

# Standards of Care



## Phoenix EMA Ryan White Part A Planning Council

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These Standards of Care  
have been developed by the Standards Committee  
of the



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Contents

**Early Intervention Services .....1**

**Food Bank/Home-Delivered Meals .....3**

**Health Education/Risk Reduction .....5**

**Health Insurance Premium/Cost Sharing Assistance (HIPSCA) .....7**

**Housing .....9**

**Medical Case Management .....11**

**Medical Nutritional Therapy.....17**

**Medical Transportation Services.....19**

**Mental Health Services .....21**

**Non-Medical Case Management.....27**

**Oral Health Care: Dental Insurance Program.....31**

**Oral Health Care: Direct Dental Program.....33**

**Outpatient Ambulatory Medical Care .....37**

**Psychosocial Support Services .....43**

**Substance Abuse Services (Outpatient).....45**

**Treatment Adherence..... 53**

**HRSA Universal and Program Standards..... <http://www.maricopa.gov/rwpc/publications.aspx>**

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# EARLY INTERVENTION SERVICES (EIS)

## A. DEFINITION:

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

**NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under Ambulatory/Outpatient Medical Care.**

## B. GOAL(S):

1. Decrease the number of underserved individuals with HIV/AIDS by increasing access to care.
2. Educate and motivate clients on the importance and benefits of getting into care.

## C. SERVICES:

**Early Intervention Services (EIS)** are the provision of a combination of services that include the following services as related to HIV/AIDS: counseling, testing, referrals, and other clinical and diagnostic services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care. These services must focus on expanding key points of entry and documented tracking of referrals. Benefits counseling, referrals, and linkages to care may include enrollment in Medicaid, Medicare, or private insurance plans through the health insurance marketplace established under the Affordable Care Act.

## D. QUALITY MANAGEMENT:

### Program Outcome:

- Decrease the number of underserved individuals with HIV/AIDS by increasing access to care.

### Indicators:

- Number of clients brought into care
- Number of clients returned to care.

**Service Unit(s):** Number of EIS clients reported in CAREWARE

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Service Provider shall provide client education concerning the HIV disease process, risk reduction, and maintenance of the immune system.	Documentation of client education in client files.	Number of newly enrolled clients	Number of EIS Clients	Client Charts and CAREWare	90% of newly enrolled EIS clients will have documentation of education given regarding HIV disease process, risk reduction, and maintenance of the immune system.
EIS programs will ensure that clients are connected to Central Eligibility and Primary Medical Care within 90 Days of initial intake.	Documentation of central eligibility appointment and first medical visit within 90 days of EIS intake in client files.	Number of newly enrolled clients	Number of EIS Clients	Client Charts and CAREWare	90% of newly enrolled EIS clients will have their first medical visit and central eligibility appointment within 90 days of their EIS intake in their client files.

## *FOOD BANK/HOME DELIVERED MEALS*

**A. DEFINITION:**

*Food Bank/Home-Delivered Meals* includes the provision of actual food and/or vouchers to purchase food.

**B. GOAL(S):** Clients accessing service show a maintained/improved nutritional state.

**C. SERVICES:**

This category includes the provision of actual food and/or food vouchers for clients who have been assessed to have a nutritional support need by a licensed Registered Dietitian as outlined in the EMA's Medical Nutrition Therapy service category.

**D. QUALITY MANAGEMENT:**

**Program outcome:** 50% of clients accessing food vouchers show a maintained/improved nutritional state.

**Indicators:**

- Number of requests completed for food vouchers
- Number of approved requests for food voucher program

**Service Unit(s):** Number of food vouchers in CAREWARE

<b>Standard of Care</b>	<b>Outcome Measure</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Data Source</b>	<b>Goal/Benchmark</b>
A written record of food card distribution will be maintained.	A written record of food card distribution will be maintained.			Written food card log will be maintained to support information entered into CAREWARE.	100% of all food cards distributed to clients will be recorded in food card log maintained by provider.
Service provider provides counseling to client related to access to other community resources for nutritional support	Planning sessions occur with clients regarding alternate source investigation for food bank/home-delivered meals.	Number of clients with alternate food sources session	Number of food clients	Client Chart CAREWARE	90% of charts document planning sessions with client regarding food source investigation.
Clients receiving food cards have at least one (1) documented medical visit within 6 month period of measurement year.	Clients show medical visit and retention of medical care	Number of clients with documented medical visit within 6 months of measurement year	Number of food clients	Client Chart CAREWARE	90% of clients receiving food cards have at least one (1) documented medical visit within 6 month period of measurement year.
Clients accessing food vouchers show a maintained/improved nutritional state	Clients accessing food vouchers show a maintained/improved nutritional state	Number of clients who show a maintained/improved nutritional state	Number of food clients	Client Chart CAREWARE	50% of clients accessing food vouchers show a maintained/improved nutritional state

## *HEALTH EDUCATION/RISK REDUCTION (HE/RR)*

### **A. DEFINITION:**

Health Education/Risk Reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

### **B. GOALS**

The overall goal of Health Education/Risk Reduction is to create and provide quality education programs to increase the health literacy of PLWHA including how to reduce the risk of HIV transmission.

### **C. SERVICES:**

Activities of Health Education/Risk Reduction include, but are not limited to:

- a. Multi-media presentations that educate PLWHA on topics including: basic health insurance understanding; importance of HIV medical care including prevention services; and avoidance of risk behaviors for HIV transmission.

### **D. QUALITY MANAGEMENT:**

#### **Program outcome:**

75% of clients demonstrate a higher level of HIV health literacy after completion of HERR sessions.

#### **Indicators:**

- Number of clients with increased level of HIV health literacy.

**Service Unit(s):** Face to face visits in CAREWare

<b><i>Standard of Care</i></b>	<b><i>Outcome Measure</i></b>	<b><i>Numerator</i></b>	<b><i>Denominator</i></b>	<b><i>Data Source</i></b>	<b><i>Goal/Benchmark</i></b>
Multi-media presentations that educate PLWHA on topics including: basic health insurance understanding; importance of HIV medical care including prevention services; and avoidance of risk behaviors for HIV transmission.	Clients participating in HERR sessions	Number of clients enrolled in HERR services	Number of clients	Client Files CAREWare	75% of clients demonstrate a higher level of HIV health literacy after completion of HERR sessions.

## *HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE*

### **A. DEFINITION:**

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

**B. GOAL(S):** Maintain client's access to and retention in medical, dental and behavioral healthcare.

### **C. SERVICES:**

The HIPCSA program is intended to help HIV positive individuals continue medical, dental and behavioral healthcare without gaps in health insurance coverage or disruption of treatment. Continued insurance coverage allows clients to obtain care not limited to HIV treatment, therefore resulting in greater overall client health outcomes. Continued coverage also reduces the burden on publicly-funded medical care systems.

Ryan White funds for the HIPCSA program can be used toward co-payments, co-insurance, deductibles (not to exceed \$3,000 per unduplicated client per grant year) and premiums (not to exceed \$350 per month per unduplicated client per grant year totaling \$4,200) for individual and group policies. No Ryan White funds can be used toward co-payments associated with hospitalization and/or emergency room care.

No Ryan White Part A funds will be used to pay out-of-network costs. Part A funds from the HIPCSA program may assist with prescription drug co-payments. Ryan White funds may NOT be used to cover a client's Medicare Part D "true out-of-pocket" (i.e. TrOOP or donut hole) costs.

If a client is receiving tax credits or subsidies through the Affordable Care Act to purchase insurance, the client must apply the subsidy or credit to monthly premiums. Ryan White funds will not be used to pay the subsidized portion of the cost of insurance.

Ryan White funds can only be used to purchase insurance plans whose drug benefits are equivalent to those provided by the ADHS HIV Medication Program.

**D. QUALITY MANAGEMENT:**

**Program outcome:** 100% of clients who are enrolled in HIPCSA receive allowable services.

**Indicators:** 100% of clients access HIV-related primary medical care supported by co-payment/co-insurance/premium/deductible assistance

**Service Unit(s):**

- Number of successful co-payments/co-insurance/premium/deductible

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Client receives HIPCSA based on accurate coordination of benefits with 3 <sup>rd</sup> party payer.	Documentation verifying accurate coordination of benefits with 3 <sup>rd</sup> party payer.	Number of clients receiving HIPCSA.	Number of HIPCSA clients	Client Chart CAREWare	100% of clients who are enrolled in HIPCSA receive allowable services.

# HOUSING SERVICES

## A. DEFINITION:

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

## B. GOAL(S):

Provide permanent housing, which supports consistent adherence and retention in medical care.

## C. SERVICES:

Housing services, first month of rental assistance is for the purpose of maintaining an individual or family in a long-term, stable living situation. The housing strategy plan will be conducted at intake to ensure the individual or family is capable of sustaining a stable long-term living situation; follow up contact to ensure the move occurred.

Financial assistance is limited to the first month of rental assistance. The maximum amount of emergency assistance is \$800.

## D. QUALITY MANAGEMENT:

### Program outcome:

- 75% of clients receiving rental assistance have access to permanent housing, which supports consistent adherence and retention in medical care.

### Indicators:

- Number of clients accessing rental assistance for permanent housing
- Number of clients with documentation that permanent housing was initiated.

**Service Unit(s):**

- Successful completed application as documented in CAREWare
- Face-to-face or phone contacts

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
First month rental payment is made out to the appropriate vendor. No payment may be made directly to clients, family or household members.	The Agency providing first month rental assistance must maintain the following documents in each client's case file, in addition to any other documentation which may be required by the Standards of Care: <ul style="list-style-type: none"> <li>• Copy of signed rental agreement and/or lease</li> <li>• Copy of vendor check for payment;</li> <li>• Copy of documentation of application for other assistance, if applicable;</li> </ul>	Number of clients receiving Housing Assistance payments	Number of clients	Client Files CAREWare	75% of client charts have documentation of rental assistance payments made to appropriate vendor.
All completed requests for assistance shall be approved or denied within one (1) working day of the receipt of signed rental agreement and/or lease. A check shall be issued within seven (7) working days of approval of request.	Documentation in client's file of Housing assistance funds to clients within 7 working days of approved request.	Number of clients receiving Housing Assistance funds within 7 working days	Number of Housing Assistance funds requests	Client Files CAREWare	75% of client charts document funds to clients within 7 working days of approved request.

# MEDICAL CASE MANAGEMENT SERVICES

## A. DEFINITION:

**Medical Case Management Services (including treatment adherence)** are a range of client-centered services designed to ensure timely and coordinated access to medically appropriate levels of health and support services, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and other forms of communication and activities that include at least the following:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Continuous client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan as least every 6 months, during the enrollment of the client

## B. GOAL(S):

1. All eligible new (or newly diagnosed) and returning to care (out-of-medical care for a minimum of six months and/or out of the Ryan White continuum of care for 1 year) clients will be referred to medical case management.
2. Improve clients' health by increasing access to primary medical care and the support services necessary to maintain retention in care and/or reduce barriers to care.

## C. SERVICES:

Medical Case Management services are designed to facilitate access to primary medical care through a process of linkage to medical services and reduce barriers to care. Additionally, medical case management services are designed to facilitate access to community services as a process of enabling linkage to medical care and other needed services.

## D. STAFF QUALIFICATIONS:

1. Medical Case Managers will have a Bachelor's Degree in a licensed field or 4 years of experience.
2. Case Management Supervisors will have a Master's Degree in Social Work or comparable human service field and minimum 2 years of experience in direct service or case management **OR** Bachelor's Degree in Social Work or comparable human service field and minimum of 4 years of experience in direct service or case management.

**E. QUALITY MANAGEMENT:**

**Program Outcome:**

- 90% of client charts have documentation of access to primary medical care within 3 months of initial assessment
- 80% of client charts have documentation that treatment adherence was discussed with the client
- 100% of client charts contain a comprehensive individualized care plan.

**Indicators:**

- Number of client charts that have documentation of access to primary medical care within 3 months of initial assessment
- Number of client charts that have documentation that treatment adherence was discussed with the client
- Number of client charts that contain a comprehensive individualized care plan

**Service Unit(s):**

- Number of clients accessing Medical Case Management services

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Part A Eligibility: After the establishment of Part A eligibility, the following timelines for entry into services are adhered to: <ul style="list-style-type: none"> <li>• Upon referral to Medical Case Management agency assignment to a case manager is completed within 3 business days</li> <li>• Initial contact with client, initial medical case management assessment and care plan completed within 10 business days of assignment to case manager</li> </ul>	Client chart documents case manager assignment, initial client contact, initial medical case management assessment and completion of care plan occurred in compliance with established timeframe.  Clients chart documents circumstances regarding why case manager assignment, initial client contact, initial medical case management assessment and completion of care plan did not occur within established timeframe.	Number of compliant client charts  Number of compliant client charts	Number of clients  Number of clients	Client Files  CAREWARE	90% of client charts have documentation of access to primary medical care within 3 months of initial assessment
Client Contact: Contact with	Client chart documents that	Number of	Number of	Client Files	90% of client charts have

client, initiated by the medical case manager, will occur at least quarterly, and will include at least one face-to-face annually.	case manager initiated contact with client occurred in compliance with established timeframe. Clients chart documents circumstances regarding why case manager initiated contact with client did not occur within established timeframe.	compliant client charts	clients	CAREWARE	documentation of at least quarterly contact with Medical Case Manager.
Medical Case Management Assessment & Service Needs: The client's medical case management assessment provides the foundation for the care plan.	Each client's initial assessment will include a review of the following areas: <ul style="list-style-type: none"> <li>• Medical</li> <li>• Treatment adherence</li> <li>• Dental</li> <li>• Nutritional</li> <li>• Mental Health</li> <li>• Psychosocial</li> <li>• Substance abuse</li> <li>• Financial</li> <li>• Educational</li> <li>• Social Support</li> <li>• Legal needs</li> <li>• Transportation</li> <li>• Housing</li> <li>• Risk reduction</li> <li>• Cultural factors</li> <li>• Life Skills</li> <li>• Functional capabilities</li> </ul>	Number of compliant client initial assessments	Number of clients	Client Files CAREWARE	90% of client charts have documentation that treatment adherence was discussed with the client  90% of client charts will have a comprehensive assessment.
Medical Case Management Comprehensive and Individualized Care Plan: At a minimum the medical case	Each client's comprehensive individualized initial and periodic (revised every six (6) months) care plan shall	Number of compliant charts	Number of clients	Client Files CAREWARE	100% of client charts contain a comprehensive individualized care plan.

management comprehensive and individualized care plan.	outline the range of services required to implement the plan with an identified goal and one or more interventions for each identified need and all appropriate referrals.				90% of client charts have documentation of access to primary medical care within 3 months of initial assessment.
Clinical Care Team Identification and Communication: HRSA Part A Medical Case Management Standards has made mandatory the need for the Medical Case Manager to identify the Clinical Care Team (CCT) and to establish and maintain communication with the team in order to provide coordination of services required to implement the client(s) comprehensive, individualized care plan. The medical case manager will be responsible for documentation in the client chart.	Listing Client's individualized Clinical Care Team Members by: <ul style="list-style-type: none"> <li>• Category of service/care</li> <li>• Agency Name</li> <li>• Staff Member</li> <li>• Contact Information and Preferred Method(s) of Communication</li> <li>• Dates and subject of communication</li> </ul>	Number of complaint charts	Number of clients		90% of client files have documentation of clinical care team members.
Ongoing Documentation Requirements: After initial and periodic medical case management assessment and care plan completion, the ongoing documentation in each client's chart will include: contacts, or attempts to contact, the client regarding progress toward goals and the status of referrals.	Client's chart documents the periodic re-assessments and adaptation of the care plan at least every 6 months, or as necessary to meet the clients need. Reassessments reflect client's progress in obtaining services and changes in client status.  Client's chart documents the coordination of services required to implement the client's comprehensive individualized medical case	Number of compliant charts  Number of compliant charts	Number of clients  Number of clients	Client Files CAREWARE  Client Files CAREWARE	100% of client charts contain a comprehensive individualized care plan.

	management care plan.				
	Client's chart contains documentation of all contacts, or attempts to contact, the client regarding progress toward goals and the status of referrals.	Number of compliant charts	Number of clients	Client Files CAREWARE	
	Client's chart documents monitoring to assess the efficacy of the care plan for the types of services provided, including: the types of encounters/communication; duration and frequency of encounters.	Number of compliant charts	Number of clients	Client Files CAREWARE	
	All medical case management care plans will include the client's signature and date annually.	Number of compliant charts	Number of clients	Client Files CAREWARE	
	The medical case management care plan reflects a timeline for all goals and service referrals agreed upon by the client and case manager.	Number of compliant charts	Number of clients	Client Files CAREWARE	
	The medical case management care plan goals reflect the projected treatment end date agreed upon by the client and case manager.	Number of compliant charts	Number of clients	Client Files CAREWARE	

	Supervisor reviews a sample of client charts, within 30 business days after completion of a new or updated assessment and care plan, to ensure all required record components are present and planned services are appropriate. At a minimum, the sampling methodology will comply with HIVQUAL standards or 20% of charts ( <i>aligns with Non-Medical Case Management</i> ).	Number of compliant charts	Number of clients	Client Files CAREWARE	90% of supervisor reviewed client charts have all required components.
Case Closure: A client chart will be closed when deemed necessary by client circumstances, including but not limited to, verifiable notification of client's death, moving out of the Phoenix EMA, lost to contact, or documented client-initiated withdrawal from the Ryan White Part A program.	The client's chart includes a closure note which documents criteria for closure within ten business days of notification of the status change.	Number of clients discharged from MCM	Number of clients	Client Files CAREWARE	90% of discharged clients have documentation of case closure and reason in client files.

## *MEDICAL NUTRITION THERAPY*

### **A. DEFINITION:**

**Medical Nutrition Therapy** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

### **B. GOAL(S):**

1. All clients that demonstrate a need for Medical Nutrition Therapy will be referred to Medical Nutrition Therapy service.

### **C. SERVICES:**

Medical Nutrition Therapy (MNT) will include education/counseling for nutrition needs, development and provision of individual nutritional care plans and provide counseling in health promotion, disease progression and disease prevention as it relates to nutrition. Other services may include referral for medical nutritional therapy Body Mass Index Assessment (BMI), bioelectrical impedance analysis (BIA) or other appropriate measures of nutritional status; review of lab results to gauge nutritional status; nutritional supplements and food secure assessment. Services may include the provision of nutritional supplements.

### **D. QUALITY MANAGEMENT:**

#### **Program outcome:**

- 90% of clients enrolled in Medical Nutrition Therapy will have at least one Medical Nutrition Therapy assessment per year
- 50% of clients will show maintained/improved Bioelectric impedance analysis (BIA).

#### **Indicators:**

- Nutritional plans detail client goals in nutrition in relation to their medical treatment needs
- Number of nutritional care plans updated to enhance medical care

**Service Unit(s):** Medical Nutrition Therapy appointments in CAREWARE

<b>Standard of Care</b>	<b>Outcome Measure</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Data Source</b>	<b>Goal/Benchmark</b>
An initial MNT assessment will be conducted by a Registered/Licensed Dietitian to ensure appropriateness of service.	Documentation of nutrition assessment on file in client's chart.	Number of nutrition assessments completed in client files	Number of clients	Client Files CAREWARE	90% of client files have nutritional assessments documented.
The nutrition care process will include: <ul style="list-style-type: none"> <li>• Nutritional assessment</li> <li>• Nutritional diagnosis</li> <li>• Nutrition intervention</li> <li>• Nutrition monitoring and evaluation</li> </ul>	Signed, dated nutritional plan including measurable goal oriented strategies on file in client records.	Number of signed/dated nutritional plans	Number of clients	Client Files CAREWARE	90% of client files have signed/dated nutritional plans documented. Nutritional plans should be signed/dated by registered dietician.
Nutrition care plan will be updated as necessary, at least annually, and may be shared with client's primary care provider and/or other personnel involved in client's care.	Updated, signed plan on file in client's record.	Number of updated nutritional plans	Number of clients	Client Files CAREWARE	90% of client files have documentation of updated signed nutritional plans at least annually.
Nutritional care plan will assess client's weight, Bioelectric impedance analysis (BIA), and dietary intake.	Documentation in client file.	Number of nutritional care plans	Number of clients	Client Files CAREWARE	90% of client files have documentation of care plan assessment including client weight, BIA and dietary intake.
Nutritional care plan will be individualized by Registered Dietitian assessing clients' medical needs.	Documentation in client file.	Number of nutritional care plans	Number of clients	Client Files CAREWARE	90% of client files have documentation of individualized nutritional care plans addressing clients' medical needs.
Clients will show maintained or improved Bioelectric impedance analysis (BIA)	Documentation in client file.	Number of nutritional care plans	Number of Clients	Client Files CAREWARE	50% of clients will show maintained/improved Bioelectric impedance analysis (BIA)

# MEDICAL TRANSPORTATION SERVICES

## A. DEFINITION:

**Medical Transportation Services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

## B. GOAL(S):

3. Clients demonstrate retention in care.

## C. SERVICES:

**Medical Transportation Services** enable an eligible individual to access HIV- related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens

May be provided through:

- Contracts with providers of transportation services
- Voucher or token systems

## D. QUALITY MANAGEMENT:

### Program Outcome:

- 90% of eligible clients demonstrate retention in care

### Indicators:

- The number of clients who arrived at core/support service appointments as a result of Medical Transportation Services.

### Service Unit(s):

- Successfully completed transport to Core/Support Services via Medical Transportation Services.

<b>Standard of Care</b>	<b>Outcome Measure</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Data Source</b>	<b>Goal/Benchmark</b>
Client eligibility for taxi utilization will be for those whom public transportation imposes an unreasonable barrier to care.	Unreasonable barriers to care will be determined by chart documentation of the barrier to care, which may include one of the following: <ul style="list-style-type: none"> <li>- Lack of availability of personal or public transport</li> <li>- Traveling with children</li> <li>- Safety reasons</li> <li>- Extreme weather</li> <li>- Documented health issues</li> <li>- Services are in excess of 30miles from client's residence</li> </ul>	Number of clients with appropriate documentation accessing taxi services.	Number of Clients accessing taxi services.	Client Charts and CAREWare	90% of the reviewed files have documentation of the selected, allowable taxi utilization criteria in the client's file.
Taxi requests are authorized by Case Management and coordinated by the Transportation Coordinator.	Response to a request for taxis will be documented and completed within 3 business days of client's request.	Number of authorized taxi referrals completed in 3 business days.	Number of taxi referrals.	Client Charts and CAREWare	90% of client files have documentation of taxi referral being completed in 3 business days.
Clients receiving taxi services are transported from pick-up to designated destination as ordered.	Taxi services are provided as scheduled.  Follow-up is documented by the service provider and the vendor.	Number of clients with a completed taxi ride.	Number of Clients accessing taxi services.	Taxi Order Log CAREWare	90% of the files have documentation that the <i>ordered</i> taxi ride was completed.
Clients receiving bus passes have documentation of attendance at or future appointment for HIV services in client file.	Documentation of appointment or attendance at HIV services.	Number of clients with appropriate documentation receiving bus passes.	Number of clients utilizing bus passes.	Client Chart	90% of the reviewed files have appropriate documentation for clients utilizing bus passes.

# MENTAL HEALTH SERVICES

## A. DEFINITION:

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

## B. GOAL(S):

1. Assist HIV-positive clients with reduction of symptoms related to mental health disorders thereby reducing barriers to medical care
2. Provide psychiatric evaluation and medication monitoring if indicated
3. Comply with the State of Arizona requirements for the provision of behavioral health services, and the Planning Council's Universal Standards of Care

## C. SERVICES:

Mental health counseling services includes intensive mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Arizona. Counseling services may include general mental health therapy, counseling, bereavement support for clients. General mental health therapy, counseling and short-term\* bereavement support is available for non-HIV infected family members or significant others. Crisis counseling and referral will be available to clients and care givers. Medical services are provided by a licensed medical, board certified psychiatrist.

\* Short term is defined based on the mental health professional's judgment.

## D. QUALITY MANAGEMENT:

### Program Outcome:

- **90%** of treatment goals are addressed and **50%** are met, upon completion of mental health treatment.
- **85%** of clients receive an assessment prior to implementing the treatment plan.
- **85%** of clients have a completed treatment plan within 90 days from the clients' first visit.
- **85%** of treatment plans address primary medical care needs and make appropriate referrals as needed.

**Indicators:**

- Number of clients attending Mental Health services who are engaged in treatment.\*
- Number of clients who have addressed at least 2 treatment goals.

\*Engaged=individual invested in treatment and attends a minimum of 50% of substance abuse services appointments

**Service Unit(s):**

- Face-to-face individual level Mental Health visit and/or face-to-face group level Mental Health visit

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
An appointment will be scheduled within seven (7) working days of a client’s request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	Documentation in patient’s file.	Number of days documented between client request and appt.	Number of clients	Client Files CAREWARE	70% of clients will have an appointment scheduled within seven (7) working days of request for mental health services.
Assessment will occur that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 10. A comprehensive assessment including the following will be completed within seven (7) days of intake or no later than and prior to the third counseling session: <ul style="list-style-type: none"> <li>• Presenting Problem</li> <li>• Developmental/Social history</li> </ul>	Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I.	Number of new client charts with assessment completed within 10 days of intake	Number of new clients	Client Files CAREWARE	70% of new client charts have documented comprehensive assessments initiated within seven (7) days of intake.

<ul style="list-style-type: none"> <li>• Social support and family relationships</li> <li>• Medical history</li> <li>• Substance abuse history</li> <li>• Psychiatric history</li> <li>• Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks)</li> <li>• Cognitive assessment (level of consciousness, orientation, memory and language)</li> <li>• Psychosocial history (Education and training, employment, Military service, Legal history, Family history and constellation, Physical, emotional and/or sexual abuse history, Sexual and relationship history and status, Leisure and recreational activities, General psychological functioning).</li> </ul>					
<p>A treatment plan must be completed that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 10. A treatment plan shall be completed within 90 days that is specific to individual client needs. The</p>	<p>Documentation in client's file.</p>	<p>Number of client charts with completed treatment plans within 90 days of first visit</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts will have documentation of a completed treatment plan within 90 days of first visit.</p>

<p>treatment plan shall be prepared and documented for each client. Individual, and family case records will include documentation of the following:</p> <ul style="list-style-type: none"> <li>• Client’s presenting issue</li> <li>• Identification of entities to provide all services</li> <li>• Signature of client or guardian</li> <li>• Signature and title of behavioral health professional and date completed</li> <li>• One or more treatment goals</li> <li>• One or more treatment methods</li> <li>• Frequency of treatment sessions</li> <li>• Projected treatment end date</li> <li>• Date the treatment plan shall be reviewed</li> <li>• Discharge planning, which includes education on relapse prevention</li> </ul>					
<p>Progress notes are completed for every professional counseling session and must include:</p> <ul style="list-style-type: none"> <li>• Client name</li> <li>• Session date</li> <li>• Observations</li> <li>• Focus of session</li> <li>• Interventions</li> <li>• Assessment</li> </ul>	<p>Legible, signed and dated documentation in client record.</p>	<p>Number of client charts with progress notes</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts will have documented legible, signed and dated progress notes.</p>

<ul style="list-style-type: none"> <li>• Duration of session</li> <li>• Counselor authentication, in accordance with current accreditation or state standards.</li> </ul>					
<p>Discharge planning is done with each client after 30 days without client contact or when treatment goals are met:</p> <ul style="list-style-type: none"> <li>• Circumstances of discharge</li> <li>• Summary of needs at admission</li> <li>• Summary of services provided</li> <li>• Goals completed during counseling</li> <li>• Discharge plan</li> <li>• Counselor authentication, in accordance with current accreditation or state standards.</li> </ul>	Documentation in client's record.	Number of discharged clients	Number of clients	Client Files CAREWARE	70% of client charts have documentation of discharge planning within 30 days of treatment goals being met or no client contact.
Clients accessing Psychiatric care are medically adherent and are engaged in their psychiatric treatment plans.	Clients are assessed for psychiatric care and when engaged in psychiatric care, are medically adherent.	Number of psychiatric clients	Number of clients	Client Files CAREWARE Agency Policy and Procedure Manual	70% of clients accessing psychiatric care are medically adherent and are engaged in their psychiatric treatment plans.
Access to and maintenance in Medical Care: RW clients' ongoing participation in primary HIV medical care	Each client is assessed and verified for engagement in HIV medical care and assisted with establishing linkages to care if not currently receiving care. Assessed initially, then re-assessed and documented twice annually.	Number of clients assessed/verified for medical care initially and twice annually.	Number of clients	Client Files CAREWARE	70% of clients are assessed and verified for engagement in medical care. This is assessed initially, then re-assessed and documented twice annually.



## NON-MEDICAL CASE MANAGEMENT SERVICES

### A. DEFINITION:

**Non-Medical Case Management** includes the provision of advice and assistance in obtaining:

- medical
- social
- community
- legal
- financial
- other needed services

Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. NOTE: The provision of advice is to be based on the professional parameters of the non-medical case manager.

### B. GOAL(S):

1. Clients will be provided Non-Medical Case Management services that support the clients' linkage to, and retention in medical care.

### C. SERVICES:

Non-Medical Case Management services are designed to facilitate access to, and retention in medical care and other needed community services.

### D. STAFF QUALIFICATIONS:

1. Non-Medical Case managers will have a Bachelor's Degree in a licensed field or 3 years of experience.
2. Case Management Supervisors will have a Master's Degree in Social Work or comparable human service field and minimum 2 years of experience in direct service or case management **OR** Bachelor's Degree in Social Work or comparable human service field and minimum of 4 years of experience in direct service or case management.

**E. QUALITY MANAGEMENT:**

**Program Outcome:**

- 90% of client charts reviewed demonstrate support of the clients’ health by increasing access to services and/or resources necessary to reduce barriers to care.

**Indicators:**

- Number of client charts that have documentation of access to primary medical care and other needed community services

**Service Unit(s):**

- Number of clients accessing Non-Medical Case Management services

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Central Eligibility: Central Eligibility Services will be provided to all individuals presenting for Ryan White Part A services, to determine eligibility and individual client referral needs.	New or returning to care clients: Client chart documents an intake assessment, with offered referrals to medical case management services.	Number of compliant client charts	Number of clients	Client Files CAREWARE	90% of client charts reviewed demonstrate support of the clients’ health by increasing access to services and/or resources necessary to reduce barriers to care.
	Renewing clients: Client chart documents that appropriate referrals were made based on identified client need.	Number of compliant client charts	Number of clients		
Client Contact, Identification of Resources and Referrals: Initial, client contact with the non-medical case manager will be initiated by client request or referral	Client chart documents that case managers contact with client occurred within 10 business days of client request or referral.	Number of compliant client charts	Number of clients	Client Files CAREWARE	90% of clients contacted within 10 business days of client request or referral
	Client chart documents the	Number of	Number of	Client Files	90% of client charts documents

	<p>circumstances regarding why the case manager's contact with the client did not occur.</p> <p>Client chart documents the identification of applicable resources, that the client was informed of those resources, and the provision of appropriate referral/interventions</p> <p>Client chart contains documentation of:</p> <ul style="list-style-type: none"> <li>• Date of each encounter</li> <li>• Type of encounter (e.g. fact to face, telephone etc.)</li> <li>• Duration of encounter</li> <li>• Client's request and disposition of request</li> <li>• Key activities, including interventions and referral services.</li> </ul>	<p>compliant client charts</p> <p>Number of compliant client charts</p> <p>Number of compliant client charts</p>	<p>clients</p> <p>Number of clients</p> <p>Number of clients</p>	<p>CAREWARE</p> <p>Client Files</p> <p>CAREWARE</p> <p>Client Files</p> <p>CAREWARE</p>	<p>why contact did not occur</p> <p>90% of client charts document the identification of applicable resources, client was informed of those resources and the provision of appropriate referral/interventions</p> <p>90% of client charts contain appropriate documentation.</p>
<p>Supervisor Review: Supervisor completes a monthly review of a sample of client charts to ensure all required record components are present.</p>	<p>The supervisor will sign and date each client record reviewed, and maintain a record of all charts reviewed. At a minimum, the sampling methodology will either comply with HIVQUAL standards or equal 20% of all client charts for each month.</p>	<p>Number of compliant client charts</p>	<p>Number of clients</p>	<p>Client Files</p> <p>CAREWARE</p>	<p>90% of sampled client charts reviewed by supervisor</p>
<p>Case Closure: A client chart will</p>	<p>The client's chart includes a</p>	<p>Number of</p>	<p>Number of</p>	<p>Client Files</p>	<p>90% of case closures have</p>

<p>be closed when deemed necessary by client circumstances, including but not limited to, verifiable notification of client's death, moving out of the Phoenix EMA, lost to contact, or documented client-initiated withdrawal from the Ryan White Part A program. Any client who has no contact with the case management agency after a three year period may have their case closed and the client's file will be handled in accordance with the agency's record retention policy.</p>	<p>closure note which documents criteria for closure within ten business days of notification of the status change.</p>	<p>compliant charts</p>	<p>clients</p>	<p>CAREWARE</p>	<p>documentation of case closure and reason in client files.</p>
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# ORAL HEALTH SERVICES: DENTAL INSURANCE PROGRAM

## A. DEFINITION:

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

## B. GOAL(S):

1. Provide clients access to oral health care thereby reducing barriers to care
2. Improve overall client health care

## C. SERVICES:

Dental Insurance coverage to access services that include routine dental examinations, prophylaxis, x-rays, fillings, endodontistry, prosthodontics and basic oral surgery.

## D. QUALITY MANAGEMENT:

### Program Outcome:

- 75% of client charts who had a periodontal screen or examination at least once in the grant year.

### Indicators:

- Number of clients who had a periodontal screen or examination at least once in the grant year.

**Service Unit(s):**

- Oral exams

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
HIV-infected oral health patients <sup>1</sup> who had a periodontal screen or examination <sup>2</sup> at least once in the grant year.	Documentation of periodontal screen or examination	Number of clients with periodontal screen or examination	Number of clients	CAREWARE  Office of Oral Health Report	75% of HIV-infected oral health patients have a periodontal screen or examination at least once in the grant year.

<sup>1</sup> "Patient" includes all patients aged 13 year or older.

<sup>2</sup> A periodontal screen should include the assessment of medical and dental histories, the quantity and quality of attached gingival; bleeding; tooth mobility; and radiological review of the status of the periodontium and dental implants. A comprehensive periodontal examination includes "the evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation" (Source: American Dental Association. Current Dental Terminology: CDT 2009-2010.) The screening or examination may be performed and documented by either a licensed dentist or, where state regulations allow, by a dental hygienist, but the interpretation of data and diagnosis must be made by a licensed dentist.

## ORAL HEALTH SERVICES: DIRECT DENTAL PROGRAM

### A. DEFINITION:

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

### B. GOAL(S):

3. Provide clients access to oral health care thereby reducing barriers to care
4. Improve overall client health care

### C. SERVICES:

Oral Health Services coverage to access services that include routine dental examinations, prophylaxis, x-rays, fillings, endodontistry, prosthodontics and basic oral surgery.

### D. QUALITY MANAGEMENT:

#### Program Outcome:

- 75% of client charts who had a periodontal screen or examination at least once in the grant year.
- 50% of clients initiate their treatment plan

#### Indicators:

- Number of clients who had a periodontal screen or examination at least once in the grant year.
- Number of client who initiate their treatment plan
- Number of client who receive an initial periodontal exam and follow-up exam as appropriate

#### Service Unit(s):

- Oral exams
- Treatment plans

<b>Standard of Care</b>	<b>Outcome Measure</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Data Source</b>	<b>Goal/Benchmark</b>
The baseline health history should be consistent with the American Dental Association guidelines.	The baseline health history may include, but is not limited to, the following: <ul style="list-style-type: none"> <li>• Co-morbidities</li> <li>• Allergies and drug sensitivities</li> <li>• Current medications</li> <li>• Heart problems</li> <li>• Kidney problems</li> <li>• Alcohol use</li> <li>• Recreational drug use</li> <li>• Hepatitis A, B and C</li> <li>• Tobacco use history</li> <li>• General health and surgery history</li> <li>• Joint replacement and presence of pins</li> <li>• Review and update of medical history at recall appointments, or more frequently if the patient's health requires it</li> </ul>	Number of clients with a baseline health history.	Number of clients	Client Files CAREWARE	75% of oral health clients will have a baseline health history consistent with American Dental Association guidelines.
HIV-infected oral health patients <sup>3</sup> who had a periodontal screen or examination <sup>4</sup> at least once in the grant year.	Documentation of periodontal screen or examination	Number of clients with periodontal screen or examination	Number of clients	Client Files CAREWARE	75% of HIV-infected oral health patients have a periodontal screen or examination at least once in the grant year.

<sup>3</sup> "Patient" includes all patients aged 13 year or older.

<sup>4</sup> A periodontal screen should include the assessment of medical and dental histories, the quantity and quality of attached gingival; bleeding; tooth mobility; and radiological review of the status of the periodontium and dental implants. A comprehensive periodontal examination includes "the evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation" (Source: American Dental Association. Current Dental Terminology: CDT 2009-2010.) The screening or examination may be performed and documented by either a licensed dentist or, where state regulations allow, by a dental hygienist, but the interpretation of data and diagnosis must be made by a licensed dentist.

		on			
HIV-infected oral health patients that initiate their treatment plan	Documentation of treatment plan initiation	Number of clients that initiated their treatment plan	Number of clients that initiated their treatment plan established in the year prior to the grant year.	Client Files CAREWARE	50% of HIV-infected oral health patients have documentation of treatment plan initiation



## OUTPATIENT/AMBULATORY MEDICAL CARE

### A. DEFINITION:

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

### B. GOAL(S):

1. Retain clients in Outpatient/Ambulatory Medical Care to achieve viral suppression.

### C. SERVICES:

Outpatient medical care provided to HIV+ individuals by or under the direction of a licensed physician, physician assistant, nurse practitioner or registered nurse. Services focus on appropriate medical intervention, continuous health care and/or chronic disease care over time as the patient's condition progresses.

### D. QUALITY MANAGEMENT:

#### Program Outcome:

- 85% of newly diagnosed clients referred to OAMC will be seen within 30 days
- 70% of retained OAMC clients will demonstrate viral suppression (<200)

**Indicators:**

- Number of clients retained in OAMC

**Service Unit(s):** OAMC visits in CAREWare.

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
<p>All HIV infected patients receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP or PA in accordance with professional and established HIV practice guidelines (<a href="http://www.aids.gov">www.aids.gov</a>) within 4 weeks of initial contact with the patient.</p> <p>Treatment shall be offered and delivered according to most recent Health and Human Services (HHS) guidelines for the treatment of people with HIV/AIDS.</p>	<p>Clients have HIV viral loads monitored every 6 months.</p> <p>Clients will receive a health assessment and comprehensive physical exam including a mental health assessment that includes screening for clinical depression and a substance use/abuse history.</p> <p>All newly diagnosed clients will receive an HIV drug resistance test.</p> <p>Clients who meet current guidelines for ART are offered and/or prescribed ART.</p> <p>Clients will have at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-</p>	<p>Number of clients offered and/or prescribed ART.</p> <p>Number of clients with medical visits every 6 months.</p> <p>Number of clients offered and/or prescribed ART.</p> <p>Number of clients with medical visits every 6 months.</p> <p>Number of</p>	<p>Number of clients.</p> <p>Number of Clients.</p> <p>Number of clients who meet guidelines.</p> <p>Number of clients.</p>	<p>CAREWare or chart audits.</p>	<p>75% of clients have 2 or more HIV viral loads annually.</p> <p>75% of clients will receive a health assessment and comprehensive physical exam including a mental health assessment that includes screening for clinical depression and a substance use/abuse history.</p> <p>75% of newly diagnosed clients will receive an HIV drug resistance test.</p> <p>100% of clients who meet current guidelines for ART are offered and/or prescribed ART.</p> <p>75% of clients will have at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-</p>

	month period.  Clients with a CD4 count below 200 who are recommended and/or prescribed PCP prophylaxis.	clients with CD4 counts <200 who are recommended and/or prescribed PCP prophylaxis.	Number of clients with CD4 counts <200.		month period.  75% of clients with a CD4 count below 200 who are recommended and/or prescribed PCP prophylaxis.
Basic laboratory tests are ordered per HHS guidelines.	Clients' medical record document the following screenings:  Clients on ART receive lipid screens annually;  Clients receive syphilis screens annually;  Clients receive Chlamydia screening annually;  Clients receive gonorrhea screening annually;  Clients receive Hepatitis A, B & C screens if not immune and then annually for high-risk individuals;  Clients receive a TB screen at initial HIV diagnosis, then annually	Number of clients on ART with annual lipid screen;  Number of clients with annual syphilis screen;  Number of clients with annual Chlamydia screening;  Number of clients with annual gonorrhea screening;  Number of clients with hepatitis screens as indicated;  Number of clients with annual TB	Number of clients on ART;  Number of clients;  Number of clients;  Number of clients;  Number of clients needing hepatitis screens as indicated;  Number of	CAREWare or chart audits.	75% of clients on ART receive lipid screens annually.  75% of clients receive syphilis screens annually.  75% of clients receive Chlamydia screens annually.  75% of clients receive gonorrhea screens annually  75% of clients receive Hepatitis A, B & C screens if not immune and then annually for high-risk individuals.  75% of clients receive TB screens at least once since diagnosis.

	for high-risk individuals, as determined by their medical provider.  Female clients receive pap smears annually.	screen;  Number of female clients with annual pap.	clients;  Number of female clients.		75% of female clients receive pap smears annually.
A hepatitis C (HCV) protocol is in place for clients testing positive for hepatitis C.	All clients with hepatitis C will be evaluated or referred for evaluation of treatment suitability.	Number of hepatitis C clients evaluated for treatment.	Number of clients with hepatitis C.	Client charts.	75% of clients will have a document evaluation or referral for treatment suitability.
Clients are offered immunizations or have documentation of decline of immunizations.	Documentation that clients receive vaccinations according to current standards (or document decline): <ul style="list-style-type: none"> <li>• Influenza</li> <li>• Pneumococcal as Appropriate</li> <li>• Completion of hepatitis A vaccines series, unless otherwise documented as immune.</li> <li>• Completion of hepatitis B vaccines series, unless otherwise documented as immune.</li> <li>• Tetanus</li> <li>• HPV as appropriate</li> </ul>	Number of clients with influenza vaccine.  Number of clients with pneumococcal vaccine.  Number of clients with hepatitis A vaccine series completed.  Number of clients with hepatitis B vaccine series completed.  Number of clients with tetanus vaccine.	Number of clients.  Number of clients needing pneumococcal vaccine.  Number of clients.  Number of clients.  Number of clients.	CAREWare or client charts.	75% of clients receive vaccinations according to current standards (or document decline): <ul style="list-style-type: none"> <li>• Influenza</li> <li>• Pneumococcal as appropriate</li> <li>• Completion of hepatitis A vaccine series, unless otherwise documented as immune.</li> <li>• Completion of hepatitis B vaccines series, unless otherwise documented as immune.</li> <li>• Tetanus</li> <li>• HPV as appropriate</li> </ul>

		Number of clients with HPV vaccine.	Number of clients needing HPV vaccine		
Assessment of treatment adherence and counseling, which adhere to current HHS guidelines.	<p>Documentation that clients' are assessed for treatment adherence and counseling at a minimum of twice a year.</p> <p>If adherence issue is identified, follow-up action is documented.</p> <p>Documentation of missed clients appointments and efforts to bring the client into care.</p>	<p>Number of clients on ART with treatment assessment minimum of twice a year.</p> <p>Number of clients with adherence issues have follow-up.</p> <p>Number of documented missed appts and efforts to bring clients into care.</p>	<p>Number of clients on ART.</p> <p>Number of clients with adherence issues.</p> <p>Number of clients with missed appts.</p>	Client Charts	<p>75% of charts with assessment of treatment adherence documented at a minimum of twice a year.</p> <p>75% of charts document follow-up action if adherence issue is identified.</p> <p>75% of document missed client appointments and efforts to bring the client into care.</p>
Clients are assessed for risk behaviors and receive risk reduction counseling to reduce secondary transmission of HIV.	Charts document a risk behavior assessment and clients receive risk reduction counseling.	Number of clients with risk reduction counseling.	Number of clients.	Client charts	75% of charts document a risk behavior assessment and clients receive risk reduction counseling.

<p>Clients are screened and receive tobacco cessation counseling annually (or document decline of tobacco use).</p>	<p>Charts document screening for tobacco use and cessation counseling (or document decline).</p>	<p>Number of clients with tobacco cessation counseling.</p>	<p>Number of clients.</p>	<p>Client charts</p>	<p>75% of clients are screened and receive tobacco cessation counseling annually (or document decline of tobacco use).</p>
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## PSYCHOSOCIAL SERVICES

**A. Definition:** Support for **Psychosocial Support Services** may include: Support and counseling activities, Child abuse and neglect counseling, HIV support groups, Pastoral care/counseling, Caregiver support, Bereavement counseling, and nutrition counseling provided by a non-registered dietitian. **Note:** Funds under this service category may not be used to provide nutritional supplements

**Pastoral care/counseling** supported under this service category to be:

- Provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider)
- Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available
- Available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation

**B. GOALS:** The overall goal of Psychosocial Support Services within the Phoenix EMA is to provide high quality, effective support and counseling to all eligible PLWHA, as well as to improve social connectivity and community engagement.

### C. SERVICES

- Support and counseling activities
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian

**D. Quality Management:**

**Program Outcome:** 75% of client charts have documentation that primary care discussions are taking place as part of regularly offered services, at a minimum quarterly

100% of out of care clients are offered a referral to outpatient/ambulatory medical care.

**Indicators:** Number of clients accessing Psychosocial Services

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Staff or volunteers providing psychosocial support will include discussions about access and engagement in primary care in individual and/or group discussions, at a minimum quarterly.	Documentation in client's file.	Number of clients who attend individual and/or group session(s).	Number of clients who attend individual and/or group session(s).	Client Files	75% of client charts have documentation that primary care discussions are taking place as part of regularly offered services, at a minimum quarterly.  100% of out of care clients are offered a referral to outpatient/ambulatory medical care.
Clients participating in psychosocial services will have completed a post session survey	Completed post session surveys	Number of clients who have a completed post session survey	Number of clients who attend individual and/or group session(s)	Client Surveys	75% of clients participating in psychosocial services will have completed a post session survey.
Documentation of topic of discussion is included with sign in sheet for support groups held by provider agency.	Documentation in log book/support group log.	Number of support groups held with documentation of topic with sign in sheet	Number of support groups held	Agency Files	100% of support group logs reflect documentation of topic with the sign in sheet.

# SUBSTANCE ABUSE OUTPATIENT SERVICES

## **A. DEFINITION:**

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

- Pre-treatment/recovery readiness programs
- Harm reduction
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Opiate Assisted Therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

## **B. GOAL(S):**

1. Assist HIV-positive clients with cessation of substance abuse thereby reducing barriers to medical care
2. Provide psychiatric evaluation and medication monitoring if indicated
3. Comply with the State of Arizona requirements for the provision of Substance Abuse Services

## **C. SERVICES:**

Provision of treatment and/or counseling addresses substance abuse and addiction/dependency for alcohol and other drugs. Services consist of outpatient treatment, counseling, social detoxification and/or referral to medical detoxification (including methadone treatment) when necessary as appropriate to the client. A goal of the continuum of substance abuse treatment is to encourage individuals to access primary medical care and adhere to HAART as well as other treatments indicated. All treatment providers will have specific knowledge, experience, and services regarding the needs of persons with HIV/AIDS. Examples of services include regular, ongoing substance abuse treatment and counseling on an individual and/or group basis by a state-licensed provider. Services must include provision of or links to the following: social and/or medical detoxification when necessary, recovery readiness, harm reduction, 12-step model, rational recovery approach model, aftercare, mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse, medical treatment for addiction, and drug-free treatment and

counseling. These services will include women with children and persons with disabilities. Referring provider will ensure collaboration across the various groups that work with the substance abuse population and those at risk and that share the best practices to overcome philosophical barriers.

**D. QUALITY MANAGEMENT:**

**Program Outcome:**

- 75% of clients enrolled in Substance Abuse Services-Outpatient who decrease substance use or maintain sobriety under treatment after accessing Substance Abuse Services-Outpatient

**Indicators:**

- Number of clients attending Substance Abuse services who are engaged in treatment.\*
- Number of clients who have addressed at least 2 treatment goals.

\*Engaged=individual invested in treatment and attends a minimum of 50% of substance abuse services appointments

**Service Unit(s):**

- Individual Level Treatment Session (An individual visit where the Treatment Plan is discussed)
- Group Level Treatment Session (A group counseling session)
- Medication Assisted Treatment Visit (A visit where medication for substance abuse treatment is dispensed)

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Case conferences with members of the client’s multi-disciplinary team shall be held as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.	Number of client records with case conference documentation	Number of clients	Client Files CAREWARE	70% of client records have documentation of case conferences with members of the client’s multi-disciplinary team.
An appointment will be scheduled within seven (7) working days of a client requesting substance abuse treatment services. In emergency circumstances, appointments will	Client chart contains documentation of each item listed above.	Number of clients with appointments scheduled	Number of clients	Client Files CAREWARE	70% of client charts will have documentation of an appointment scheduled within seven (7) working days of request for substance abuse treatment services.

<p>be scheduled within one (1) working day. If services cannot be provided within these time frames, the agency will offer to refer the clients to another organization to provide the requested services in a timelier manner.</p>					
<p>The intake process will include:</p> <ul style="list-style-type: none"> <li>• Screening for substance abuse and/or dependency for alcohol and other drugs using SAMISS</li> <li>• Verification of Medicaid/Medicare eligibility</li> <li>• Client's demographic information</li> <li>• Client's address</li> <li>• Client's phone number(s)/e-mail address</li> <li>• Client's housing status</li> <li>• Client's employment and income status</li> <li>• Client's alcohol and drug history and current usage</li> <li>• Client's physical health</li> <li>• List of current medications</li> <li>• Presenting problems</li> <li>• Suicide and homicide assessment</li> </ul>	<p>Documentation of intake information in client's file and in CAREWARE.</p>	<p>Number of clients with intakes</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts will have documentation of intake process as indicated.</p>
<p>Initial assessment protocols shall provide for screening individuals to determine level of need and</p>	<p>Client's chart contains documentation of each assessment item listed</p>	<p>Number of clients with initial assessments</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts will have documentation of initial assessments as indicated.</p>

<p>appropriate service plan. The initial assessment shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> <li>• The presenting problem</li> <li>• Substance abuse history</li> <li>• Medical and psychiatric history</li> <li>• Treatment history</li> <li>• Psychological history and current status</li> <li>• Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks)</li> <li>• Cognitive assessment (level of consciousness, orientation, memory and language)</li> <li>• Social support and family relationships</li> <li>• Strengths and Weaknesses</li> </ul> <p>Specific assessment tools such as the Addiction Severity Index (ASI) could be used for substance abuse and sexual history, the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) for substance abuse and</p>	<p>and documentation that a copy was given to the client.</p>				
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<p>mental illness symptoms and the Mini Mental State Examination (MMSE) for cognitive assessment. A copy of the assessment(s) will be provided to the client.</p>					
<p>A psychosocial history will be completed and must include:</p> <ul style="list-style-type: none"> <li>• Education and Training</li> <li>• Employment</li> <li>• Military Service</li> <li>• Legal History</li> <li>• Family history and constellation</li> <li>• Physical, emotional and/or sexual abuse history</li> <li>• Sexual and relationship history and status</li> <li>• Leisure and recreational activities</li> <li>• General psychological functioning</li> </ul>	<p>Client's chart contains documentation.</p>	<p>Number of clients with psychosocial histories completed</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts have documentation of completed psychosocial history as indicated.</p>
<p>Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth per ADHS guidelines A.A.C. Title 9, Health Services Chapter 10 Department of Health Services Health Care Institution: Licensing Article 10: Outpatient Treatment Center and Title 4, Professions and Occupations Chapter 6. Board of Behavioral Health Examiners. The plan must also address the</p>	<p>Client chart contains documentation of client's treatment plan and that client was given a copy of the plan.</p>	<p>Number of clients with treatment plans completed no later than 7 working days after admission</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts have documentation of treatment plans completed no later than 7 working days after admission.</p>

<p>full range of substances the client is abusing.</p> <p>Treatment plans must be completed no later than seven (7) working days of admission and the client must be provided a copy of the plan. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV-related risk behaviors including substance abuse as clinically indicated.</p>					
<p>The treatment plan shall be reviewed at a minimum midway through treatment or at least every 12 sessions and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in ADHS Board of Behavioral Health Examiners Title 4. Professions and Occupations Chapter 6. Article 11 Standards Practice</p>	<p>Documentation of treatment plan review in client's file and agency treatment review policies and procedures on file at site.</p>	<p>Number of clients with updated/reviewed treatment plans</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>70% of client charts will have documentation of updated treatment plans midway through treatment or at least every 12 sessions.</p>

Client and family participation in service planning should be maximized.	Documentation on site.	Number of clients with documentation of family participation	Number of clients	Client Files CAREWARE	70% of client charts with documented family participation have documentation of their participation in service planning for the client's needs.
<p>A client may be discharged from substance abuse services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include:</p> <ul style="list-style-type: none"> <li>• Circumstances of discharge</li> <li>• Summary of needs at admission</li> <li>• Summary of services provided</li> <li>• Goals completed during counseling</li> <li>• Counselor signature and credentials and date.</li> <li>• A transition plan to other services or provider agencies, if applicable</li> <li>• Consent for discharge follow-up</li> </ul> <p>Discharge from substance abuse treatment must be compliant with ADHS Board of Behavioral Health Examiners Title 4. Professions and Occupations Chapter 6. Article 11 Standards Practice</p>	<p>Documentation of case closure in client's record.</p> <p>Documentation of reason for discharge/case closure (e.g., case closure summary).</p>	Number of discharged clients	Number of clients	Client Files CAREWARE	70% of discharged client charts have documentation of case closure or reason for discharge.
In all cases, providers/case	Documentation in	Number of clients	Number of	Client Files	70% of discharged client charts will

managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the provider/case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the provider/case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	client's record indicating referrals or transition plan to other providers/agencies.	needing referrals to other agencies	clients	CAREWARE	have documentation of referrals or transition plans to other providers/agencies.
Clients demonstrate decreased drug use frequency or maintenance of decreased drug use in a 6 month time frame through urine or blood drug screens or self-report.	Decreased use of drugs and alcohol frequency or maintenance of decreased drug use.	Number of clients show decreased drug use frequency or maintenance of decreased drug use in a 6 month time	Number of clients	Client Files CAREWARE	70% of clients show decreased drug use frequency or maintenance of decreased drug use in a 6 month time frame demonstrated through urine or blood drug screens or through self-report.

## *TREATMENT ADHERENCE*

### **A. DEFINITION:**

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by nonmedical personnel outside of the medical case management and clinical setting.

### **B. GOALS**

To provide guidance to PLWHA regarding the management of ART adherence.  
To support and assist PLWHA in achieving viral load suppression.

### **C. SERVICES:**

Assessment of patient understanding of disease state, medication indication, benefits of medication, side effects, medication storage, medication administration, patient instructions and education to improve client knowledge and medication compliance.

### **D. QUALITY MANAGEMENT:**

**Program outcome:** 75% of clients participating in Treatment Adherence services will demonstrate a decrease in viral load.

**Indicators:** Number of clients that demonstrate decrease in viral loads.

**Service Unit(s):** Viral load results in client chart and CAREWare

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
Assessment of patient understanding of disease state, medication indication, benefits of medication, side effects, medication storage, medication administration, patient instructions and education to improve client knowledge and medication compliance.	Clients participating in Treatment Adherence services will demonstrate a decrease in viral load.	Number of clients with a decreased viral load	Number of clients enrolled in Treatment Adherence services.	Client Charts CAREWare	75% of clients participating in Treatment Adherence services will demonstrate a decrease in viral load.



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