

Re-engagement
Tier I
Peer Services
Treatment Adherence
Reassessment
Case Conference
Medical Care

Retention and Adherence Program Standards

Crisis Intervention
Intake
Viral Load Suppression
Case Closure
Retention in Care
Self-Management
Service Plan
Tier II
ART
Eligibility



Department
of Health

AIDS
Institute

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I. Introduction

On June 29, 2014, Governor Andrew Cuomo announced a three point plan to end the AIDS epidemic in New York State (NYS). The goal of the plan is to reduce the number of new HIV infections from an estimated 3,000 to 750 by 2020. The Governor's three point plan includes:

1. Identifying all persons with HIV who remain undiagnosed and link them to health care;
2. Linking and retaining persons diagnosed with HIV in health care and treating them with antiretroviral therapy (ART) to maximize viral load suppression so they remain healthy and prevent further transmission; and
3. Providing access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

Efforts to support the three point plan included the development of a new program model, the Retention and Adherence Program (RAP). In 2015, grant funding to implement the RAP was released through competitive solicitations. The intent was to provide resources to facilities licensed under Article 28 of the New York State Public Health Law to address the needs of patients with unsuppressed viral loads. Funding awarded under these solicitations amounted to \$6.5 million. A total of 31 providers were funded: three providers located in Methadone Maintenance Treatment Programs with co-located HIV-primary care, and 28 providers in HIV primary care ambulatory clinic sites. RAP offers a framework for continuous HIV/AIDS treatment, care and supportive services in a medical setting to enable patients to sustain viral load suppression. The RAP also offers support to patient partners at risk of contracting HIV by encouraging HIV testing and the provision of harm reduction counseling and services including, if appropriate, PrEP.

Health care providers funded under the RAP are required to meet the standards set forth in this document. These standards define the minimum level of quality in RAP service delivery and ensure uniform services across programs.

II. Intent of Program

The intent of RAP is to support people living with HIV/AIDS (PLWHA) in building capacity to independently manage their health care and achieve sustained viral load suppression, which is defined as suppression greater than 6 months at the end of a 12 month period.

Clinical interventions exist to treat and increase the lifespan of individuals diagnosed with HIV/AIDS. New York State's Medicaid and AIDS Drug Assistance Program (ADAP) make clinical treatment available and affordable to the HIV-positive community. The RAP seeks to identify and address the individual barriers preventing some PLWHAs from engaging and adhering to HIV care and treatment. The RAP is a vital part of the clinical model. A team approach is used to provide support to the patient on implementing and sustaining the clinical treatment plan. The support provided increases the ability of the patient to improve personal health outcomes.

The RAP is intended to increase the number of PLWHAs adherent to ART thereby diminishing their viral load, improving their health, and reducing their ability to transmit the virus to others. The program focuses on individuals new to care; at risk for being lost to care; and those not currently adherent to ART. The program design requires intensive interventions to minimize barriers to care and adherence to ART. Funding does not support blanket enrollment of all individuals enrolled in HIV primary care. It is targeted to those at highest risk with the ultimate goal of achieving patient self-management.

Appendices I and II provide a brief overview of the program as well as a flow chart illustrating the steps of progression based on performance indicators.

III. Peer Services

Peer services are an integral component of the RAP model. All agencies funded for the RAP are required to use peers in service delivery to patients. The value and effectiveness of peer interventions are well documented in literature.

The services peers may provide include, but are not limited to:

- Orientation to new patients on RAP, clinic services, and clinic staff;
- Navigation for patients to medical visits or other health and human service appointments;
- Support, education, and adherence assistance through individual or group activities;
- Reminder calls and follow-up for missed appointments; and
- Home visits (which may provide a valued insight to the medical teams' patient management strategies).

Peers serving the RAP are PLWHA who have been successful in managing their HIV care and treatment as well as navigating health care systems. Peers have a deep understanding of what the patient is experiencing. Patients have an opportunity to discuss personal issues with peers in a safe environment and with someone who can relate to their situation. In addition, being a peer is therapeutic and can improve self-esteem as well as empower the peer to sustain optimal health.

The scope of peer services are determined by the education, training and skill level of the peer, informed by the facility's administrative personnel policies and/or the volunteer policies, and defined within the RAP Policy and Procedures Manual. The RAP Policy and Procedure Manual must include:

- A process for recruiting and selecting peers;
- Peer job description;
- Timeframes for an initial and annual peer training program inclusive of HIV confidentiality, HIPAA rules and regulations, professional conduct, outreach skills, safety protocols, active listening and boundaries for peer/patient relationships;
- Peer supervision;
- Provision of support for the peers; and
- Performance evaluation.

Compensation of peers is dictated by the agency policy. Peers may be salaried employees of the agency or compensated for cost associated with "services" provided with a stipend. If the peer is receiving health or social service benefits, the effect a stipend or salary may have on the peer's benefits must be considered.

NY Links developed a *Peer Support Intervention Manual* that may be used as a reference for one type of a model of peer support, please see

<http://www.newyorklinks.org/files/peer-support/peer-support-manual-09-01-2014-pdf/>.

RAPs may choose to use this model, however, programs are **not required** to implement this exact model. The peer model chosen must best support the needs of the consumers and the individual agency.

IV. Eligibility

Patients must be independently assessed for meeting RAP criteria as well as other funding criteria (e.g., HRSA Ryan White funding: income eligibility, NYS residency, etc.). The program dictates the use of two tiers of service which provide a level of intervention that is patient centered and commensurate with patient needs.

A. Definition

All HIV-positive RAP patients are assigned to a tier service level by the following criteria:

Tier I: Newly diagnosed and/or treatment naïve.

Tier II: Must meet one of the following:

- Virally suppressed for less than 3 months based on at least two viral load tests 90 days apart. Viral load suppression is defined as < 200 copies/mm³ whether detectable or undetectable or < 400 copies/mm³ and undetectable;
- Missed two consecutive HIV clinic appointments; or
- No contact with the clinic for greater than 90 days or lost to follow-up.

B. Intent

The overall intent of eligibility determination is to ensure the patient is appropriate for services as defined by the funding requirements and assigned to the appropriate tier.

C. Expected Outcomes

Patients are assigned to the tier that will enable them to achieve the best possible outcomes for their care and treatment. **Note:** *The funding award amount and the availability of funding for similar services will define the number of individuals to be served by this grant. The number of patients to be served under this contract award may be negotiated. These parameters will be defined in the contract agreement.*

D. Process

A review of the documentation must be conducted. Documentation may include the following histories:

- HIV-related laboratory test results;
- Appointments; or
- Assessment and reassessments.

Documentation of the HIV status and criteria used for enrollment in the RAP and assignment to the appropriate tier must be documented in the assessment section of patient charts. Continued participation in the program is determined through routine reassessments.

Eligibility is not synonymous with enrollment. Once eligibility is determined an offer for the patient to participate and enroll in the RAP is extended. Patient refusals must clearly be documented in the medical record.

The RAP Policies and Procedures Manual must document the process for conducting a universal review of the HIV patient population for eligibility for RAP services.

E. Frequency

Upon initiating the RAP, and routinely thereafter, a review of the HIV patient universe is conducted to identify those patients eligible for the RAP.

As new patients present for HIV care or as existing patients demonstrate need, eligibility is assessed.

For existing RAP patients continued eligibility is dictated by the guidance provided in the Assessment and Reassessment sections of this document. Eligibility and placement in Tier I or Tier II is then determined.

F. Best Practices

Clinical staff will be invested in working with the RAP Specialist to ensure patients in need of services are reviewed for eligibility.

All staff involved in clinic operations are aware of the RAP and criteria for eligibility.

Supervisory staff will ensure that patients are routinely assessed for appropriate tier assignment.

Systems will be implemented to flag patient missed appointments with the intent of identifying patients eligible for the RAP.

V. Intake

A. Definition

Intake is the initial meeting(s) with the patient during which the RAP Specialist provides an overview of the program services, gathers information to address the patient's immediate needs and barriers to care, and encourages his/her engagement in the program. The RAP Specialist will assure the patient that his/her privacy and confidentiality is maintained in all phases and activities of the program.

B. Intent

Intake is a sentinel event for establishing rapport between the patient and the care team. The care team encourages the patient to "stay connected." At intake, members of the care team will obtain key personal patient information, insight on patient barriers to care, and identify urgent situations to be addressed immediately.

C. Expected Outcomes

The patient is enrolled in the RAP; understands the services provided and his/her role in achieving self-management; and immediate needs are addressed.

D. Process

Through interviewing, basic patient information and social service needs are discussed and documented. Documentation is obtained along with appropriate consents and releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F of the NYS Public Health Law, and other releases for information as required by applicable law.

Initial documentation must be presented as a distinct component of the patient's chart and at a minimum include:

- Contact and identifying information including preferred method of contact (name, birth date, address, phone, email address, Facebook, etc.);
- Language(s) spoken, including preferred language;
- Demographics (race, ethnicity, age and sex at birth);
- Sexual orientation and gender identity;
- Living situation: Identify head of household; if dependent children are living with the patient; the housing status (e.g., rent, own); if housing is adequate;
- Household data: Household size and annual household income;
- Health insurance status;
- Citizenship;
- Emergency contact including phone and email address;
- Confidentiality concerns;

- Former HIV medical providers, including reasons for terminating care;
- Current/former medications;
- Other current health care and social service providers, including community case management and care coordination providers (Health Homes or grant funded); and
- Transportation options.

The patient is oriented to clinic staff and procedures, and informed about ancillary/sub-specialty services available on-site or through referral.

Issues that impact patient's ability to be retained in care are identified. The patient's history regarding their continuity of medical care is assessed, and strategies for keeping next scheduled medical appointment are identified. Immediate needs identified during the intake are addressed promptly.

AIRS Intake is completed post intake interview. The *AIRS Intake Data Form* includes most of the information bulleted above.

E. Frequency

Intake is conducted once, however, the process may require more than one encounter with the patient to obtain all documentation. AIRS should document the first date of the intake process. The intake must be completed no later than 14 days after eligibility has been determined and the client has agreed to services.

F. Best Practices

Clinicians providing HIV primary care discuss the role of the RAP Specialist with their patients. Emphasis on the collaborative partnership and role of the care team in the patient's care plan are explained.

The RAP Specialist must have good interviewing skills, be able to put patients "at ease" and establish roles and responsibilities between themselves and the patient.

The RAP Specialist should use techniques such as motivational interviewing to enhance open dialogue with patients.

VI. Assessment

A. Definition

The assessment is a systematic gathering and evaluation of the strengths, resources, medical and psychosocial needs of patients. Information gathered through the process is analyzed, and patient acuity and multidisciplinary service needs identified. Identified needs are prioritized and a corresponding service plan is developed.

B. Intent

The intent of the assessment is to provide a standardized method of identifying unmet medical and psychosocial needs and barriers to retention and adherence to care. It serves as a functional, responsive tool that drives the development of a medically focused service plan. Information gathered through the assessment determines the intensity of services required and appropriateness for enrollment in the RAP. The assessment provides a mechanism for monitoring patient progress and tracking outcomes.

C. Expected Outcomes

The assessment will provide a baseline evaluation of patient functioning. Patient acuity is determined. The identified medical, behavioral and psychosocial factors likely to impact patient retention and adherence to care are summarized and translated into a corresponding initial service plan.

D. Process

Utilizing a strengths based approach, the RAP Specialist will facilitate discussion with the patient to elicit information. The RAP Specialist will use a tool to assess patient medical, behavioral and psychosocial functioning factors.

The RAP Specialist must utilize information obtained from other sources such as medical records, multi-disciplinary team members, or external care coordinators (with appropriate releases) to inform the assessment process.

The assessment may be conducted over several meetings, one of which must be a face-to-face contact.

Information elicited and identified deficiencies are noted for inclusion in the service plan.

Priority needs detected are documented and immediately addressed.

At a minimum, the assessment tool must document:

- Date of most recent CD4 test result with count;
- Date of most recent viral load test result with count;
- Name and address of current primary care provider;
- HIV primary care visit history;
- Current medication regimen;
- Ability to adhere to medication regimen;
- Language barriers;
- Health literacy barriers;
- Patient's cognitive competence;
- Needs related to:
 - Housing;
 - Income;
 - Insurance; and
 - Access to medications.
- Behavioral and psychosocial needs and supports inclusive of:
 - Mental health;
 - Alcohol and substance use treatment;
 - Family and social supports;
 - HIV disclosure assistance;
 - Crisis intervention plan; and
 - Partner Services.
- Unmet medical needs and gaps in care coordination; and
- Service providers, service provision and access.

Determine that form DOH 4189, Medical Provider HIV/AIDS and Partner Contact was completed and submitted as specified on the form.

The assessment will identify:

- Adherence facilitators and potential barriers to adherence;
- The need for medication reminders or organizers;
- Challenges with keeping medical appointments (review of any past difficulties with keeping appointments);
- Self-management skills;
- Issues managing other chronic diseases;
- Immediate concerns or referrals needed to improve treatment adherence or retention in care; and
- Prevention and/or risk reduction needs.

The assessment process is outlined in the RAP Policies and Procedures Manual and includes the following requirements:

- Each assessment encounter must be signed and dated by the RAP Specialist;
- The completed assessment must be signed and dated by the RAP Specialist;
and
- Protocols for supervisory review and sign-off.

E. Frequency

The assessment is conducted once, but may require several patient encounters to ensure completion. The assessment must begin upon intake and be completed within 30 days.

F. Best Practices

The assessment is completed within 14 days to ensure rapid engagement and facilitation of needed services.

The RAP Specialist should conduct at least one (1) home visit, whenever possible, during the assessment process.

Patient acuity scales are used by the RAP Specialist as part of behavioral health screening.

The completed assessment is shared with multidisciplinary team members for input into development of the service plan.

VII. Case Conference

A. Definition

A case conference is a formal, multidisciplinary meeting involving team members responsible for the treatment and care of the patient. It is structured to: 1) exchange information, 2) review patient progress, and 3) ensure collaborative development of a coordinated patient-centered care plan to improve patient engagement, retention and adherence.

Case conference team members include the RAP Specialist and others responsible for the treatment and care of the patient, including primary care or HIV physicians, mid-level providers (e.g., nurse practitioners and physician assistants), mental health counselors and specialists, patient care coordinators, nurses, social workers, case managers, nutritionists, dentists, substance abuse treatment counselors, prevention counselors, etc.

Case conferencing promotes the integration of patient services, reduces service duplication, and improves health outcomes by:

- Reviewing the patient's progress in achieving current goals;
- Identifying or clarifying current issues affecting the patient's medical status, psychosocial needs and health outcomes;
- Promoting consensus on strategies developed to address issues and/or barriers identified;
- Delineating the roles and responsibilities of the care team and patient; and
- Informing service plan development.

B. Intent

Case conferencing provides the opportunity to review and plan for patients with complex medical and psychosocial needs. Patient progress in engagement, retention and adherence to their service plan is reviewed. Specific strategies are developed to respond to identified barriers, improve coordination of care and health outcomes.

C. Expected Outcomes

As a result of case conferencing, patient strengths and barriers to engagement, adherence and retention in care are identified. Corresponding strategies and recommendations are developed to respond to barriers and result in expedited linkage to care, increased retention in care, increased adherence to treatment, and achievement of viral load suppression.

All case conference activities are documented in the case conference summary. The summary is a distinct component of the patient medical record.

D. Process

Case conferences are regularly scheduled meetings attended by multidisciplinary team members. They are designed to facilitate the active participation of team members (including external providers) to present and discuss individual patients in their care.

Clinical leadership ensures active participation of multidisciplinary team members and provides support to the RAP Specialist.

The RAP Specialist is responsible for initiating, scheduling and coordinating formal case conferencing meetings.

Patients are systematically selected for review in accordance with the frequency specified in Sections V and VII.

External providers that share patients are encouraged to participate whenever possible. This may occur in person or by telephone. When this is not possible, input and recommendations are obtained from external providers prior to the case conference, and shared with other team members during the case conference. Patients may be included in the case conference as appropriate.

Specific case conference activities include the following:

- Review of patient's medical, treatment and psychosocial status;
- Identification of the patient's multidisciplinary care needs, including known barriers to engagement, medication adherence and/or retention in care;
- Review of outcomes of previous interventions/strategies implemented, including referrals;
- Development of responsive recommendations and/or interventions with desired outcomes identified by each multidisciplinary team member;
- Identification of action steps required to achieve outcomes, delineating patient and/or case conference team member's implementation responsibilities;
- Evaluation of appropriateness of current tier assignment; and
- Development of a case conference summary that is included in the patient medical record. The case conference summary serves to document each team member's required action steps and includes the date, name, title and signature of each participant.

E. Frequency

Case conferences will be coordinated with the assessment and reassessment process but will occur prior to service plan development.

Tier I patients will be case conferenced:

- Within 30 days of initial appointment; and 90 days thereafter;
- As needed based on significant medical and/or psychosocial events likely to impact treatment and care outcomes;
- When patients are lost to follow-up (no contact for more than 90 days); and
- Prior to RAP case closure.

Tier II patients will be case conferenced:

- Within 30 days of enrollment in Tier II; and 90 days thereafter;
- As needed based on significant medical and/or psychosocial events likely to impact treatment and care outcomes;
- When patients are lost to follow-up (no contact for more than 90 days); and
- Prior to RAP case closure.

F. Best Practices

Clinical leadership, in conjunction with the RAP Specialist, will provide input into the selection of patients for case conferencing based on viral load suppression, medication adherence or other clinical indicators.

Systems will be developed with external providers that allow for the collaborative exchange of information pertinent to the case conference.

The RAP Specialist shares the case conference summary with external providers that participated in the case conference either directly or by providing input/recommendations prior to the conference.

Multidisciplinary team members will be knowledgeable of Diffusion of Effective Behavioral Interventions (DEBI's) and Evidence Based Interventions (EBI's), and will track the outcomes of interventions implemented as a result of case conference activities.

Whenever appropriate, patients are encouraged to participate in their case conference review. Case conference outcomes are shared and discussed with patients, and patient input is obtained prior to development or revision of the service plan.

VIII. Reassessment

A. Definition

The reassessment process re-evaluates a patient's current medical and psychosocial needs through a systematic gathering of information to inform action steps of the RAP Specialist. This includes acknowledgement of successes, addresses previously identified barriers to care and prioritizes next steps for addressing new barriers, if any. A reassessment informs a corresponding service plan.

B. Intent

The intent of the reassessment is to provide a standardized method of reevaluating medical and psychosocial needs, barriers to retention, and adherence to care. It serves as a functional, responsive tool that drives the development of a medically focused service plan. Information gathered through the reassessment determines the intensity of services required and appropriateness for tier assignment in the retention and adherence services program. The reassessment provides a mechanism for ongoing monitoring of patient's progress and tracking outcomes.

C. Expected Outcomes

A determination is made for appropriateness of tier assignment at the time of reassessment and the need for continued or additional services. The reassessment will provide a summarized evaluation of patient's functioning. Any identified medical, behavioral and psychosocial factors likely to impact patient retention and adherence to care are outlined and translated into a corresponding service plan.

D. Process

Utilizing a strengths based approach, the RAP Specialist will facilitate discussion with the patient to elicit information. The RAP Specialist will use a tool to reassess patient's medical, behavioral and psychosocial functioning factors. This process requires the use of evidence based interventions that are proven to facilitate a reassessment such as motivational interviewing (see www.effectiveinterventions.cdc.gov).

The RAP Specialist must utilize information obtained from other sources such as medical records, multi-disciplinary team members, or external care coordinators (with appropriate releases) to inform the reassessment process.

The reassessment may be conducted over multiple patient encounters.

An update of information elicited and identified deficiencies are noted for inclusion in the service plan. Priority needs detected are immediately addressed and documented.

At a minimum, the reassessment should include an update on:

- Most recent CD4 test and result with count;
- Most recent viral load and result with count;
- Name and address of current primary care provider;
- HIV primary care visit history;
- Current medication regimen;
- Ability to adhere to medication regimen;
- Language barriers;
- Health literacy barriers;
- Patient's cognitive competence;
- The presence of barriers (e.g. housing status, income, inadequate/lack of insurance or continuous access to medications, etc.);
- Behavioral and psychosocial needs and supports inclusive of:
 - Mental health;
 - Alcohol and/or substance use treatment;
 - Family and social supports;
 - HIV disclosure assistance;
 - Crisis intervention plan; and
 - Partner Services.
- Any unmet medical needs and gaps in care coordination. This includes an updated assessment of services:
 - Being provided and by whom;
 - Barriers to access;
 - Care coordination; and
 - Inconsistent or episodic engagement in care.
- The reassessment will identify:
 - Facilitators for, and potential barriers to, adherence;
 - Ability to take medications as directed and the need for medication reminders and organizers;
 - Challenges with adherence (e.g., difficulty keeping appointments, adverse effects from medications);
 - Issues managing other chronic diseases;
 - Self-management skills needed to initiate/continue and maintain medication regimen;
 - Immediate concerns or referrals needed to improve treatment adherence or retention in care; and
 - Prevention and/or risk reduction needs.

The reassessment process is outlined in the RAP Policies and Procedures Manual.

- Each reassessment encounter is to be signed and dated by the RAP Specialist;
- Supervisory review and sign-off of the reassessment is required; and
- Protocols for the timeline of supervisory review and sign-off are documented.

E. Frequency

Reassessments are required and are completed, at a minimum, every 90 days. Significant life changes may require more frequent reassessments.

F. Best Practices

The reassessment is completed within 14 days of initiation.

Patient acuity scales are used by the RAP Specialist as part of behavioral health screening.

The completed reassessment is shared with multidisciplinary team members for input into development of the service plan.

IX. Service Plan

A. Definition

The retention and adherence service plan is a medically focused document that guides the actions that address treatment and care goals. It is a mutually agreed upon plan that prescribes the activities conducted by the care team and the patient. It responds to the needs identified during the assessment, reassessment, case conference, and as significant life events occur which impact the patient's ability to achieve goals. The service plan must be referenced at each patient encounter.

B. Intent

The intent of the service plan is to address barriers to care identified in the (re)assessment and develop incremental goals to assist patients in reaching optimal health outcomes, including viral load suppression and self-management. The service plan is patient-centered and will outline action steps, identify all parties necessary for completion of goals, and include a timeline.

C. Expected Outcomes

As a result of the service plan, the patient will be aware of their current health status, existing strengths, as well as barriers to treatment. In addition, the patient will develop the skills needed to achieve adherence, viral load suppression, and self-management.

D. Process

Oversight of the service plan is the responsibility of the RAP Specialist.

The RAP Specialist and patient jointly discuss barriers to care and develop strategies to remove the barriers. The process requires that the RAP Specialist has the ability to facilitate the exchange of information about the patient's health care and negotiate patient buy-in.

This process requires that CDC Evidence Based Interventions (EBIs) be used to facilitate elements of the service plan (see www.effectiveinterventions.cdc.gov).

The RAP Specialist will ensure that every enrolled patient's medical history, including laboratory information and progress notes from other care team members, is reviewed during service plan development.

The service plan is monitored during subsequent patient encounters. Achievement or barriers toward meeting goals are addressed and documented in the progress notes and the service plan is updated accordingly.

Direct education is provided to the patient as needed including treatment adherence and prevention with positives activities.

The RAP Specialist documents activities or interventions to meet the goals of the service plan as designed with the patient and records next steps and outcomes in the patient's chart.

The service plan reflects all care team activities and must document the following:

- Date of most recent CD4 test and result;
- Date of most recent viral load and count with result;
- HIV primary care visit history;
- Current ARV treatment regimen;
- Needs, goals, timeframes, and responsible parties for achieving stated goals;
- Outcomes;
- Signature and date of the RAP Specialist upon completion of the service plan;
- Signature of the patient on the service plan as an attestation of agreement. A copy is provided to the patient; and
- Supervisory review and approval. Supervisory review and approval must be within two weeks of completion of the service plan.

E. Frequency

Service plans are developed in conjunction with all assessments, reassessments, case conferences, and as significant life events occur which impact the patient's ability to achieve goals. Plans should be completed/updated within 72 hours of these activities. At a minimum, service plans must be reviewed and updated every 90 days.

F. Best Practices

Timelines for supervisory review and approval of the service plan are outlined in the RAP Policies and Procedures Manual. The manual is a valuable resource to staff and administration providing information on how the care team's coordination efforts are documented in the patient's record and communicated to the RAP Specialist.

Service plans are incorporated into the medical record so that they are accessible by every member of the care team.

The supervisor monitors service plan completion to ensure that the plan is timely and responsive to patient needs.

X. Crisis Intervention

A. Definition

Crisis intervention refers to the methods of immediate, short term help available to individuals who experience an event that produces mental, physical, emotional, and behavioral distress.

B. Intent

To provide a short term intervention to help patients receive assistance, resources, stabilization and support to address a crisis.

C. Expected Outcomes

To minimize damaging consequences from acute medical, social, physical or emotional issues that patient's present.

D. Process

The agency has a policy for patient crisis intervention services that is included in the agency's policies and procedures manual. All RAP program staff are trained on the agency crisis intervention policy and how to be an effective first responder given a crisis situation.

All onsite emergencies are immediately and effectively addressed.

The RAP Specialist discusses with the patient what constitutes a crisis.

A crisis intervention plan is determined for each patient. Individual plans must include, at a minimum, information on emergency contact information that includes internal and external resources and guidance to secure assistance outside of agency business hours.

E. Frequency

Individual crisis intervention plans are developed during the (re)assessment and revisited as dictated by changing life circumstances.

F. Best Practices

A crisis plan is specific to an individual patient's needs and cognitive ability. Plans are developed to ensure a patient is able to navigate services during crisis and has specific instructions and provider contact information. Co-occurring disabilities or life circumstances affect the nature and extent of the plan (i.e., people with mental illness or

at risk of domestic violence need to have their special needs addressed in advance to minimize the impact of emergencies.)

The agency assesses crisis intervention service providers to ensure quality and appropriateness of their services and care. Best practice dictates a site review of an agency annually.

Programs develop a mechanism to assess a pattern of individual use of crisis intervention services (i.e., frequency, repeat types of situations, or resolutions) in order to minimize situations leading to crisis and ensure linkage and coordination with internal and external programs to respond to crises.

XI. Re-engagement

A. Definition

Re-engagement is a process used to reconnect a patient to care. Strategies and resources are aimed at patients who are episodically involved in care or who are lost to care.

B. Intent

The intent of re-engagement is to re-establish continuity of care for patients with episodic encounters or who are lost to care.

C. Expected Outcomes

Patient contact for re-engagement will result in a reassessment and service plan update and, when appropriate, a case conference. This will promote active patient engagement in care and treatment adherence.

D. Process

In order to support the re-engagement process, information culled from agency records, as well as from other patient service partners, should be utilized. A proactive approach to re-engagement should include agreements with external programs serving the patient to assist in the patient's return to care. In addition, patient charts are flagged to alert the RAP if the patient accesses other services at the agency.

Once patient contact is established, the reasons for a patient's non-adherence to medical appointments or episodic involvement in care are discussed and documented, including psychosocial issues, health beliefs or other barriers. Counseling and education are initiated for a patient whose health beliefs are having a negative impact on treatment adherence. If the patient has had a prolonged absence from the provider, information on care and treatment received elsewhere is documented and addressed with the clinician. This process requires a solutions based approach to determine interventions and resources needed to improve adherence. Immediate psychosocial needs identified during the re-engagement interview, as well as immediate service needs and barriers, are addressed promptly.

The RAP Specialist is responsible for coordinating re-engagement efforts. The RAP Policies and Procedures Manual will identify the sequence of events and the number of attempts that need to occur for re-engagement, and supervisory oversight. This will include the methods for patient contact (i.e., letters, phone calls, e-mails, texts, contact via collaterals, or home visits). Peers may be used for re-engagement activities.

E. Frequency

The re-engagement plan is initiated from the first point of the patient's contact with the RAP Specialist. This will enable the implementation of a proactive plan in response to a future need should there be interruption in the patient's care.

The plan will be implemented when the patient does not keep medical appointments or is not adherent to the treatment regimen.

F. Best Practices

When appropriate, the patient is re-oriented to clinic staff and procedures, and re-educated about ancillary/sub-specialty services available on-site or through referral.

Patients who have a history of missed appointments should be given additional services such as a peer escort for appointments.

Incentives may be appropriate for patients who are non-compliant. Use of incentives may be restricted based on requirements of the funder for the grant.

XII. Case Closure

A. Definition

Case closure is the final activity when releasing a patient who can now self-manage their medical needs or is discontinuing RAP services for other reasons.

Self-management is demonstrated by adherence to medical appointments and treatment regimen **and** viral load suppression as follows:

- Tier I – Virally suppressed for more than 3 months as of the end of the 12 month enrollment period.
- Tier II – Virally suppressed for more than 6 months as of the end of the 12 month enrollment period.

Other reasons for case closure may include:

- Lost to care and not re-engaged in service;
- Chose to terminate service;
- Relocation outside of service area;
- Termination by the agency due to issues defined in the Agency's Policies and Procedures Manual or RAP Policies and Procedures Manual;
- Incarceration;
- Transferred to another agency; or
- Death.

B. Intent

The intent of case closure is to ensure that dedicated services and resources are made available to those in need. In addition, case closure allows for the agency to best manage the RAP Specialist case load.

C. Expected Outcomes

The expected outcomes of case closure are twofold: management of the active RAP patient caseload and transition of care services.

D. Process

Upon termination of RAP services, a patient's case is closed and the medical record contains a closure summary documenting the case disposition. Depending on the reason for closure, the summary must include documentation such as reengagement efforts, transfer of medical records, date of death, etc.

Documented supervisory review and approval is required for case closure.

The RAP Policies and Procedures Manual outlines the criteria and protocol for case closures. All required activities, individuals responsible and the number of attempts for required activities must be documented in the RAP Policies and Procedures Manual (e.g. phone call, letter, home visit, text messages).

When a patient's RAP case is closed, the corresponding AIRS enrollment must be ended.

E. Frequency

Case closure is conducted each time services in the RAP are terminated.

F. Best Practices

When services are terminated by the patient, or if self-management is achieved, an exit interview is conducted.

Case closure due to the achievement of self-management should include a review of skills developed to sustain performance.

A management review is completed in situations where an agency terminates services due to the patient being threatening, harassing or inflicting physical harm to staff.

If a patient is not engaged in any services at the agency for one year, at a maximum, the agency will close the RAP enrollment in AIRS.

Process for supervisory review and sign-off is defined in the RAP Policies and Procedures Manual.

Appendix I

Retention and Adherence Program Guidance

INTENT

The intention of Retention and Adherence Program is to assist people living with HIV/AIDS achieve viral load suppression and to build their individual capacity to manage their health.

Sufficient clinical interventions exist to treat and increase the lifespan of individuals diagnosed with HIV/AIDS. New York State's Medicaid and ADAP programs make clinical treatment accessible and affordable to its HIV-positive population. Studies also show individuals adherent to HIV treatment drastically reduce their risk of transmitting the virus to others.

The Retention and Adherence Program seeks to address the individual barriers preventing some persons living with HIV from engaging and adhering to HIV care and treatment. The Retention and Adherence Program is a vital part of the clinical model because it supports the clinical decisions of the provider and increases the ability of the patient to implement the clinician's recommendations.

This funding is congruent with the AIDS Institute's (AI) commitment to ending AIDS by reducing transmissions and increasing HIV viral load suppression among people living with HIV/AIDS. The Retention and Adherence Program funding is ultimately designed to increase the total number of those in New York State who receive and adhere to antiretroviral therapy (ART) by targeting those individuals new to care, likely to withdraw from care, and those not currently adherent to ART. It is designed to reach as many individuals as possible and to stabilize patients on medications. This funding is not designed to enroll patients long term nor for their lifetime. Through adherence to medications the AI hopes to improve the medical outcomes of people living with HIV and AIDS and reduce the annual number of individuals diagnosed with HIV in New York State.

RETENTION AND ADHERENCE PROGRAM

The Retention and Adherence Program will assess an individuals' readiness for clinical treatment, identify and address short-term and persistent barriers to seeking or adhering to treatment, and develop an individual's ability to maintain and self-manage their HIV treatment. The model is a two-tiered approach and designed to provide time-limited and goal-oriented support to patients. Both tiers will incorporate linkage to medical care, retention in care, and treatment adherence services. Both tiers must have effective linkage and collaboration with community case management programs and/or Health Homes to address social issues that present barriers to achieving positive medical outcomes. The Tier Model is comprised of:

- Tier 1—Tier I will include individuals who are treatment naïve. Programs will be expected to aggressively engage patients that have been scheduled for an initial medical appointment after diagnosis to ensure linkage to care. All newly diagnosed and treatment naïve patients will receive the following retention and adherence services for a 12 month period:
 - Base-line assessment of retention and adherence barriers, including housing, social support, mental health, substance use within 30 days of initial appointment followed by, at a minimum, reassessment every three months;
 - A service plan that ensures care coordination and outlines steps to address retention and adherence barriers, updated at every reassessment;
 - Evidence based education and counseling regarding medications, regimens, adherence and side effects;
 - Viral load monitoring upon the initiation of ART, as specified by New York State HIV Clinical Guidelines. Guidelines for monitoring ART can be found at <http://www.hivguidelines.org/clinical-guidelines/adults/antiretroviral-therapy/#VI>.
 - Evidence based interventions and tools that support adherence (pill boxes, timers, texting, adherence coaches, peer support, etc.);
 - Measurement of adherence through self-report at 1 month, 3 months, 6 months, and 9 months.

Agencies should prioritize patients' needs into Tier I with the goal of providing adequate services and staff to successfully transition them after achieving stability. Tier I patients should be aggressively monitored by all staff involved in patient care. All treatment naïve patients who achieve and maintain viral suppression for > 3 months at 12 months will be "discharged" from this level of retention and adherence services, with continuing adherence monitored by the primary care provider. Post discharge from Tier I, if sustained viral load is not maintained, patients should continue retention and adherence services under Tier II.

- Tier II—The second tier will be for those who have not been virologically suppressed for > than 3 months (viral load suppression is defined as the viral load is < 200 copies/mm³ whether detectable or undetectable or < 400 copies/mm³ and undetectable), those who have missed 2 consecutive HIV primary care appointments and/or those who have been lost to follow-up for unaccountable reasons. These patients will receive all the services listed above. In addition they will receive:
 - Enhanced assessment of barriers to retention and adherence as needed and at minimum every 3 months;
 - A service plan that ensures care coordination and outlines steps to address retention and adherence barriers, updated at every reassessment;

- o Supportive services (e.g., support groups or individual level treatment adherence interventions) and peer support services;
- o Quantitative and qualitative measurement of adherence (pill counts, pharmacy refill, modified DOT) in addition to self-report.

Patients in Tier II who have achieved and maintained viral suppression for > 6 months will be "discharged" from retention and adherence services, with continuing adherence monitored by the primary care provider. For Tier II, programs should identify and aggregate the most frequent factors related to non-adherence to HIV care and treatment in order to ensure that appropriate interventions are available. If sustained viral load is not maintained, patients unsuccessful with adherence should again re-enter retention and adherence services under Tier II.

MEASUREMENT OF RETENTION AND ADHERENCE AND PROGRAM SUCCESS

Linkage to Care Services

Programs will be required to measure linkage to care of all newly diagnosed PLWHAs referred to the RAP. Current literature on linkage and retention clearly indicates that newly diagnosed patients are often vulnerable and efforts to ensure linkage to care early on improves longer term retention. Programs are expected to identify the factors most frequently related to failure to link to primary HIV care and use this information to guide their engagement efforts.

Programs will systematically engage those individuals who have been scheduled for an initial appointment for HIV primary care because of a new diagnosis. Collaboration is necessary with other sub-specialty departments of the agency or community who will identify newly diagnosed individuals (i.e., general primary care, dental, obstetrics/gynecology, emergency medicine, community HIV testing sites). Program follow-up activities will engage those who do not keep the scheduled appointment and provide data on:

- The percentage of newly diagnosed patients in the reporting period who had their first HIV primary care visit within 30 days of the date of their confirmatory HIV test.

Retention of New Patients in HIV Primary Care Services

Agencies will be required to measure the retention of all newly diagnosed PLWHIV/AIDS receiving primary HIV care at their agency using the following measure:

- New Patient Retention: Percentage of newly diagnosed patients who have their initial HIV primary care medical visit during their first four months of the 12 month measurement period and who had an HIV clinical care visit in each of the subsequent 4 month periods in the measurement period.

Viral Load Suppression

Funded programs will be required to provide data on the following:

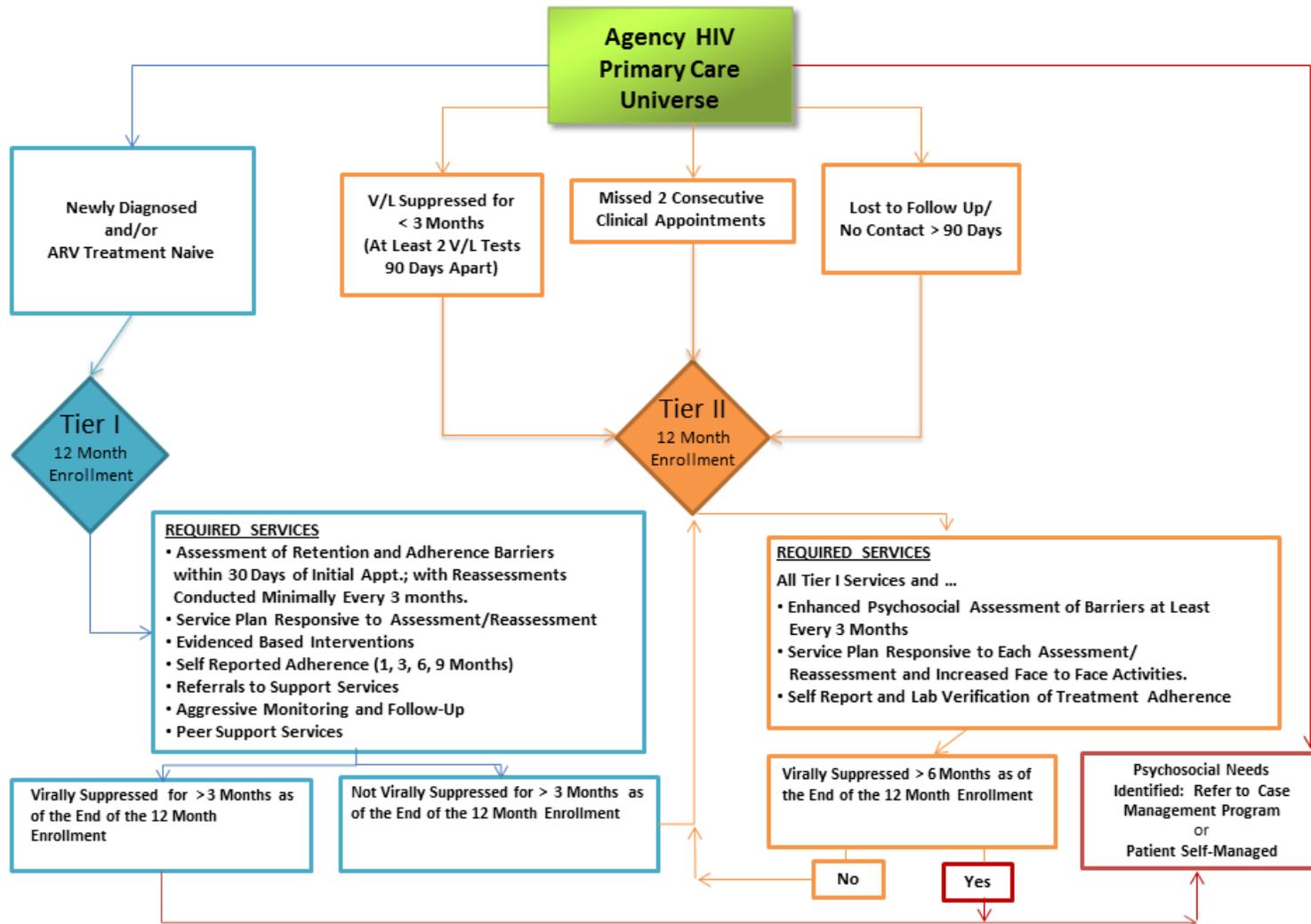
- Percentage of patients enrolled in Tier II who were virally suppressed for greater than 6 months.
- Percentage of patients in the HIV primary care clinic who were always virally suppressed within the review period.

EXPECTATIONS

- Provide a clinic wide approach to linkage and retention of patients in HIV primary care.
- Identify specific strategies to reengage clinic patients lost to follow-up and confirm return to care.
- Provide a comprehensive approach to assessing and assisting patients at risk for non-retention and non-adherence.
- Create and implement systems to identify and engage patients who are either treatment naïve or virally unsuppressed. Agencies should routinely screen all HIV+ patients to assess for services needed to achieve and sustain viral load suppression.
- Utilize a multidisciplinary team approach. Teams should include staff responsible for clinical oversight (clinical director) and administrative oversight of HIV services, HIV primary care providers, and staff responsible for the linkage, retention, treatment adherence and data management activities that are outlined in this document.
- Use evidence based retention and medication adherence interventions (www.cdc.gov/hiv/prevention/research/compendium/ma/index.html/ and http://www.iapac.org/uploads/iapac_three_pillars_guidelines_summary_table-03_05_12.pdf).
- Demonstrate collaboration with supportive services such as grant funded case management, Health Homes, pharmacy services, substance use treatment, mental health services and other services shown to improve retention, adherence and medical outcomes for PLWHA.
- Outline specific activities with community organizations and other health care providers to enhance linkage to care for newly diagnosed patients, retention of existing patients in care, and treatment initiation and adherence.
- Services should be integrated and documented in the electronic health record (EHR). Providers in transition to an EHR will document services in the patient's paper chart until implementation of the EHR.

Appendix II

Retention and Adherence Services Flow Chart



Retention and Adherence Standards Contributors

The standards were developed through a process that, over many months, solicited contributions of experienced AIDS Institute staff. We would like to recognize and thank all contributors. It is hoped that these standards will be used to improve medical outcomes for all PLWHA and ultimately, through education and treatment as prevention, support efforts to end the AIDS Epidemic.

Retention and Adherence Workgroup

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