

# Administration

**An HIV program administrative structure is in place to ensure that the program is properly organized, equipped and staffed, consistent with the scope of services and patient care needs.**

**Agency administrative commitment is adequate to support program objectives and missions. HIV program director and executive staff meets regularly.**

**Organization has a system to establish, review and implement policies and procedures for the HIV program. Written policies and procedures are in place. Guidelines include but are not limited to the following:**

- confidentiality
- infection control
- exposure to hazardous substances
- HIV reporting requirements

**Agency has a program in place to promote and market the availability of HIV services in the program and/or the community. Methods of promotion and marketing include:**

- marketing/promotion materials
- written referral/linkage agreements with agencies serving high risk clients
- planning council/network committee membership

## **Personnel**

**Comprehensive personnel policies and procedures are in place.**

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

**A system is in place to assess the need for and provide training for all HIV program staff.**

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

**Timely performance evaluations are conducted with supervisory input.**

**Comprehensive personnel files are in place, which include all transactions regarding the employee and position information. File should include:**

- copy of licenses
- signed HIV confidentiality statement
- documentation of annual HIV confidentially training
- certificates of training and/or proof of attendance

# Grant Management

**A system exists that promotes the efficient and effective expenditure of grant funds.**

- ◆ The status of grant spending is regularly and systematically reviewed by program and fiscal staff.
- ◆ Budget allocations are regularly reviewed to ensure that they are consistent with program needs and activities.
- ◆ A system exists to identify the need for budget modifications in a timely manner, and to communicate that need to appropriate program and fiscal staff.
- ◆ A system exists to review, at least annually, which HIV program costs are most appropriately budgeted to grants and which should be supported through third party revenue and agency “in kind” contributions.

## **Third Party Revenue**

**A system exists for maximizing third party revenue.**

- ◆ Systems are in place to enroll/dis-enroll clients in Medicaid/ADAP.
- ◆ Patient eligibility is systematically and regularly reviewed.
- ◆ A system exists to periodically review the agency's billable encounter reporting system.
- ◆ A system exists for ensuring that the agency is accurately and reliably billing Medicaid, ADAP, and private insurers for HIV related services.
- ◆ There is a quality review process to ensure integration between fiscal, MIS, and program operations.

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

- ◆ An accounting system exists which distinguishes revenue generated through grant funded HIV services.
- ◆ A budgeting system exists to ensure the allocation of this revenue to HIV program related expenses.

# Consumer Involvement

- ◆ Structures are in place for consumer involvement and active participation in the continuous development/improvement of the HIV/AIDS program. Indicators of consumer involvement include, but are not limited to the following:

- advisory committee participation
  - annual consumer satisfaction surveys
  - systematic feedback to consumers
  - written policy/plan on consumer participation

- ◆ Consumers are informed of and encouraged to participate actively in city/county/area/statewide AIDS planning groups.
- ◆ The agency fosters consumer participation in AIDS conferences and other related meetings outside the agency.

# Clinical Services

**Comprehensive HIV primary medical treatment and evaluations are provided to HIV-positive clients in order to stage the disease for prognostic and treatment purposes and to identify active opportunistic infections, including TB, opportunistic malignancies and other HIV-related conditions. A full range of additional services appropriate for the continuous care of clients is provided on-site or through referral arrangements.**

- ◆ Core clinical services are provided on-site, including:
  - initial and annual comprehensive medical examinations
  - HCV and HBV testing at the initial visit
  - annual screening for HCV if indicated by continued risk
  - substance abuse and mental health assessments
  - on-going clinical HIV disease monitoring
  - HIV-specific therapies and prophylactic treatment
  - patient health education.
  
- ◆ Core-related services are provided either on-site or through linkage, 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
  - diagnostic and therapeutic services:
    - laboratory
    - radiology, including MRI
    - pharmacy
    - dental services
    - mental health services
    - routine gynecological care and follow-up (including reproductive counseling, pelvic examination and pap smears)
  
- ◆ Clinical leadership is provided through designation of an HIV clinical coordinator, who is an HIV Specialist. The responsibilities of the HIV 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 policies, protocols and systems for care coordination
  - Ensuring that all providers have access to the latest clinical guidelines, including HCV to provide decision support
  - Ensuring HIVQUAL results are submitted or participate in IPRO reviews

**Referrals are provided to other primary care, specialty and sub-specialty services, including:**

- obstetrics
- ophthamology
- dermatology
- neurology
- out-patient surgery
- sub-specialties of internal medicine, including gastroenterology, hematology, pulmonology and oncology
- medical care for HIV-infected pregnant women
- HIV health care for infected children and their mothers
- post-test counseling for HIV-infected women after delivery

**Clients are referred for off-site laboratory services, diagnostic consultations, clinical trials and other services not available on-site.**

**Medical information about the primary care client is communicated to the off-site provider.**

**Reports from off-site providers are documented in the medical chart of the primary care client.**

**Procedures are in place to follow up on missed appointments for on-site and off-site medical care.**

**A program has been established to assess and improve treatment adherence. Measurement of individual treatment adherence may include:**

- client self-report
- reporting by significant others
- clinical outcomes
- checking pills, bottles and prescription refills
- treatment education, problem-solving strategies and referrals for additional support are available to clients

**Clients have access to clinical research programs including those for investigational new drugs. Policies are in place for managing clients on protocols including coordination of medical care with the principal investigator.**

**All clinical staff providing HIV diagnostic and treatment services receives appropriate HIV-specific clinical education, training and technical assistance.**

**Primary ambulatory care of HIV-infected clients must be provided either by an HIV specialist with expertise in the practice of HIV medicine or in close consultation with an HIV specialist. 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, including:**

- ◆ recent prior experience with direct clinical management of persons with HIV, including those receiving retroviral therapy over an extended period of time

- ◆ on-going CME that includes information on the use of antiretroviral therapy in the ambulatory care setting

# Quality

**The HIV Program has developed a formal Continuous Quality Improvement (CQI) program to evaluate performance in meeting its qualitative and quantitative objectives. The CQI plan which is reviewed and updated annually describes a process for ongoing evaluation and assessment of program performance in various areas.**

- ◆ The CQI process focuses on the performance of systems and work processes instead of individual workers.
- ◆ A systematic approach exists for ongoing data collection and evaluation to continue setting priorities, planning changes, monitoring processes and sustaining improvement.
- ◆ Performance in various areas of program functioning are measured by clearly defined indicators.
- ◆ The quality program routinely assesses continuity of care for clients on the primary care caseload, and includes a review of clients that meet eligible caseload requirements (at least 2 visits within the last 12 months, at least one of those in the last 6 months).
- ◆ Opportunities for improvement are identified and form the basis of specific CQI projects.
- ◆ Multi-disciplinary teams drawn from all levels of program staff are formed to address specific CQI projects.
- ◆ CQI teams utilize problem-solving strategies to identify and recommend specific changes needed to improve performance in the program area being assessed.
- ◆ The ongoing role and responsibility of participants in CQI teams has been delineated.
- ◆ Clear lines of accountability are established for CQI initiatives, including the implementation of recommended changes.
- ◆ Consumer input is included in quality-related activities through client satisfaction surveys, consumer advisory boards, focus groups etc.
- ◆ Management of the program, both clinical and administrative, provides support and leadership to the CQI process.

- ◆ Successes and/or needs for improvement identified through the CQI process are communicated to senior management of the program whose subsequent feedback is included in the process.
  
- ◆ Staff development/training in the CQI process is provided for all levels of staff on a regular basis. Adequate resources are made available.
  
- ◆ CQI activities are communicated to all staff members within the HIV program and, if applicable, to senior management of the larger institution in which the program resides.

# Case Management

**A system is in place to provide continuous care and medical case management for each client.**

- ◆ Procedures are in place to follow-up on missed appointments.
- ◆ Agency employs strategies to improve adherence for clients who miss appointments.
- ◆ Agency monitors and evaluates the overall rate of missed appointments.

**New clients have access to HIV health and support services through onsite intake, assessment and initial service plan development.**

- ◆ Case management services are offered and explained to all clients.
- ◆ An intake is conducted on all clients and should include the following items:

- date, name, address, phone number
- referral source
- living arrangements
- number of children, their ages and HIV status
- significant others/domestic partner
- exposure category
- emergency contact
- consent for treatment and case management services
- signed consent for the case manager to contact external case management agencies and/other service providers as needed
- employment status
- income
- health insurance
- diagnosis
- languages spoken
- name of person completing intake/assessment

- ◆ An assessment of needs is conducted on all clients within 30 days of intake and includes the following items:

- family, support system, and disclosure issues
- client's medical condition
- nutritional needs
- functional status
- chemical dependencies and drug treatment status
- parole/probation status and legal history
- social needs, including housing, recreation and transportation

## Case Management Continued

parenting support needs  
partner notification needs (past and present partners)  
legal needs, including living will and guardianship issues  
contact persons and services provided  
currently involved service agencies including addresses, phone numbers,  
specialized services for children (e.g., day care, foster care, adoption, neuro-  
developmental assessments and educational services) if needed

- ◆ An initial service plan is developed for each client that includes short- and long-term goals to meet the needs identified in the assessment. The plan should identify the staff and/or agency responsible for meeting the goals.
- ◆ The client is involved in developing the initial service plan. Client signature is needed to indicate agreement.

**Case management of psychosocial needs is provided on-site or by referral to an appropriate community-based case management or other service provider.**

- ◆ On-site case managers arrange services to meet identified needs, facilitate receipt of services, monitor results of services and document outcomes.
- ◆ When services are provided by referral, there is evidence of communication and coordination with the off-site service provider.

**A re-assessment or re-examination of the care plan is conducted every 6 months or when warranted by a significant change in the client's condition for the purposes of revising the client's comprehensive care plan. Re-assessment includes the following items:**

information on changes in the client's health and social status  
a review of the client's (or family's) social support needs  
service plan updates  
reports from off-site service providers (e.g., case managers, mental  
health, substance abuse)

**Case conferences conducted with the client's care team including the case manager are recommended at entry into care and at reassessment. Where possible drug treatment staff should be included in order to facilitate integration of services.**

**Quality reviews of case management services are conducted on a quarterly basis by appropriate staff and include a representative sample of case management records.**

# HIV Counseling and Testing

## **HIV counseling and testing is available and accessible.**

- ◆ Specimen collection or phlebotomy services are preferably co-located with counseling services.
- ◆ If specimen collection or phlebotomy services are housed separately, procedures for coordination and follow-up are in place.
- ◆ Services are offered in a manner that is culturally competent, linguistically specific, developmentally appropriate, and ensures client privacy.

## **New testing technologies are being used to meet the needs of clients.**

- ◆ Clients are assisted in choosing the appropriate test method (rapid, oral fluid or venipuncture blood testing)
- ◆ New testing technologies (rapid, oral fluid) are being used as available to meet the needs of clients

## **HIV test counseling is client centered.**

- ◆ Counseling is interactive, allows the client to contribute to risk assessment and readiness to change.
- ◆ Counseling results in a realistic and incremental personalized plan for the client to reduce the risk/harm of acquiring or transmitting HIV.

## **Individuals receiving counseling and testing services are referred to appropriate services.**

- ◆ Clients who test HIV positive are referred to the appropriate services such as: health care, case management, supportive services, risk reduction services, and partner assistance and referral services.
- ◆ Individuals who are at high risk of HIV infection are referred to appropriate prevention services such as: peer support groups, needle exchange, on-site risk reduction counseling and domestic violence services.
- ◆ Mechanisms are in place to follow up on referrals.

## **Data is collected on Counseling and Testing (C&T) and referral activities.**

## **Counseling and Testing Continued**

### **Pregnant women are HIV counseled with testing recommended.**

- ◆ HIV counseling provided as early as possible during pregnancy, subsequently offered if initially declined, or later in pregnancy if at continuous risk.
- ◆ Counseling includes information on routes of transmission, including breast-feeding and on therapies to reduce perinatal transmission.
- ◆ Appropriate referrals are made to counseling and care for HIV positive pregnant women such as: counseling regarding prenatal, intra-partum, and newborn anti-retroviral therapy, or to a pediatric/maternal care center.

### **A process exists to evaluate the quality of HIV counseling and testing services provided by the agency.**

- ◆ Staff providing counseling receive appropriate training.
- ◆ Methods are in place to evaluate and improve the quality of HIV counseling and testing including the following: peer or supervisory observation of counseling session, supervision, chart audits and documentation review, collection and review of data regarding service quality and consumer satisfaction, and feedback on data to program staff.

# Partner Assistance Counseling and Referral

**Clients are educated about confidential voluntary partner assistance and referral services for sex and needle sharing partners who may have been exposed to HIV.**

- ◆ HIV+ persons are educated as to the importance of partner assistance services and related legal requirements.
- ◆ An explanation as to the available partner assistance options and a discussion with respect to which option(s) would best serve the needs of the client must be provided. The options include:

referral systems to PNAP, CNAP  
staff- supported assistance  
self disclosure with coaching

- ◆ Potential barriers to immediate assistance must be assessed, with particular attention to domestic violence.

**Partners who seek services are provided with appropriate services, including:**

education about HIV, modes of transmission  
benefits of knowing serostatus  
risk reduction strategies  
referrals  
confidential client-centered counseling and education about HIV  
HIV testing either on site or by referral

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

- ◆ The entire care team is involved in providing support, educating and monitoring the progress to/of the client.
- ◆ The care team is aware of their options for warning partners ( article 27F)
- ◆ Adequate space that ensures confidentiality during partner assistance counseling is available.
- ◆ Staff are trained and developed to provide partner assistance and referral services.

**Data on partner assistance and referral activities is used in planning and monitoring progress in meeting program objectives.**

## **Risk/Harm Reduction- Stages of Change**

**A system exists to provide client-centered risk/harm reduction services for persons at risk for HIV/STD or infected with HIV. Given the importance of interrupting secondary transmission, persons who are HIV infected should be given priority.**

- ◆ Policies and procedures for risk/harm reduction services in place include:
  - protocols for identifying and referring individuals who potentially need or request risk/harm reduction services;
  - methods including self-assessment for screening the client's level of need for risk/harm reduction services including:
    - general health
    - adherence to HIV-related treatment
    - sexual history, including STD, sexual orientation, trauma, etc.
    - substance use history and associated risk behaviors
    - mental health
    - skills to reduce HIV
    - intentions and motivations
    - barriers and/or adverse consequences to safer behaviors, e.g., domestic violence
  - behavior change models and other interventions to assist persons with varying levels of need for risk/harm reduction services;
  - protocols, which address the legal and ethical issues, associated with risk/harm reduction services, including:
    - confidentiality
    - voluntary client participation
    - state HIV reporting requirements
  - a referral list of agencies offering risk/harm reduction services in the community served, including prevention case management, recovery readiness, and syringe exchange.

**Risk/harm reduction systems were developed in collaboration with consumers.**

**Staff providing risk/harm reduction services has access to appropriate initial and ongoing training.**

**Risk/Harm Reduction Continued**

**New concepts, advances, strategies and/or research are routinely assessed for program integration.**

**Risk/harm reduction services are accessible and consumer-centered.**

**Risk/harm reduction services are offered in a manner that is:**

- culturally appropriate
- linguistically specific
- developmentally appropriate
- gender sensitive

**Services are provided in physical surroundings that ensure client privacy, comfort and safety.**

**Risk/harm reduction services are individualized and tailored to the client's capacity to initiate or sustain practices that reduce or prevent HIV/STD acquisition, transmission or re-infection.**

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

- ◆ Mechanisms are in place that assure the quality of risk/harm reduction services, including:

- supervision of staff performance
- chart review to ensure clear documentation and appropriate assessment and intervention
- case conferencing with the client's care team
- methods for obtaining client feedback (e.g., advisory committees, satisfaction surveys, interviews and focus groups)

- ◆ The program conducts process and outcome evaluation of risk/harm reduction services.

# Street Outreach, Community Education and Inreach

**A needs assessment of the community and/or target population is conducted and updated as needed.**

- ◆ Information is gathered and utilized from the following sources, as appropriate:

- client satisfaction surveys
- program staff
- persons living with HIV/AIDS
- representatives of the target population
- community leaders, organizations, and networks
- epidemiological data
- demographic data
- ethnographic data

- ◆ Results of the needs assessments are communicated to program staff and administration, as well as key community leaders and groups.

**Information from the needs assessment is used to develop plans for street outreach, community education, and inreach.**

**Plans are developed, reviewed and updated as needed.**

- ◆ Plans address the following issues:

- target groups
- identification of gatekeepers
- target/location area
- appropriate times/schedules
- staff responsible
- scope of activities
- security/safety issues
- review of educational information
- distribution of safer sex and harm reduction supplies
- strategies to be utilized
- referral procedures

- ◆ Plans are communicated to program staff and administration, as well as key community leaders and groups.

**Training and staff development is provided to all education, training and outreach staff, including volunteers and peer educators.**

- ◆ 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 ETO plan.

**Strategies for ETO are developed and activities are organized to maximize effectiveness.**

- ◆ ETO interventions and strategies incorporate the following:

- current behavioral theory
- best practices
- individual client and community needs
- broad health messages
- harm and risk reduction messages
- culturally appropriate messages

- ◆ Written curricula are developed for ETO.
- ◆ Staff coordinate with other organizations to offer consistent prevention and health promotion messages and avoid duplication of effort.
- ◆ A referral system is in place that links individuals to the program and other services that exist within the community.
  - Resource information is accessible and current.
  - There is a plan for clients in crisis.
  - Referrals are appropriate to the clients' needs.
  - Referrals are reviewed periodically and updated accordingly.

**Inreach is conducted to clients regarding HIV transmission, methods of prevention, the medical benefits of knowing one's serostatus, and to promote the availability of on-site and community based services.**

Street Outreach Continued

**A formal mechanism is in place to routinely evaluate and supervise the ETO program and staff. Both process and outcome evaluations are used.**

- ◆ Program is evaluated using both quantitative and qualitative measures such as the following:
  - referral tracking
  - client satisfaction surveys
  - feedback from providers/community groups
  - data reports
- ◆ Client interventions are evaluated for desired outcomes as identified in the plan.
- ◆ ETO plan is modified based on the results of process evaluation and outcome evaluation.
- ◆ ETO supervisory staff directly observes staff as needed, or at least annually.

# Transitional Case Management

**A system exists to provide transitional case management services to assist active injection drug users in accessing drug treatment and health care. The primary function of transitional case management is to identify clients seeking drug treatment and encourage clients, in general, to accept drug treatment. Clients may need to be prepared for referrals to treatment. Preparing the clients may include staging and engaging in short term counseling to provide emotional support regarding what to expect in drug treatment.**

**The enhanced services for getting clients into drug treatment and transitional case management are actively promoted through in-reach and outreach efforts that are provided in low threshold settings, such as:**

- street outreach in neighborhoods where IDUs live and/or obtain and use drugs
- presentations at schools and to community groups
- participation in health fairs
- door-to-door canvassing
- hotlines

**Provide expanded access to drug treatment for its clients by establishing and maintaining linkages and working relationships with all the following modalities of substance use treatment:**

- methadone maintenance
- maintenance to abstinence (MTA)
- drug-free residential treatment
- drug-free ambulatory treatment

**The provider is responsible for taking the lead in creating and sustaining these relationships through regular meetings so that interdisciplinary case conferencing may occur in order to provide coordination of care.**

**Clients are made aware that they can return to the provider if drug treatment is not successful.**

**Facilitate referral by assisting clients to obtain all documentation necessary to qualify for Medicaid, drug treatment and health care services.**

**Support clients contemplating or awaiting drug treatment by offering clients additional core services as needed, including:**

## Transitional Case Management Continued

- ◆ Assistance with housing and other concrete services, such as: entitlements, emergency shelter, Section 8, HASA housing, food stamps, WIC and legal counsel.
- ◆ Referrals to health care, including: community-based health care facilities, HIV counseling and testing, HIV primary care, pre-natal care, mental health services, nutritional services and dental care.
- ◆ HIV risk reduction education to decrease the harm of drug use and sexual behavior, including: safer injecting techniques and safer alternatives to injecting, safer sex techniques and information about obtaining clean syringes through the NYS Expanded Syringe Access Program.
- ◆ HIV risk reduction counseling to promote behavioral change and to move clients toward more stable drug use and sexual behavior, including: cost-benefit analysis, negotiation skills, refusal skills and brief solution based counseling to assist clients in finding solutions to problems in living which motivate drug use.
- ◆ Advocacy to assist clients experiencing difficulty with service providers.
- ◆ Referral to long-term case management in the community for follow up and continued care.
- ◆ Have representatives from the drug treatment programs on-site to provide education and counseling (where possible)

**An intake and needs assessment is conducted by the transitional case manager on all clients newly enrolled in transitional case management and should include the following:**

client demographics  
signed release of information  
HIV status  
HIV risk factors  
medical needs  
nutritional needs  
service needs, such as housing, legal, financial etc.  
history of substance use and treatment  
mental health needs  
barriers to accessing services  
resources and skills, including social support and motivation to change

**An initial service plan is developed with the client at intake by the transitional case manager which provides the following for each of the needs indicated in the assessment:**

short and long term goals  
interventions to accomplish goals  
individuals responsible for the interventions  
anticipated timeline to reach transitional case management goals

## Transitional Case Management Continued

**Ongoing case management services are provided either directly by the transitional case management team or by referral to an appropriate community-based service provider.**

**A system exists to track and follow up on referrals to drug treatment programs and other services.**

**HIV prevention interventions are culturally and developmentally appropriate, linguistically specific and gender sensitive to clients being targeted for transitional case management.**

**Quality reviews of transitional case management staff are conducted on a regular basis by appropriate staff and include a representative sample of outreach logs and client charts.**

**The performance of the transitional case management program in meeting its qualitative and quantitative objectives will be evaluated by process and outcomes measures, using such measures as referral tracking, number of individuals contacted through outreach, feedback from clients, behavior change.**

**Training and staff development is provided to all transitional case management staff, including volunteers and peer educators.**

- ◆ Documentation of staff training contains the following information:

- training topics
- training agency name
- duration and date of training
- staff attendance
- copies of certificates awarded

- ◆ **Training topics are relevant to both agency and transitional case management goals.**

# Uniform Reporting System

**In order to accurately report contract deliverables and other relevant data through the Uniform Reporting System, adequate resources, policies, procedures, and systems exist, which include:**

- system administration
- staff training
- data collection and input
- report and extract generation and timely submission
- security and confidentiality
- quality control
- technical support

# HIV Prevention Service Projections

Number of HIV negative individuals receiving behavioral counseling during a 3 month period:	
Number of sessions conducted during a 3 month period:	

Number of HIV positive individuals receiving behavioral counseling during a 3 month period:	
Number of sessions conducted during a 3 month period:	

Number of individuals receiving HIV prevention education in a group setting during a 3 month period:	
Number of group sessions conducted during a 3 month period:	
Number of individuals receiving HIV prevention education during outreach and/or mass events during a 3 month period:	
Number of outreach and/or mass events conducted during a 3 month period:	

## HIV Counseling & Testing Service Projections

Number of individuals receiving pre-test counseling during a 3 month period:	
Number of individuals tested during a 3 month period:	
Number of individuals receiving post-test counseling during a 3 month period:*	
Number of individuals tested during a 3 month period that have previously tested positive:	

\* The expectation of the AIDS Institute is that at least 90% of individuals who are tested for HIV will receive their results, along with post-test counseling. If you project a post-test return rate of less than 90%, please attach a detailed justification. This justification should refer to your program model, target populations, and strategies to be employed to maximize the number of individuals returning for their results.

## Primary Medical Care Service Projections

Number of persons with HIV receiving ambulatory diagnostic and treatment services as of the beginning of the contract period:	
Number of persons with HIV receiving ambulatory diagnostic and treatment services at the end of the contract period:	
Total number of persons with HIV receiving ambulatory diagnostic and treatment services during the contract period:	
Number of HIV+ clients meeting the eligible caseload requirements (Clients who have received two or more encounters in a 12 month period, with at least one being in the most recent 6 months of the period)	
Number of primary care encounters for a 3 month period, including initial and annual comprehensive exams, disease monitoring visits, and all other medical visits for HIV infected patients:	

Number of face-to-face case management encounters for a 3 month period:	
Total number of case management encounters (including face-to-face) for a 3 month period:	

# Transitional Case Management Service Projections

Number of individuals receiving transitional case management during the contract period:	
Number of face to face transitional case management encounters for a 3 month period:	
Total number of transitional case management encounters (including face to face) for a 3 month period:	
Number of referrals to drug treatment programs:	
methadone maintenance	
methadone to abstinence (MTA)	
drug-free residential treatment	
drug-free ambulatory treatment	
Number of referrals for other services:	
HIV counseling and testing	
medical services	
mental health services	
social services	
long term case management	
Housing	
Legal	
Other	
Number of risk reduction education/counseling encounters for a 3 month period:	

**Transitional Case Management Service Projections Continued**

Number of individuals referred who enter drug treatment:	
methadone maintenance	
methadone to abstinence (MTA)	
drug-free residential treatment	
Drug-free ambulatory treatment	
Outreach to drug treatment providers to establish and/or maintain linkages:	
meetings	
case conferences	
telephone calls	
other	

**List of current linkages, especially for drug treatment, including programs targeting special populations (e.g., residential for women and children, bi-lingual etc.).**

# Nutritional Care

**Comprehensive and continuous nutritional care assessment and intervention to persons with HIV disease is provided. Nutritionists provide nutrition intervention to persons with HIV as indicated by medical and non-medical factors.**

- ◆ An initial (baseline) nutritional assessment is provided to newly identified persons with HIV.
- ◆ Reassessments are provided on an as-needed basis, but at least annually.
- ◆ Patients are offered individual nutritional counseling related to the assessment of their nutritional needs. Ongoing nutritional counseling related to the assessment of their nutritional needs. Ongoing nutritional counseling, either individually or in groups, include the following information:

- Food handling and preparation techniques
- Careful storage and heating of leftovers
- Avoidance of raw or undercooked meats, fish and eggs
- Boiling of water in areas where the water supply may be contaminated

- ◆ The nutritionist participates in case conferences as a member of the HIV team.

**A policy and procedures manual regarding the provision of nutritional care to persons with HIV exists.**

**Staff development is provided to the staff providing nutritional care.**

**Nutritional care is incorporated into the facility's existing quality of care program.**

**A process exists to evaluate the nutritional care program.**

## Nutritional Care Projections

<b>NUTRITIONAL CARE: Projected Activity Levels</b>	
Projected number of HIV patients to receive nutritional assessments monthly.	
Estimated number of unduplicated clients receiving nutritional counseling monthly.	
Estimated number of nutrition counseling sessions monthly.	
Estimated number of group nutritional counseling sessions monthly.	
Estimated number of HIV patients attending each group session.	

## Case Finding (Targeted Outreach/In-reach)

**The Ryan White-funded program conducts case finding to identify people with HIV disease so that they may become aware of and may be enrolled in primary care and/or case management and supportive services. Case finding can be done as targeted outreach and/or in-reach. These activities must be planned and delivered in coordination with local HIV prevention outreach /in-reach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, and be conducted at times and in places where there is a high probability that HIV infected individuals will be reached. Case finding is designed to:**

- ◆ Target high-risk groups including substance users, the homeless, migrant and seasonal farm workers, 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, gay bars, migrant and seasonal farm worker camps;
- ◆ Target programs within an agency that includes the high-risk groups mentioned above (in-reach);
- ◆ Provide HIV+ individuals with demonstrations of activities which can lower the risk of transmission, impart risk-reduction information, and develop skills to support safe behaviors;
- ◆ Utilize behavioral change theory, including behavior change messages and assessments of the individual's stage of readiness for change.
- ◆ Facilitate access to HIV primary care and/or case management and supportive services.

**Information from community needs assessment(s) is used to develop a written plan for case finding. The plan is reviewed and updated at least annually.**

- ◆ Plans address the following issues:
  - Target groups
  - Identification of gatekeepers
  - Target/location sites
  - Appropriate times/schedules
  - Staff responsible
  - Scope of activities
  - Intensity of interventions expected in Case Finding
  - Security/safety issues
  - Review of educational information
  - Distribution of safer sex and harm reduction supplies
  - Strategies to be utilized
  - Behavior change messages
  - Referral procedures
- ◆ Plans are communicated to program staff and administration, as well as key community leaders and groups.

**Training and staff development is provided to all case finding 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 case finding plan.
- ◆ All staff, volunteers, peer educators and supervisors have received training on how to integrate behavior change messages and risk-reduction into case finding activities.
- ◆ Case finding staff are trained in the protocol for crisis intervention.
- ◆ Issues of sobriety and recovery are considered when identifying case finding staff, volunteers or peers to work in the community.
- ◆ Ongoing supervision and support is provided to those conducting case finding to encourage maintenance of healthy behaviors and development of these workers as role models.

**Strategies for case finding interventions are designed to maximize effectiveness.**

- ◆ Case finding interventions and strategies incorporate the following:
  - Current behavioral theory
  - Best practices
  - Individual client and community needs
  - Broad health messages
  - Harm and risk reduction messages
  - Culturally appropriate messages
  - Skills development
- ◆ Staff coordinates with other organizations to offer consistent health promotion messages and to avoid duplication of effort.
- ◆ A referral system is in place that links 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
  - Referrals are reviewed periodically and updated accordingly.

**A formal mechanism is in place to routinely evaluate and supervise the case finding staff activities and messages.**

- ◆ Case finding is evaluated using both quantitative and qualitative measures such as the following:
  - Referral tracking
  - 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 Case Finding Plan is modified based on the results of quantitative and qualitative evaluations.

- ◆ Supervisors directly observe case finding activities conducted by each staff member at least annually.
- ◆ The case finding team meets frequently to debrief on team activities and on progress made with high-risk individuals.

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

**Materials are reviewed to insure that the most current and accurate information available is included**

# MENTAL HEALTH SERVICES FOR PERSONS LIVING WITH HIV/AIDS

## SCOPE OF SERVICES

Mental health services must be a part of an integrated system of care for persons living with HIV/AIDS which includes, at a minimum, clinical care (HIV and mental health), case management; and if indicated, substance use treatment. Services throughout the continuum of care should be delivered in a manner that reduces stigmatization and promotes self-respect and personal dignity.

A **mental health program** must have at a minimum the following services available on site:

- Intake and full psycho-social assessment
- Diagnostic Evaluation
- Treatment Planning
- Crisis Intervention
- Psycho-therapy
- Mental Health Care Coordination

**Agencies must ensure that clients have timely access to psychiatric services. If these services are not available on site, the agency must submit a plan that demonstrates how availability, timely access and coordination of psychiatric services will be provided.**

Agencies must also ensure that clients have access to the full continuum of mental health and allied services. Services not offered on site require a formal memorandum of agreement that includes explicit bi-directional service provision agreements.

### **The full continuum of mental health services includes:**

- a. Initial Screening (Screening may be conducted by a non-professional staff. Screening shows some evidence of the need for services).
- b. Intake and Assessment (Intake and Assessment must be conducted by a professional staff and demonstrate the appropriateness of the referral, the need for treatment and the appropriate setting).
- c. Diagnostic Evaluation (This evaluation must be reviewed and signed by psychiatrist or psychologist. It serves as a basis for treatment plan).
- d. Psychological testing (Client may be referred out for this testing).
- e. Treatment planning and coordination.
- f. Psychiatric services: (Psychiatric services include medication assessment and management by a psychiatrist or psychiatric nurse practitioner).
- g. Psychotherapy
- h. Crisis Intervention
- i. Inpatient services (Client may need to be referred to another setting).
- j. Case Management

**Persons living with HIV/AIDS, who receive mental health services must have access on-site or by referral to a case manager who is responsible for coordinating mental health, HIV care, substance use treatment if indicated, and other appropriate services. The case manager is responsible for the integration of a total system of care.**

## **STAFF QUALIFICATIONS AND SUPERVISION**

Mental health services are psycho-social assessments, psychological and psychiatric treatment, counseling services (individual and group), provided by mental health professionals who are licensed/certified in New York State. This includes psychiatrists, psychologists, psychiatric nurse practitioners, Master's prepared psychiatric nurses, and social workers. Services must be provided by a licensed professional mental health clinician. MSWs are qualified if they have graduated from a social work program that is approved by the NYS Department of Education. MSWs not yet certified must receive supervision from a licensed professional, and that supervisor is responsible for the review and sign off on all documentation.

## **OBJECTIVES**

1. To provide the full continuum of mental health services directly or through referral agreements.
2. To provide face to face client orientation to all new clients to introduce them to program services, to ensure their understanding of the need for continuous care, and to empower them in accessing services.
3. To provide an intake/assessment by a mental health professional for all referred clients.
4. To provide a diagnostic evaluation by a licensed mental health professional for all clients as soon as possible, based on client need, but no later than two weeks after admission. This evaluation must be reviewed and signed off by a psychiatrist within 30 days of the completion of the evaluation.
5. To provide a timely psychiatric consultation for clients evaluated to be in need of one.
6. To complete a comprehensive individualized treatment plan for all clients within two weeks of admission. Treatment plans must be reviewed and modified at least every ninety days, or more frequently if clinically indicated.
7. To provide either individual, group, or family therapy on site at the program. Services not provided on site must be available through linkage arrangements.
8. To provide psychiatric services for medication management, either on site or through linkage arrangements.
9. To establish systems promoting mental health and HIV treatment adherence.
10. To establish a crisis intervention plan, including off-hours coverage.

## **OBJECTIVES**

1. To ensure that client care is supervised by a licensed professional mental health clinician.
2. To ensure that psychiatric services are provided by a qualified psychiatrist.
3. To ensure that client care is provided by qualified mental health professionals.
4. To ensure that supervision and professional development programs are provided for all staff.

# MENTAL HEALTH SERVICES PROJECTIONS

Service Type	Projected unduplicated # of Clients Receiving Services	Projected # of Encounters
Intake/Assessment/Evaluation		
Psychiatric Evaluation		
Individual Therapy		
Treatment Plan Development		
Treatment Plan Update		
Psychological Assessment/Treatment		
Follow up Activities		
Family Therapy		
Psychopharmacology		
Case Closure Activities		
Referrals		