outreach workers as role models.

Strategies for Enhanced Outreach interventions are designed to maximize effectiveness.

- ◆ Enhanced Outreach interventions and strategies incorporate the following:
 - Current behavioral theory including, but not limited to implementation of evidence based practices such as CDC/DEBI models (Diffusion of Effective Behavioral Intervention project – see <http://www.effectiveinterventions.org>)
 - Best practices
 - Individual client and community needs
 - Broad health messages
 - Harm and risk reduction messages
 - Culturally and linguistically appropriate messages
 - Skills development
- ◆ Staff coordinates with other organizations to offer consistent prevention and health promotion messages and to avoid duplication of effort.
- ◆ A referral process is in place that links and or navigates individuals to the program and community services.
 - Resource information is accessible and current.
 - There is a plan for individuals in crisis.
 - Referrals are appropriate to the individual's needs.

Outreach staff understand the community and are reflective of populations targeted.

- ◆ A system is in place to recruit, hire and retain appropriate outreach staff.

A formal mechanism is in place to routinely evaluate and supervise the Enhanced Outreach program, staff activities and messages.

- ◆ Enhanced Outreach is evaluated using the following quantitative and qualitative measures:
 - Referral tracking to ensure service acquisition
 - Client satisfaction surveys
 - Feedback from providers/community members
 - Data reports
 - Regular group discussion by staff of activities and their outcomes
- ◆ Interventions are evaluated for desired outcomes as identified in the plan.
- ◆ The Enhanced Outreach Plan is modified based on the results of the quantitative and qualitative measures.
- ◆ Supervisors directly observe enhanced street outreach activities conducted by each staff member as needed, or at least quarterly.

- ◆ The Enhanced Outreach team meets frequently to debrief on team activities and on progress made with high-risk individuals.

Data is collected on Enhanced Outreach and referral activities.

- ◆ Enhanced Outreach and referral activities are entered into AIRS and are reported to the AIDS Institute monthly.
- ◆ Data on Enhanced Outreach and referral activities are used in planning and monitoring progress in meeting program objectives.

A process is in place to review educational materials developed in-house, purchased, or obtained from an outside source per AIDS Institute requirements.

- ◆ Materials are reviewed to ensure that the most current and accurate information available is included.

Complete the following service projections.

Enhanced Outreach	
# Enhanced outreach events conducted during the contract period.	
# Individuals encountered through enhanced outreach activities during the contract period.	
# Individuals counseled and tested through referral from enhanced outreach activities during the contract period.	

HIV Clinical Services

HIV clinical services are provided utilizing a multidisciplinary team approach.

- ◆ Members of the team include medical, social work, case management, nursing, mental health, substance use, program administration, adherence counseling, nutrition and other specialties.
- ◆ Formal case conferences are held at least twice annually to ensure timely and comprehensive review of all patients. Patients are also case conferenced upon intake and as significant life issues arise that may impact patient care.
- ◆ Case conferences are documented in patient medical records.
- ◆ Members of the multidisciplinary team are responsible for development and implementation of an integrated patient-centered care plan.
- ◆ The multidisciplinary team works with patients to develop effective self-management of their HIV disease and foster a sense of responsibility for their own health.

Primary ambulatory care of HIV-infected clients is provided either by an HIV Specialist or, in geographic areas where there are no HIV Specialists available, in close consultation with an HIV Specialist. In addition, where there is no HIV Specialist on staff, the agency is developing clinical expertise by training existing providers to qualify as HIV Specialists within the next six months.

[Nurse practitioners, licensed midwives and physician assistants who provide clinical care to HIV-infected individuals in collaboration with an HIV Specialist physician may be considered HIV Specialists provided that all other practice criteria are met.] The following criteria define an HIV Specialist:

- ◆ Direct clinical and ambulatory care of HIV-infected persons involving management of antiretroviral therapy for at least 20 patients during the past year.
- ◆ Ten hours annually of CME that includes information on the use of anti-retroviral therapy in the ambulatory care setting.
- ◆ A system is in place to monitor and ensure compliance with HIV Specialist requirements.

Comprehensive HIV primary medical treatment is provided to HIV-positive clients. A full range of additional services appropriate for the continuous care of clients is provided on-site or through referral arrangements. Undetectable viral load should be among the measures used to monitor clinical care.

- ◆ Core clinical services provided on-site are integrated, accessible and comprised of:
 - confidential HIV counseling and testing
 - initial and annual comprehensive medical examinations
 - HCV and HBV testing and counseling and education provided at the initial visit
 - annual screening for HCV if indicated by continued risk
 - annual substance use, mental health and nutritional screening (see OMD clinical guidelines for “Annual Mental Health Assessment”)
 - screening for smoking, assessing willingness to quit, and support for smoking cessation
 - ongoing clinical HIV disease monitoring
 - HIV-specific therapies and prophylactic treatment
 - routine family planning services
 - routine gynecological care and follow-up (including reproductive counseling, pelvic examination and pap smears)
 - patient health education
 - health education services to HIV infected individuals to modify behavior and reduce the risk of infection to others as well as further risk to themselves (See Health Behavior Change Standard)

- ◆ Expanded services are provided either on-site or through linkages, including:
 - consultations by specialists in infectious diseases
 - further evaluation and treatment as indicated for HCV
 - vaccinations for Hep A and B
 - access to alcohol counseling as indicated for persons with HCV
 - policies are in place for managing clients on protocols, including coordination of medical care with the principal investigator
 - diagnostic and therapeutic services
 - Laboratory
 - Radiology, including MRI
 - Pharmacy
 - Mental health services
 - Substance use counseling and/or treatment
 - Oral health care
 - Access to clinical research programs, including those for new drugs under investigation in clinical trials.

Clinicians are informed of and follow the www.hivguidelines.org clinical recommendations for treatment of HIV infected patients.

Clinicians address health education and behavior change during routine clinical encounters in one or more of the following ways:

- ◆ Assess patient's readiness to think about and act on changing behaviors.
- ◆ Assess patient's current level of motivation to address specific sexual or drug-using risk behaviors.
- ◆ Address specific goal-oriented harm reduction strategies.

Clinical leadership is provided through designation of an HIV Clinical Coordinator, who is an HIV Specialist. The responsibilities of the HIV Clinical Coordinator, include but are not limited to:

- ◆ Education and consultation to other clinicians providing HIV care at the agency.
- ◆ Leadership role in multidisciplinary case conferences.
- ◆ Participation in the development of HIV Quality Improvement Program.
- ◆ Participation in the development of HIV policies, protocols and systems for care coordination.
- ◆ Ensuring that all providers have appropriate input and collaborative support from relevant medical specialties.
- ◆ Ensure that clinical staff has access to the latest HIV clinical guidelines and HIV health education, including HCV to provide decision support.
 - HIV education includes training on how to effectively deliver behavior change messages to patients.
- ◆ Ensures HIVQUAL results are submitted and participation in IPRO validation and special study reviews.
- ◆ Participation in HIVQUAL meetings and workshops or designating an appropriate representative.

Programs regularly assess retention and develop strategies to ensure continuity of HIV primary care.

- ◆ Feedback provided by the Primary Care section is used in assessing retention rates.
- ◆ Internal mechanisms are in place to gather data on retention in care.

- ◆ Follow-up procedures are implemented for those patients lost to care including the following: follow-up on initial visits, shorter lead time for follow-up on missed appointments, tailoring interventions when patients express problems or concerns with care, regular updating of patient contact information, and use of agency staff to engage clients who are not in continuous care.
- ◆ Retention in care and adherence to treatment services are addressed by the entire multidisciplinary team in the routine delivery of HIV care and is fully documented by clinical and supportive services staff.

The scope and intensity of retention in care and adherence to treatment issue and interventions are based on the individual needs of the client.

- ◆ Prior to the initiation of HAART therapy, the health care team ensures that the individual is prepared for the demands of therapy.
- ◆ Principles of patient self-management and collaboration with the HIV multidisciplinary team are integrated into care and foster a sense of patient empowerment and responsibility for their own health.
- ◆ An individualized adherence to care and treatment plan is developed that reflects a collaborative process between the client and all program staff (clinical and non-clinical) and is regularly re-evaluated to determine the effectiveness and appropriateness of the interventions/services provided.
- ◆ Adherence to care and treatment plans identify barriers to adherence and maintenance in care, and interventions utilized to address these barriers.
- ◆ Adherence interventions are age/developmentally appropriate.
- ◆ Adherence is monitored at clinical and supportive services visits.
- ◆ Treatment adherence is fully integrated into individual case conferences and into the HIV quality improvement program.

Ensure that strategies to assess and improve retention in care and adherence to treatment have been implemented and are monitored by the HIV Clinical Coordinator. Measurement of individual care and treatment adherence may include:

- ◆ Clinical outcomes
- ◆ Client self-reporting
- ◆ Checking pills, bottles and prescription refills
- ◆ Retention in continuous care
- ◆ Adherence to clinical appointments
- ◆ Follow up on referrals
- ◆ Identification of barriers or issues that impact on retention in care and adherence

Treatment adherence tools, supports, and educational materials are made available to staff and clients.

All patients are screened to determine their level of nutritional risk.

- ◆ Nutritional screenings are conducted on all patients upon intake and then annually thereafter. Any program staff may conduct the nutritional screening since it does not require the expertise of nutrition professional.
 - Clients found to be at nutritional risk should be scheduled for a nutrition assessment within two weeks of beginning program services. A copy of the completed screening tool should be given to the dietician completing the assessment.
- ◆ The screening tool should be developed with the assistance of or in conjunction with the RD, RDE, or CDN.

- ◆ Assessments (on-site or off-site) are required for all clients at nutritional risk and reassessments every six months thereafter or more frequently as needed by the Registered Dietician (RD), Registered Dietician Eligible (RDE) or Certified Dietician-Nutritionist (CDN).
 - Assessments may be provided on-site or off-site.
 - Referrals for nutritional assessments off-site are followed-up with the referral agency to ensure that the client is receiving appropriate care and services, and to ensure that the results of assessments are forwarded to the primary care provider in a timely manner.
 - For those at risk, a nutritional care plan is prepared with the client's participation.
 - Referrals are made for home delivered meals, congregate meals, grocery/pantry bags and vouchers and referrals are followed up to ensure that services are provided.
 - Referrals are made for nutritional counseling, nutrition group education and workshops not provided on-site and followed-up to ensure patients have received access to these services as needed.

Data is collected on clinical services and referral activities.

- ◆ Clinical services and referrals are entered into AIRS and are reported to the AIDS Institute monthly.
- ◆ Data on clinical services and referral activities are used in planning and monitoring progress in meeting program objectives.

Data is collected on nutritional services and referral activities.

- ◆ Nutritional services and referrals are entered into AIRS and are reported to the AIDS Institute monthly.
- ◆ Data on nutritional services and referral activities are used in planning and monitoring progress in meeting program objectives.

Complete the following service projections.

HIV Medical Care	
# Clients (unduplicated) to receive primary care services during the contract period.	
# Clients (unduplicated) meeting the eligible caseload requirements during the contract period. (<i>Refer to Quality Improvement Standard</i>).	
# Clients (unduplicated) to receive primary care services monthly.	
# Primary care encounters provided on-site to clients (face-to-face) monthly.	
# Initial and annual comprehensive exams provided during the contract period.	
# CD4/Disease Monitoring encounters provided during the contract period.	

Treatment Adherence	
# Clients (unduplicated) to receive treatment adherence services during the contract period.	
# Clients (unduplicated) to receive treatment adherence services monthly.	
# Treatment adherence encounters provided on-site to clients monthly.	
Screenings and Referrals	
# Nutritional screenings provided during the contract period.	
# Referrals* for nutrition services made during the contract period.	
# Mental health screenings (as defined by HIVQUAL) provided during the contract period.	
# Referrals* for mental health services made during the contract period.	
# Substance use screenings provided during the contract period.	
# Referrals* for substance use services made during the contract period.	

**Referrals include those made on-site or off-site, to funded or non-funded staff.*

Nutrition	
<i>Complete these projections only if these services are provided by a Dietitian (RD, CDN, RDE) funded on this contract.</i>	
# Clients (unduplicated) to receive nutritional services during the contract period.	
# Clients (unduplicated) to receive nutritional full assessments annually by a Dietitian (RD, CDN, RDE) funded on this contract.	
# Nutrition services provided on-site to clients (face-to-face) monthly.	

Supportive Case Management

This is a required Standard of all Primary Care contracts.

A system is in place to provide supportive case management services that promotes retention in care and enhanced coordination with all aspects of care. Case management is a multi-step process that involves assessment and service planning to ensure timely access to and coordination of medical, psychosocial and concrete services. The goal of supportive case management for primary care programs is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability.

Case Management services must adhere to AIDS Institute Standards for Case Management Services (<http://www.nyhealth.gov/diseases/aids/index.htm>).

Case management services are offered and explained to all HIV positive clients.

- ◆ Documentation is included in the chart of client acceptance or declination to receive case management services.

Health education and risk reduction messages are integrated into the full spectrum of case management services.

Principles of patient self-management and collaboration with the HIV multidisciplinary team are integrated into case management and foster a sense of patient empowerment and responsibility for their own health.

Case managers are an integral part of the HIV multidisciplinary team and participate fully in case conferences at entry into care and at each reassessment.

A brief initial intake/assessment is developed within 15 days from referral.

- ◆ Screens for domestic violence, mental health, substance use, and nutritional status are included in the intake/assessment.

For clients whose needs can be met on-site, a brief service plan is developed within 30 days of accepting case management services.

- ◆ The plan includes a description of individualized goals, activities and service referrals. Goals are measurable and realistic and assist clients in adopting and maintaining safer behaviors.
- ◆ The plan identifies staff, client and agency roles in meeting client goals with appropriate timeframes for goal achievement.
- ◆ Dates of goal completion are documented.
- ◆ Plans are designed to promote and support client independence and self-sufficiency. Clients are involved in developing the service plan, sign the plan to indicate agreement, and are offered a copy of the plan.
- ◆ Service plans are reviewed by the supervisor, signed and dated to indicate approval.

For clients accepting case management, a brief service plan reassessment is developed every 180 days (6 months) or more frequently as needed.

- ◆ The reassessment evaluates client functioning, clinical and psychosocial status, and identifies new or ongoing needs. The client is involved in developing the reassessment and signs the plan to indicate agreement.
- ◆ Updates to the service plan are documented and outcomes indicated and tracked over time. Goals carried forward from prior service plans document progress and milestones achieved.
- ◆ Frequent case manager contacts ensure follow-up on referrals, modifications to the service plan and provision of supportive interventions.
- ◆ Each reassessment/service plan update is reviewed by the supervisor, signed and dated to indicate approval.

Case managers, along with the HIV care team, provide and show evidence of:

- ◆ Counseling in behavior change and risk/harm reduction.
- ◆ Health education with risk reduction messages.
- ◆ Retention in care activities (i.e., pre-appointment reminder calls, follow-up on missed appointments, etc.)
- ◆ Treatment adherence discussions and barriers to adherence.

There is documentation of communication and coordination with external or internal mental health/substance abuse counselors, or medical service providers for psychosocial and/or medical referrals.

For clients with intensive case management needs that cannot be met on-site, referral is made to a comprehensive or COBRA case management program. Systems are in place for tracking and coordinating services with these providers.

- ◆ Case management conferences are held routinely with comprehensive or COBRA case managers on co-case managed clients and documented in progress notes.

Crisis intervention procedures are in place to provide assessment and intensive short-term treatment of acute medical, social or emotional distress.

- ◆ A process is in place to accommodate the case management needs of patients in crisis or who come in without an appointment.
- ◆ All clients are provided with emergency contact information that includes resources and guidance for assistance outside of the program's hours of operation.

A case closure summary is prepared when a client no longer requires or wants case management services.

- ◆ The summary identifies the reason for closure and, when applicable, includes linkages to other resources and services.
- ◆ Supervisory sign-off and date are required on all case closures.

Quality reviews are conducted at last twice annually and include a representative sample of case management records.

Data is collected on case management services, case conferencing, and referral activities.

- ◆ Data is entered into AIRS and used in planning and monitoring program activities.
- ◆ Case management activities are reported to the AIDS Institute monthly.

Agencies are required to have written policies and procedures in place that describe specific elements of their program design, processes, and staffing.

Complete the following service projections.

Supportive Case Management	
# Clients (unduplicated) to receive case management services during the contract period.	
# Clients (unduplicated) to receive case management assessments monthly.	
# Case management encounters provided on-site to clients (face-to-face) monthly.	
# Clients (unduplicated) to be case conferenced during the contract period.	
# Clients (unduplicated) to be case conferenced monthly.	
# Referrals for other needed services made during the contract period.	

Mental Health Services

The full continuum of mental health services is available and accessible to clients who are HIV infected.

Mental Health Services must adhere to AIDS Institute Mental Health Standards.

A system is in place to ensure coordination of mental health care for the client among the internal and external providers involved in the client's care.

- ◆ Case conferences involving internal and external providers are held at least quarterly.

Marketing and program promotion are conducted to advise HIV consumers and service providers of available HIV mental health services.

The full continuum of mental health services is provided directly or through referral agreements.

- ◆ The following mental health services are all provided on-site:
 - Initial screening/assessment
 - Treatment planning
 - Psychotherapeutic services
 - Mental health care coordination
 - Crisis intervention
 - Referral and up-to-date resource capability
- ◆ The following services are provided either on-site or through referral:
 - Psychiatric consultation and medication monitoring by a qualified psychiatrist
 - Psychological testing
 - Case management
 - Psychiatric rehabilitation
 - Inpatient services
- ◆ Formal memoranda of agreement exist for services not available on site.
- ◆ Referrals are followed-up and documented in the client record.
- ◆ The program delivers services that are linguistically and culturally appropriate.
- ◆ Systems are in place to promote mental health and HIV treatment adherence.
- ◆ Policies and procedures for mental health services are reviewed and updated annually.

Client care is provided by qualified mental health professionals and overseen by a licensed mental health clinician. Face-to-face client orientation is provided by the mental health provider to clients in need of mental health services to introduce them to mental health program services and to empower them to access mental health services as needed.

All clients referred to the program will receive an assessment/evaluation by a mental health professional.

- ◆ The initial/assessment and evaluation includes:
 - Presenting problem: duration and acuity
 - Psychiatric history including medications
 - Mental status exam
 - Current risk of danger to self and others
 - Education and employment history
 - Family history

- STD/HIV risk assessment
- Medical history including HIV treatment and medications, and adherence issues
- Substance use history and current use status
- Psychosocial assessment
- Cognitive function assessment
- Depression screening
- Anxiety screening
- Sleeping habits
- Appetite assessment
- Post traumatic stress disorder
- Domestic violence assessment
- Social support and functioning, including client strengths, coping mechanisms and self help strategies

Each client has a comprehensive individualized treatment plan that is prepared based on clinical diagnosis within 30 days of enrollment. Treatment plans are reviewed and modified with client input and sign-off at least every 90 days or more frequently as clinically indicated.

Individual, group, or family therapy is provided on-site by a mental health professional. Clients have access to all other psychotherapeutic services that they require either on-site or through linkage(s).

Staff are ensured education in professional development programs and clinical supervision.

A quality improvement program is in place that includes processes for quality improvement for mental health care.

Data is collected on mental health services and referral activities.

- ◆ Mental health services and referrals are entered into AIRS and are reported to the AIDS Institute monthly
- ◆ Data on mental health services and referral activities are used in planning and monitoring progress in meeting program objectives.

Process is in place to ensure that referral commitment/visit took place.

Structures are in place for HIV consumer involvement and active participation in the quality development/ improvement of the HIV mental health program.

Complete the following service projections.

Mental Health

These services are provided by a qualified mental health professional, overseen by a licensed mental health clinician, funded on this contract.

# Clients (unduplicated) to receive mental health counseling services during the contract period.	
# Clients (unduplicated) to receive full mental health assessments during the contract period.	
# Mental health encounters provided on-site to clients (face-to-face) monthly.	
# Clients (unduplicated) to attend mental health group meetings monthly.	
# Referrals for other psychotherapeutic services made during the contract period.	

Substance Use Services

Substance use screening, assessment, treatment readiness counseling and referral to a full range of licensed substance use programs are available and accessible to clients who are HIV infected. Relapse prevention and support services are available for those with a history of substance use.

- ◆ The following substance use services are all provided on-site:
 - Initial screening/assessment on intake and annually thereafter
 - Substance use assessment/evaluation
 - Treatment planning
 - Recovery readiness counseling
 - Care coordination
 - Crisis intervention
- ◆ The following services are provided either on-site or through referral:
 - Harm reduction services
 - Access to clean syringes through Syringe Exchange Programs or Expanded Syringe Access Program (ESAP), where available
 - Substance use treatment in facilities licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).
 - Inpatient, residential or outpatient detoxification services in OASAS licensed facilities
- ◆ Ongoing linkages with substance use treatment programs including detox, methadone and drug free modalities.
- ◆ Referrals are followed-up and documented in the client record. Referrals should be appropriate to the client age, length of use, type of substances used, intensity of use and past experiences in detox and drug treatment.
- ◆ The program delivers services that are linguistically and culturally appropriate.
- ◆ Systems are in place to promote adherence to HIV and substance use treatment.

Client care is provided by a substance use counselor, preferably with CASAC certification.

- ◆ Clinical supervision is provided preferably by someone experienced in addiction medicine and/or treatment.

Screened clients who are referred for substance use services will receive an assessment/ evaluation by a substance use counselor.

- ◆ The initial/assessment and evaluation includes:
 - Presenting problem: duration and acuity
 - Substance use history
 - Psychiatric history including medications
 - Education and employment history
 - Risk assessment
 - Social support and functioning, including client strengths,
 - coping mechanisms and self help strategies
 - Recovery readiness assessment

Each client actively using substances or recently in recovery has a comprehensive individualized substance use treatment plan that is prepared within two weeks of the initial assessment. Treatment plans are reviewed and modified at least every 90 days or more frequently as indicated.

Individual or group substance use treatment readiness counseling is provided on-site by a substance use counselor. Clients have access to all other substance use and mental health services either on-site or through linkage(s).

- ◆ On-site treatment includes short-term counseling that may be geared to:
 - Harm reduction
 - Recovery readiness counseling with a behavior change approach
 - Support recovery from less severe substance use where higher threshold treatment may not be necessary or acceptable to the client
 - Interim substance use counseling until a treatment slot becomes available

A system is in place to ensure coordination of substance use care for the client among the providers of substance use, mental health, medical and supportive services.

Timely psychiatric consultation and management of psychiatric medications is available to all clients on-site or by referral.

Staff actively participates in professional development programs provided by OASAS, ASAP, and the AIDS Institute.

Substance use services are incorporated into the agency’s quality improvement program.

Structures are in place for HIV consumer involvement and active participation in the quality development/ improvement of substance use services.

Data is collected on substance use services, and referral activities.

- ◆ Substance use services and referrals are entered into AIRS and are reported to the AIDS Institute monthly.
- ◆ Data on substance use services and referral activities are used in planning and monitoring progress in meeting program objectives.

Complete the following service projections.

Substance Use	
<i>These services are provided by a substance use counselor, funded on this contract.</i>	
# Clients (unduplicated) to receive substance use counseling services during the contract period.	
# Clients (unduplicated) to receive full substance use assessments during the contract period.	
# Substance use encounters provided on-site to clients (face-to-face) monthly.	
# Clients (unduplicated) to attend substance use group meetings monthly.	
# Referrals for long-term substance use or detox treatment made during the contract period.	