GREATER BALTIMORE HIV HEALTH SERVICES PLANNING COUNCIL

STANDARDS OF CARE: FISCAL YEAR 2004

OCTOBER 2003

Credits

Compilation

Compiled by InterGroup Services planning council support office staff under the direction of the Health Services and Support Services committees of the Greater Baltimore HIV Health Services Planning Council.

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PART A:

BACKGROUND

A.1. Introduction

The Greater Baltimore HIV Health Services Planning Council is a 40-member body, appointed by the mayor of Baltimore City. The council is responsible for: identifying service needs of people living with HIV and AIDS (PLWH/A); establishing priorities for the allocation of federal HIV/AIDS service funds under the Ryan White CARE Act, Title I; assessing of the efficiency of the administrative mechanism designated by the mayor to administer the grant (i.e., the administrative agency); and developing a comprehensive plan for delivering HIV services to PLWH/A. The council is responsible for identifying and defining HIV-related services funded through Title I of the CARE Act in the Baltimore eligible metropolitan area (or EMA). The Baltimore EMA includes the following jurisdictions: Baltimore City and the counties of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's. (Acronyms and complex terms are defined and explained at appendix C.1.)

In August 2003, the planning council identified twenty-seven direct service categories and two program support categories to be funded in fiscal year 2004, which begins March 1, 2004. The categories were determined based on the council's review of the documented need for services of people living with HIV and AIDS in the region, as well as information on funding availability from other sources and consumers' utilization of services within the last few years.

Each year, the council and its committees review and revise service standards to ensure that a minimum qualification of service delivery is being defined within the EMA. This document is a compilation of the minimum standards of care required for all but two of the direct and program support services funded under the Title I CARE Act within the Baltimore EMA. The standard for delivery of viral load testing is not included in this edition since industry standards on medical lab testing are rigorously defined for providers of this service; the same goes for the enhanced laboratory testing category.

A.2. Responsibilities

Over the course of the latter part of 2002 and the first half of 2003, two of the planning council's standing committees worked tirelessly to update the council's annual *Standards of Care* publication: the Health Services Committee and the Support Services Committee. These committees are responsible for developing and enhancing standards of care for direct services funded under the Title I CARE Act in the Baltimore EMA.

The Health Services Committee is responsible for reviewing the following medically-related services:

- Primary medical care: adults.
- Primary medical care: pediatric.
- Substance-abuse treatment.
- Mental-health services.
- Mental-health services: children and adolescents.
- Home health services
- Treatment-adherence services.
- Oral health services.
- Primary medical care: co-morbidity.
- Local/consortium drug reimbursement.
- Hospice services.

The Support Services Committee is responsible for reviewing the services that support people living with HIV and AIDS to access and maintain medical care treatment, including:

- Case management.
- Transportation: direct.
- Transportation: indirect.
- Outreach/linkage to care.
- Minority AIDS Initiative: outreach/linkage to care.
- Minority AIDS Initiative: life skills enrichment.
- Psychosocial support.
- Buddy/companion services.
- Food bank and home-delivered meals.
- Client advocacy.
- Legal services.
- Day- and respite-care services.
- Emergency financial assistance.
- Housing assistance.
- Nutritional counseling.

The revision of the standards of care was made possible thanks to the assistance and strong collaboration of the planning council's partners: (a) the Baltimore City Health Department's Ryan White Title I Quality Improvement Program, (b) Associated Black Charities' Ryan White Title I Program (the administrative agency) and (c) the providers of Ryan White services throughout the Baltimore metropolitan area.

Baltimore City Health Department's (BCHD) Quality Improvement Program contributed to planning by providing the council and its committees with reports that made revision recommendations based on: (a) a comparison of the Baltimore EMA's standards on certain categories against national public health standards and (b) measuring provider performance against the standards set by the council within the Baltimore EMA.

Acknowledgment goes to the staff of BCHD's Quality Improvement Program, headed by Richard Matens, M.Div., director of the Ryan White Title I Office, and Ralph Brisueno, assistant director, and their team: Chris Williams, LCSW-C; Kelly Stewart; Alberta Ferrari, M.D.; Shazia Kazi, M.D., M.P.H.; Page Gray, B.S.; Shirley Marc, M.P.H.; and Yvonne Nwankwo, M.Ed.

Associated Black Charities (ABC) was instrumental in providing technical assistance to the committees in describing what services are actually being delivered and being purchased in the EMA under the Title I funds. Acknowledgment goes to the staff of ABC's Ryan White Title I administrative agency office, headed by Duane Taylor, M.P.P., M.C.P.H., J.D., senior project manager, and his team: Carl Hackerman; Wanda Pigatt-Canty, R.N., M.P.A.; Marvis Patterson; Jonathan Truesdale, M.P.A., J.D.; and Siok-Bi Wee.

Technical assistance, research, writing, design and editing were undertaken by the planning council's support office staff at InterGroup Services, Inc.

A.3. Process for Developing Standards of Care

The planning council is cognizant of the importance of ensuring that quality health care and support services are available to every HIV-infected consumer in the Baltimore EMA. Establishing the level of service or care that represents the basic acceptable threshold for providers who seek Ryan White Title I funds is the first step to seeing that quality care is offered to all consumers. The planning council annually assumes the task of developing standards of service for each Title I-funded health-care and support-service category within the EMA. Many of the standards were first created several years ago and must be periodically reviewed. (All the standards herein were devised, at least in their current format, no earlier than November 1996. Each standards's origination date is given in the section of this manual pertaining to that standard. Unless otherwise stated in parentheses, a standard may be considered to have been initially ratified at the time of origination. Subsequent dates of review and revision are also given.)

The council assigns responsibility for the development of health-care and support-services standards to two of its standing committees: the Health Services Committee and the Support Services Committee. The chairs of the Health Services and Support Services committees then invite practitioners and specialists who deliver HIV health care and providers who serve the HIV-positive community through various support services to attend a series of meetings to draft the standards. This process is repeated annually.

In 2003, the Health Services Committee broke into task groups, each of which focused on specialty areas of care, such as adult mental health, adult primary medical care, pediatrics and so forth. Each of the task groups completed a draft of standards for that area of care. The full committee subsequently reviewed the draft and made suggestions that were incorporated into second draft. This new draft was then circulated to practitioners in the community specializing in the particular treatment area. At the same time, planning council members were presented with the draft to review. Comments from the community and from council members were submitted to the task group for review and incorporation where appropriate. In the few cases where there were conflicting comments or significant substantive issues, the full Health Services Committee reviewed the comments or issues and decided by majority vote what to incorporate or how to change the language of the draft. After the community review period, a final draft was developed and presented to the full council for ratification. The process for the development of support-services standards followed similar steps through the Support Services Committee.

Once ratified by the planning council, the health-care and support-services standards are forwarded by the council to the EMA's Title I "administrative agent." The administrative agent is the "lead, or administrative, agency...authorized to receive [Title I] funds and distribute them to service providers following service priorities established by the pertinent planning body" (IGS 2002:74). In short, it is the entity that actually contracts with, and disburses funds to, the providers in the EMA that supply Title I services. The Baltimore City Health Department currently contracts with Associated Black Charities to serve as the administrative agent. The council-ratified standards of care are recommended for incorporation into the requests for proposals distributed by ABC to solicit Title I service providers for the coming fiscal year. These standards represent the minimum level of service or care that a provider seeking funding or receiving funding should meet. They serve as a benchmark against which

contracts are to be monitored. This current volume of the standards of care pertains to Ryan White fiscal year 2004, which runs from March 2004 through February 2005.

Since treatment protocols for HIV-positive individuals change rapidly, both the Health Services and the Support Services committees recognize that the standards, which reflect the minimum level of service that must be given by a Ryan White Title I-funded provider, must be reviewed regularly and redrafted to reflect the latest in quality treatment or service. Therefore, built into each committee's work plan for each year is a review of the existing standards. In this manner, the standards of care and service are updated to ensure that those seeking and receiving services are getting the most current care.

Part B:

Definitions and Standards

B.1. Primary Medical Care: Adult

Origination:	November 1996.
Revision:	August 1997; ratified, October 1997.
Revision:	August 1999; ratified, September 1999.
Revision:	August 2001; ratified, August 2001.
Revision:	August 2003.

B.1.1. Service Definition

Primary medical care, also referred to as ambulatory/outpatient medical care, 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. This 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 (including all medical subspecialties). Primary medical care for the treatment of HIV infection, specifically, includes the provision of care that is consistent with the U.S. Public Health Service's treatment guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.1.2. Service Standards of Care

Care for persons with HIV disease should reflect the competence and experience in both primary care and therapeutics known to be effective in the management of persons with HIV infection. It is important to understand and address the co-morbid issues that many HIV-positive individuals have and to consider the other social issues impacting the patient's life when developing and implementing treatment plans.

The following components of care should be demonstrated in the clinical record. Actual treatment guidelines are updated frequently and patients should be offered state-of-the-art care.

B.1.2.1. Baseline Evaluation

A baseline medical evaluation (which may take up to three visits) should be performed; it should include a medical and social history/physical and should additionally document the following matters.

B.1.2.1(a). History of HIV-positive status, including route of transmission, when first diagnosed.

B.1.2.1(b). Confirmation of HIV infection by laboratory means.

B.1.2.1(c). Patients should receive an annual PPD test that must be documented in the patient medical chart. If the PPD test is positive, a chest x-ray is required. If the x-ray is negative for active TB, prophylactic therapy must be given. If the patient misses the appointment for the PPD reading, the appropriate follow-up activity should be performed and documented.

B.1.2.1(d). *Women:* Detailed reproductive history including history of menses, contraceptive methods, pregnancy and childbirth, and Pap smear results. Treatment for pregnant women should follow the guidelines for treating non-pregnant adults, as well as for prevention of perinatal transmission. The woman's health status should be prioritized. Refer to periodic guidelines from the DHHS and the Kaiser Family Foundation.

B.1.2.1(e). Baseline body weight, "normal weight," height and vital signs.

B.1.2.1(f). Laboratory data which include recent CBC with platelets, chemistry panel LFT (cholesterol, triglyceride and glucose, especially, those who are to be treated with protease inhibitors), CD4 , measurement of viral load at a sensitivity threshold of 400 or lower copies per milliliter, syphilis serology, toxoplasma IgG, CMV IgG, and hepatitis B and C screening. Repeat toxicological test if CD4 falls below 100.

B.1.2.1(g). Assessment or history of mental health and substance-abuse disorders. Appropriate referrals must be made if needed. Past antiretroviral treatments, and adherence matters relating to past treatment, should be assessed.

B.1.2.1(h). The status of vaccinations, including dates of Pneumovax and influenza.

B.1.2.1(i). Documentation of discussions of safer sex practices for both men and women is required. In addition, a screening of any barriers that may affect compliance or adherence to medications and treatment must be performed (e.g., lack of housing, mental illnesses, etc.). A relationship between the medical provider and the patient should be established before initiating or changing antiretroviral therapy.

B.1.2.1(j). Once the appropriate treatment is decided by the medical provider and patient, that treatment or therapy should be initiated using the most recent federal "Guidelines for the Use of Antiretroviral Agents" series, published periodically in the CDC Mortality and Morbidity Weekly Report *MMWR Recommendations and Reports* series (see for example, MMWR 2002), which may be searched for and found at the Internet site, http://www.cdc.gov/mmwr/ mmwrsrch.htm. There must be documentation in the patient medical chart of discussions regarding medication(s) side-affects, dosing schedule and related adherence issues. These discussions are not limited to the first three visits, but should be on going.

B.1.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.1.2.2(a). Follow-up visits should record and address:

(i). Temperature, vital signs and weight.
(ii). Problems list status and updates.

B.1.2.2(c). Adherence with the treatment plan should be assessed and reinforced at each visit.

B.1.2.2.(d). The CD4 count should be measured every three to six months and at time of diagnosis. The viral load should be measured at time of diagnosis and every three to four months thereafter. Flexibility in scheduling may be allowed, depending on each patient's health status. Viral load should be measured immediately prior to, and again two to eight weeks after the start of, HAART to evaluate the effectiveness of therapy. With optimal therapy, viral load, at six months, should become undetectable, below 50 copies of HIV RNA per milliliter of plasma. If HIV RNA remains undetectable using the < 400 copies per milliliter assay, ultrasensitive viral load assay should be used for subsequent testing. Data have shown that a drop in viral load to fewer than 50 copies per milliliter indicates more complete viral suppression and a lower incidence of resistance. Repeat the viral load testing to confirm the result and/or when a change in therapy is considered.

B.1.2.2(e). Resistant testing should be performed (if feasible) for all consumers or clients when viral failure to HAART has been demonstrated and/or when sub-optimal suppression of viral load occurs after initiation of therapy. Resistant testing standards apply to pregnant women as well. The most recent DHHS guidelines must be followed when changing therapy.

B.1.2.2(f). All laboratory tests must meet the most recent DHHS guidelines.

B.1.2.2(g). Reduction of high-risk behavior for HIV transmission should be addressed at least quarterly and discussions documented.

B.1.2.2(h). Prophylaxis of OIs should be offered to each client at the appropriate CD4 count. Refer to guidelines for prophylaxis of OIs (Bartlett and Gallant 2003:39-47). Documentation of current therapies should be maintained on all patients receiving prophylaxis.

B.1.2.2(i). All HIV-infected women should have a documented Pap smear from within the previous 12 months. Normal smears should have been, or should still be, followed with a second smear six months later. If both results are negative, subsequent Pap smears should be performed annually. Smears showing severe inflammation or reactive changes should be reevaluated within three to six months. Diagnosis of SIL or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract. Inquire about LMP and contraception, when appropriate.

B.1.2.2(j). A PPD test should be performed, with results recorded. Record attempts to follow up with clients who do not return for PPD reading. For all positive PPD tests of at least five millimeters of induration, prophylaxis should be given and a chest x-ray should be obtained to rule out active pulmonary disease. If there is a history of a positive PPD, the history of prophylactic treatment should be recorded in the chart. Risk for TB should be assessed annually.

B.1.2.2(k). An annual syphilis serology should be performed.

B.1.2.2(l). Advance directives, durable powers of attorney, living wills and other planning documents, including "DNR" (do not resuscitate) status, should addressed at the beginning of treatment and at any appropriate time in the course of the illness.

B.1.2.2(m). All reportable illnesses must be reported to the local health department and included in chart documentation.

B.1.2.2(n). When the CD4 count drops below 100, the patient should have an ophthalmic examination by a trained retinal specialist every six months or as recommended by that specialist.

B.1.2.2(o). Documentation of discussions of safer sex practices for both men and women is required at least quarterly.

B.1.2.3. Problem List

A central "problem list," separate from progress notes, should be created that clearly prioritizes problems for primary care management and additionally identifies:

B.1.2.3(a). History and activity of mental health and substance-abuse disorders.

B.1.2.3(b). The provider of ancillary continuing health care (e.g., mental-health or substance-abuse service provider, or other continuing specialty service) and its location.

B.1.2.3(c). The need for and provider of case-management services.

B.1.3. Administrative Standards of Care

In addition to demonstrating competency in the provision of HIV-disease-specific care, HIV clinical service programs must show evidence that their performance follows administrative norms for outpatient ambulatory care.

B.1.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.1.3.1(a). Current organizational licensure (and/or applicable certification) and professional licensure of all staff delivering clinical health services should be maintained.

B.1.3.1(b). Professional supervision of staff or consultation for staff with practitioners who have extensive HIV experience and active HIV practices themselves is required.

B.1.3.1(c). Staff providing direct HIV clinical services should have an active practice of 20 or more HIV-positive patients. Health-care provider agencies are encouraged to have their medical practitioners develop the expertise needed to provide the specialized care that HIV-infected patients need.

B.1.3.1(d). Clinical staff should have a minimum of 20 CME hours per year in HIV/AIDS specialty course work.

B.1.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.1.3.2.(a). Measures should be taken to assure:
- (i). The protection of patient rights and responsibilities per the requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- (ii). Assurance of patient confidentiality with regard to medical information transmission, maintenance and security in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B.1.3.2.(b). Agencies and organizations providing primary medical care should have written policies regarding: grievance, confidentiality, eligibility for services, patient rights and provider expectations of patients, and termination of care by either the patient or the provider.

B.1.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.1.3.3(a). Agencies must have:
- (i). Time-appropriate delivery of services, including 24-hour call coverage.
- (ii). Mechanisms for urgent-care evaluation and/or triage.
- (iii). Mechanisms for inpatient care (or referral) and return to ambulatory care.
- (iv). A mechanism in place to document follow-up attempts and outreach to reduce the no-show rate.
- (v). A mechanism for tracking referrals. (The referring medical provider must discuss with the client the reasons for the referral, the urgency of the appointment, if any, and the importance of keeping the appointment.)
- (vi). Specialty care services provided by the agency (or arranged by referral from the primary care physician), including but not limited to: gastroenterology, neurology, psychiatry, ophthalmology, dermatology, obstetrics and gynecology, pulmonary, oncology and dentistry.
- (vii). A mechanism for tracking referrals to or made by social-work or case-management services.
- (viii). Nutritional counseling from a registered dietitian on staff or through direct referral must be tracked and documented.
- (ix). Antiretroviral counseling/therapy for pregnant women (per most recent DHHS guidelines).

B.1.3.3(b). Referrals to substance-abuse treatment services must be documented and tracked.

B.1.3.3(c). Information for persons with inherited coagulopathies and referral to the local federally funded hemophilia treatment center must be documented.

B.1.3.3(d). Primary medical care services are expected to coordinate with social-work or case-management services and contacts must be documented.

B.1.3.3(e). Continuity should be maintained with the primary-care provider identified by the client and identified in the patient chart.

B.1.3.3(f). Education of the patient, family, significant other and/or caregiver will be documented in the chart.

B.1.3.3(g). The agency will provide information for accessing clinical investigations during intake.

B.1.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.1.4. Summary

This subsection provides miscellaneous further information on this service.

B.1.4.1. Recommendations

None.

B.1.4.2. References and Further Sources

John G. Bartlett and Joel E. Gallant. 2003. *Medical Management of HIV Infection*, 2003 ed. Baltimore, Md.: Johns Hopkins University.

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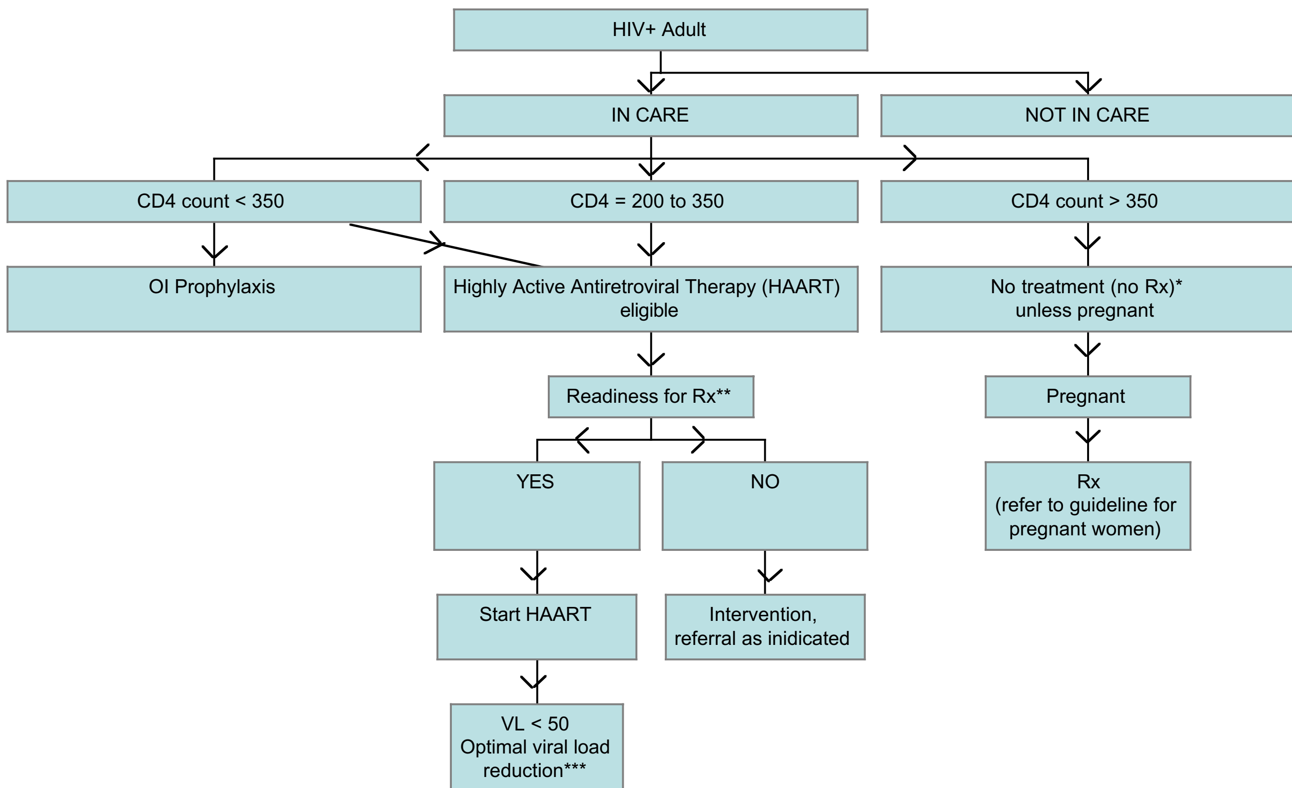
Johns Hopkins AIDS Service Internet site: http://www.hopkins-aids.edu.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2002. “Guidelines for Using Antiretroviral Agents Among HIV-Infected Adults and Adolescents: Recommendations of the Panel on Clinical Practices for Treatment of HIV.” *MMWR Recommendations and Reports* 51(RR7), May 17. Available at Internet site (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5107a1.htm), downloaded October 3, 2003.

B.1.4.3. Appendix

See following pages.

B.1.4.3(a). Outcomes for Adult HIV Primary Medical Care

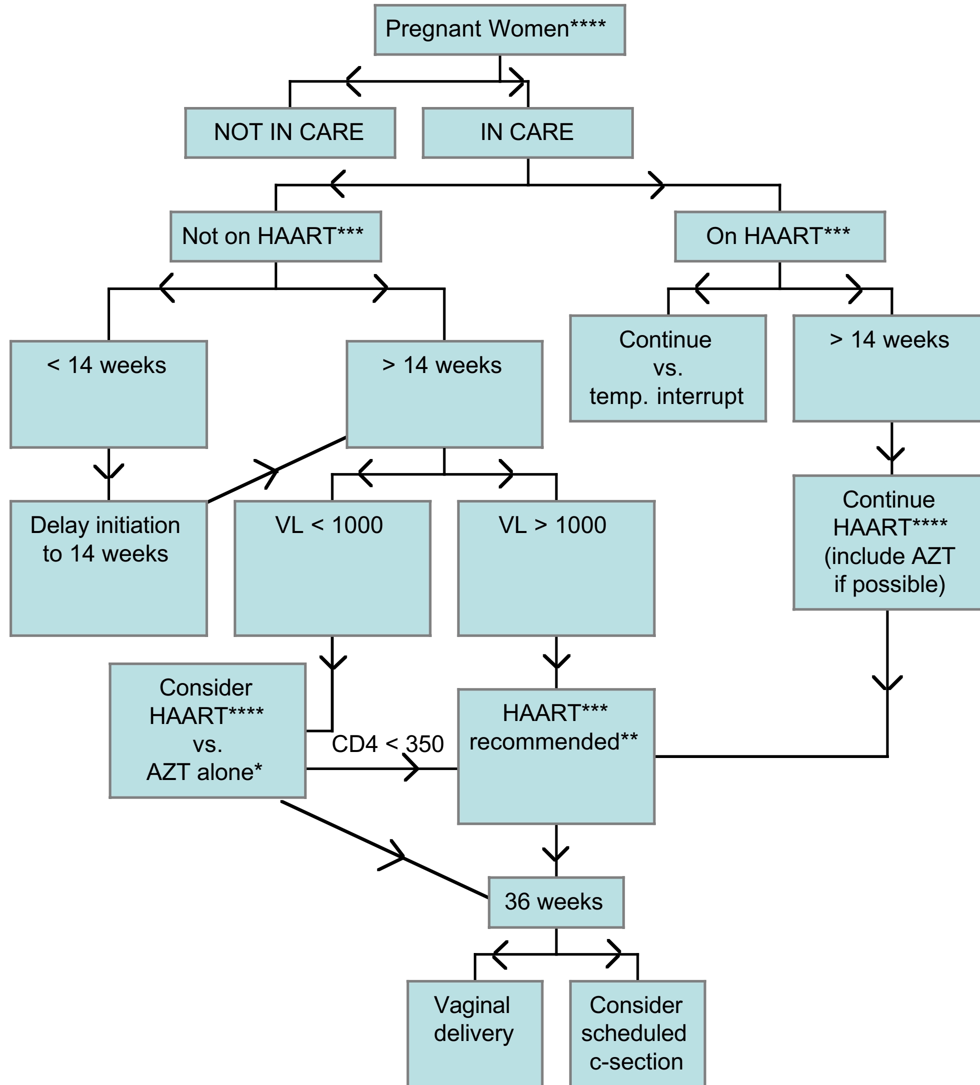


* All pregnant women should receive antiretroviral therapy, regardless of CD4 and viral load counts for the purpose of prevention of MTCT.

** Readiness for Rx: Special Considerations
1) Patient willingness.
2) Adherence concerns.
3) Co-morbid conditions, as follows:
   a) Mental illness.
   b) Acute OI.
   c) Homelessness.
   d) Active substance abuse.

***Optimal viral load (< 50)
Time to optimal viral load response will vary by individual according to beginning viral load and prior ARV exposure.

B.1.4.3 (b). Outcomes for Primary Medical Care of Pregnant Women



* Considerations include CD4, patient's desire and adherence concerns.

** AZT included, if possible.

*** Should not include efavirenz.

**** OI prophylaxis indicated (as per USPHS guidelines with CD4 < 200).

B.2. Primary Medical Care: Pediatric

Origination: August 1997 (ratified, October 1997).

Revision: July 1998; ratified, October 1998.

Revision: December 2000; ratified, July 2001.

B.2.1. Service Definition

There is no HRSA HIV/AIDS Bureau definition for this service.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.2.2. Service Standards of Care

Care for infants and children with HIV disease should reflect the competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection.

B.2.2.1. Baseline Evaluation

An initial medical evaluation should contain a history/physical and additional documentation, as follows.

B.2.2.1(a). History of HIV-positive status, including the location of the first or latest positive test.

B.2.2.1(b). Age-related developmental history or examination.

B.2.2.1(c). History of TB testing, exposure and/or prophylaxis.

B.2.2.1(d). Baseline body weight, height and head circumference, temperature and vital signs.

B.2.2.1(e). Neurological examination.

B.2.2.1(f). Confirmation of HIV exposure or infection by laboratory means. Infants should be tested by virologic tests before they are 48 hours old, at age one to two months and at three to six months. Treatment prophylaxis for *Pneumocystis carinii pneumonia* (PCP) should be started at age four to six weeks.

B.2.2.1(g). Laboratory data, which include recent CBC with platelets, chemistry panel, CD4, CMV IgG (for CMV culture negative T cell class 3), toxoplasmosis (for those over age 12 months requiring primary-care physician prophylaxis and receiving an agent other than TMP-SMX), chest x-ray and measurement of viral load.

B.2.2.1(h). PPD test results for those with no history of a positive PPD test (not Tine) or no PPD result within the past year.

B.2.2.1(i). Evaluation of need for PCP prophylaxis.

B.2.2.1(j). Assessment of health and social conditions that may affect compliance with medical appointments (e.g., homelessness, mental illness, substance abuse) or consideration for case management.

B.2.2.1(k). Education on chicken pox exposure and other reasons to call the doctor.

B.2.2.2. Further or Continued Services

Follow-up visits should record:

B.2.2.2(a). Visit frequency, averaging every three months until age two, and every six months for children older than two.

B.2.2.2(b). Body weight, height, temperature and vital signs.

B.2.2.2(c). Developmental history or examination.

B.2.2.2(d). Oral examination.

B.2.2.2(e). Neurological examination.

B.2.2.2(f). Assessment of compliance problems or consideration for case management.

B.2.2.2(g). Repeat of CD4 and HIV viral load measurements.

B.2.2.2(h). For HIV-exposed infants under four months of age, and all infected children under one year of age, implementation of appropriate PCP prophylaxis.

B.2.2.2(i). For children 1 to 5 years of age with a CD4 count of less than 500 or a CD4 percentage of less than 15 percent, or for children aged 6 to 12 with a CD4 count less than 200 or a CD4 percentage less 15 percent, implementation of appropriate PCP prophylaxis.

B.2.2.2(j). For children aged over 6 years with a CD4 count of less than 50, for children aged 2 to 6 years with a CD4 count of less than 75, for children aged 1 to 2 years with a CD4 count of less than 500, or for children aged less than 1 year with a CD4 count less than 750, implementation of appropriate PCP prophylaxis.

B.2.2.2(k). For children under 1 year old at the time of diagnosis of HIV infection, symptomatic (class A or above), or T cell class 2 or 3, or high viral load (at any age), implementation of rational combination antiviral therapy utilizing a minimum of two agents and preferably three.

B.2.2.3. Problem List

A central "problem list," separate from progress notes, should be created, containing updates on:

B.2.2.3(a). Annual PPD tests and examinations by dentists.

B.2.2.3(b). Immunization series, which includes IPV (and excludes live virus OPV).

B.2.3. Administrative Standards of Care

In addition to demonstrating competency in the provision of HIV-disease-specific care, HIV clinical service programs must show evidence that their performance follows administrative norms for ambulatory care. Clinical programs must demonstrate policies and performance regarding:

B.2.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.2.3.1(a). Current organizational licensure (and/or applicable certification) and professional licensure of all staff delivering clinical health services.

B.2.3.1(b). Professional supervision of all staff.

B.2.3.1(c). Staff training and/or experience with the medical care of children with HIV.

B.2.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.2.3.2(a). The protection of patient rights and clarification of patient responsibilities.

B.2.3.2(b). Assurance of patient confidentiality with regard to medical information transmission maintenance and security.

B.2.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.2.3.3(a). The time-appropriate delivery of services, including 24-hour call coverage.

B.2.3.3(b). Mechanisms for urgent care evaluation and/or triage.

B.2.3.3(c). Mechanisms for inpatient care (or referral) and return to ambulatory care.

B.2.3.3(d). Care services that include (either directly or by referral):
- (i). Subspecialties, including but not limited to: gastroenterology, neurology, psychiatry, ophthalmology, dermatology, and neuro-developmental assessment.
- (ii). Social-work and case-management services.
- (iii). Substance-abuse treatment services (adolescent).
- (iv). Reproductive counseling with and antiretroviral options for pregnant teens.
- (v). Information for persons with inherited coagulopathies and referral to the local federally funded hemophilia treatment center.

B.2.3.3(e). Coordination with social-work and/or case-management services.

B.2.3.3(f). Continuity with referring providers.

B.2.3.3(g). Education of the patient, family, significant other and/or caregiver.

B.2.3.3(h). Access to clinical investigations.

B.2.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken, including:

B.2.3.4(a). An overall mechanism or quality-assurance plan designed to monitor both the appropriateness and effectiveness of all services provided.

B.2.3.4(b). Documentation of care plan reviews, both peer and supervisor.

B.2.3.4(c). Documentation of utilization review.

B.2.3.4(d). Documentation of the most recent site visit by the administrative agency.

B.2.3.4(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.2.3.4(f). Documentation of periodic data and narrative reports to the administrative agency.

B.2.3.4(g). Documentation of a process to solicit information on client satisfaction with services (at least annually).

B.2.3.4(h). Documentation that service meets the service category standards and/or any applicable professional or federal practice standards.

B.2.4. Summary

This subsection provides miscellaneous further information on this service.

B.2.4.1. Recommendations

None.

B.2.4.2. References and Further Sources

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 1999. "1999 USPH/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR Recommendations and Reports* 48(RR10), August 20. Available at Internet site (http://www.cdc.gov/mmwr/preview/mmwrhtml/ rr4810a1.htm), downloaded October 4, 2003.

_____. 1999. "1999 Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection." *MMWR Recommendations and Reports* 47(RR4). No longer available at CDC on-line Internet site.

B.3. Mental Health Services

Origination: October 1997.

Review: September 1999.

Review: September 2000.

B.3.1. Service Definition

Psychological and psychiatric treatment and counseling services for 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 definition typically includes psychiatrists, psychologists and licensed clinical social workers.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.3.2. Service Standards of Care

Mental health and psychiatric care for persons with HIV disease should reflect competence and experience in evaluation, formulation and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.

B.3.2.1. Baseline Evaluation

An initial evaluation must be conducted prior to the initiation of any treatment. This evaluation must be conducted by a licensed mental-health professional working as part of an interdisciplinary team. At a minimum, this team must consist of a psychiatrist and any of the following professionals: a psychologist, a social worker or a mental-health clinical specialist nurse. Non-licensed providers may also provide services under the supervision of appropriately licensed providers.

The evaluation must consist of the following:

B.3.2.1(a). History, including chief complaint, present illness, past psychiatric history, family history, social and personal history, substance-use history, medical history, review of systems, current and recent medications, and pre-morbid personality.

B.3.2.1(b). Complete mental-status evaluation, including appearance and behavior, talk, mood, vital sense, self-attitude, suicide risk, homicidal risk, abnormal beliefs (delusions, overvalued ideas), perceptual disturbances (hallucinations, illusions), obsessions/compulsions, phobias and panic attacks.

B.3.2.1(c). Cognitive assessment, including level of consciousness, orientation, memory, language, praxis and executive (may substitute the Mini-Mental State and Verbal Trails Test).

B.3.2.1(d). Laboratory assessment, as clinically indicated.

B.3.2.1(e). Multi-axial differential diagnosis leading to final diagnostic formulation.

B.3.2.1(f). A plan of care with specific measurable treatment goals through the use of appropriate outcome assessment. The treatment plan must include input from the client.

B.3.2.1(g). Practice guidelines for specific conditions, situations and disorders, such as those published by the American Psychiatric Association or the American Psychological Association, should inform the treatment plans.

B.3.2.2. Further or Continued Services

Follow-up visits should be made to provide or monitor treatments and to assess progress toward meeting care plan goals.

B.3.2.2(a). Visit frequency should average every week to two weeks for patients with active symptoms working toward a short-term goal. For those whose symptoms are in remission but who remain on psychotropic medicines, visits averaging every three months are necessary.

B.3.2.2(b). Supportive services and educational counseling should be provided at all visits. This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse, as clinically indicated.

B.3.2.2(c). Specific types of psychotherapy — e.g., interpersonal, behavioral, psychodynamic, cognitive (individual, group or family) — should be provided as indicated by the clinical situation, based on practice guideline recommendations, and linked to specific treatment goals.

B.3.2.2(d). The prescription and monitoring of appropriate psychotropic medications should occur as indicated by the clinical situation and in accordance with evidence-based practice guideline recommendations, and should be linked to specific treatment goals. Psychotropic medications must be provided under the supervision of a psychiatrist. Clients must have the opportunity to develop on-going relationships with the psychiatrist(s) prescribing their psychotropic medication(s).

B.3.2.2(e). Medication side effects assessment and teaching should be provided for patients on psychotropic medications.

B.3.2.2(f). Monitoring of progress toward care-plan goals should occur through the use of appropriate outcome assessments, which must include input from the client.

B.3.2.2(g). Reassessment of each client's case and care plan should occur at least every three months.

B.3.3. Administrative Standards of Care

HIV-mental-health providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness and continuity of care; and (d) quality-of-care improvement efforts.

B.3.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.3.3.1(a). All staff delivering mental health services will possess current organizational and professional licensure.

B.3.3.1(b). Non-licensed staff or trainees delivering mental health services will receive professional supervision of the care they are providing to individual clients, by a licensed mental health provider.

B.3.3.1(c). All staff delivering mental-health services will either have specific experience in caring for HIV-infected patients or receive appropriate training.

B.3.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.3.3.2(a). The provider organization will provide assurances and a method for protection of patient rights in the process of care provision.

B.3.3.2(b). The provider organization will provide assurances and a method for protection of patient confidentiality (in accordance with Maryland Annotated Code), with regard to medical information transmission, maintenance and security.

B.3.3.2(c). The provider organization will provide assurances regarding the provision of culturally appropriate care to their clients. Specifically, the provider must have training or experience with caring for those groups most affected by the epidemic, such as gay men, African-Americans and substance-abusing persons.

B.3.3.2(d). The provider organization will provide assurances that mental-health treatment services will be provided regardless of the sexual orientation of the client. Respect, confidentiality and equal access will be assured.

B.3.3.2(e). If unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received from specific licensed providers.

B.3.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.3.3.3(a). The provider organization will provide clinical services in a timely fashion to all clients. Emergencies must be addressed within two hours of notification of the provider. New client evaluations will generally be conducted within 10 working days of notification of the provider. The provider must consider providing access to their staff on a 24-hour basis.

B.3.3.3(b). The provider organization must provide mechanisms for urgent-care evaluation or triage.

B.3.3.3(c). The provider organization will provide mechanisms to make available to its clients, if clinically indicated, access to the full range of mental-health treatment settings, including day programs, day hospitals and inpatient psychiatric units.

B.3.3.3(d). The provider organization will provide mechanisms for assuring continuity of mental health/psychiatric care to its clients in all settings in which they may receive care, including but not limited to, day programs, day hospitals, substance-abuse programs, inpatient psychiatric units, inpatient medical units and chronic-care units (nursing homes). Provisions will be made for off-site care if clinically necessary.

B.3.3.3(e).The provider organization will develop and maintain linkages with substance-abuse treatment service providers to maintain care continuity for patients with dual diagnoses of substance-use disorders and other mental disorders.

B.3.3.3(f). The provider organization will develop and maintain linkages with primary-medical-care service providers to maintain care continuity for patients receiving primary or specialty medical care.

B.3.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.3.3.4(a). The provider organization will provide for methods to monitor services areas in need of improvement.

B.3.3.4(b). The provider organization will provide for methods for the development of corrective action and the assessment of the effect of such actions, addressing areas in need of improvement.

B.3.3.4(c). Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

B.4. Mental Health Services: Children and Adolescents

Origination: October 1997.
Review: September 1999.
Review: September 2000.

B.4.1. Service Definition

Psychological and psychiatric treatment and counseling services for children and adolescents (ages birth through 18 years) 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 definition typically includes psychiatrists, psychologists and licensed clinical social workers.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.4.2. Service Standards of Care

Mental health and psychiatric care for persons with HIV disease should reflect competence and experience in evaluation, formulation and diagnosis as well an in evidence-based therapeutics, using contemporary practice guidelines where available. These standards are specifically for use with children and adolescents, ages birth through 18.

4.2.1. Baseline Evaluation

An initial evaluation should be conducted prior to the beginning of any treatment. This evaluation must be conducted by a licensed mental-health professional, working as part of an interdisciplinary team. At a minimum, this team should consist of a pediatrician or child psychiatrist, a licensed psychologist, and a nurse or a social worker. The evaluation must consist of the following:

B.4.2.1(a). History, including chief complaint, prenatal and neonatal history, developmental history (including milestones), social/emotional factors of infancy and childhood, family history, medical history, pre-morbid functioning, review of systems, current and recent medication, school history, sibling and peer relations, placement history (e.g., foster care, kinship care), and review of any prior treatment and evaluations.

B.4.2.1(b). Developmentally appropriate mental-status exam.

B.4.2.1(c). A cognitive, emotional or behavioral assessment should be conducted by a psychologist with appropriate training and experience (either a licensed psychologist or a supervised psychology associate). This evaluation may include formal, individually administered, standardized

developmental, intellectual, achievement, personality or neuropsychological tests; parent-reported or patient self-reported behavioral or emotional measures; or a screening assessment in one or more of the above areas.

B.4.2.1(d). Laboratory assessment as clinically indicated.

B.4.2.1(e). Multi-axial differential diagnosis leading to final diagnostic formulation assessment.

B.4.2.1(f). Treatment plan with specific measurable goals through the use of appropriate outcome measures.

B.4.2.1(g). Practice guidelines for specific conditions, situations or disorders consistent with the practice of the evaluators (American Psychological Association/American Psychiatric Association). This should include written communication with the patient's primary care provider or referral source at the time of the initial evaluation and at points of regular review (three-month intervals), and at the time of discharge from mental-health services.

B.4.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.4.2.2(a). Follow-up visits should be made to provide or monitor treatments and to assess progress toward meeting goals.

B.4.2.2(b). One significant issue in the treatment of HIV-affected children is the matter of disclosure. Many HIV-positive children have not been told their sero-status. Furthermore, other individuals involved in their care may not know about their status (e.g., family members, school staff). Another major question in the treatment of children involves the actual referral for treatment. Many children who enter treatment are referred by family, school or health-care providers. Children, unlike adults, do not seek services and are frequently unaware of the reason for referral. Finally, age, developmental level and presenting complaint are major considerations in the selection of treatment modality, as well as the scope and intensity of services provided.

B.4.2.2(c). Visit frequency should average once every one or two weeks for patients with active symptoms working toward a short-term goal. For those whose symptoms are in remission but who remain on psychotherapeutic medicines, visits averaging once every three months are necessary.

B.4.2.2(d). Therapeutic services for children vary significantly with the age, developmental level and disclosure status of the child. Specific types of psychotherapy for children may include: individual play therapy, therapeutic play groups (e.g., play groups for children of four to eight years of age), parent/child therapy (e.g., behavior management, parenting skills, communication enhancement, parent/child interaction therapy), parent/caregiver therapy groups, social skills groups, family therapy, school-based consultation around mental-health issues, and grief/bereavement therapy.

B.4.2.2(e). The prescription and monitoring of appropriate medication as indicated by the clinical situation, evidence-based practice guideline recommendations, and linked to specific treatment goals. Prescription and monitoring of stimulant medications (e.g., Ritalin) and central antihypertensive medications (e.g., Clonidine), used to treat attention deficit hyperactivity disorder (ADHD), can be provided by a pediatrician, while a child psychiatrist must provide psychotropic medications.

B.4.2.2(f). For those children or adolescents on medication, the pediatrician, child psychiatrist or nurse will provide medication-administration training and side-effect monitoring to the parent or caregiver of the child, and developmentally appropriate medication information to the child.

B.4.2.2(g). Monitoring of the patient's progress toward treatment-plan goals should occur through the use of appropriate outcome assessment (e.g., parental report or child self-report, school report).

B.4.2.2(h). Reassessment of each patient treatment plan and progress by the interdisciplinary team should occur every three months.

B.4.3. Administrative Standards of Care

HIV-mental-health providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness and continuity of care; and (d) quality-of-care improvement efforts.

B.4.3.1. Licensing, Knowledge, Skills, and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.4.3.1(a). All staff delivering mental-health services will possess current organizational and professional licensure.

B.4.3.1(b). Non-licensed staff or trainees delivering mental-health services will receive professional supervision of the care they are providing to individual clients by a licensed mental-health provider.

B.4.3.1(c). All staff delivering mental-health services will either have specific experience in caring for HIV-infected patients or receive appropriate training.

B.4.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.4.3.2(a). The provider organization will provide assurance and a method for protection of patient rights in the process of care provision.

B.4.3.2(b). The provider organization will provide assurances and a method for protection of patient confidentiality, with regard to medical information transmission, maintenance and security.

B.4.3.2(c). In working with children, confidentiality must be broken, in accordance with Maryland law, if the provider feels that the child is in danger or in some way threatens someone else.

B.4.3.2(d). The provider organization will provide assurances regarding the provision of culturally appropriate care to its patients.

B.4.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.4.3.3(a). The provider organization will provide clinical services in a timely fashion to all patients.

B.4.3.3(b). The provider organization will provide mechanisms for urgent-care evaluation or triage.

B.4.3.3(c). The provider organization will provide mechanisms to make available to its clients, if clinically indicated, access to the full range of mental-health treatment settings, including therapeutic day care, therapeutic foster homes, day hospitals, residential treatment facilities and inpatient psychiatric units.

B.4.3.3(d). The provider organization will provide mechanisms for continuity of mental health/psychiatric care to its patients in all settings in which they may receive care, including but not limited to, therapeutic day care, level V school programs, residential treatment facilities, day hospitals, substance-abuse programs, inpatient psychiatric units, inpatient medical units, rehabilitation hospitals and hospice programs.

B.4.3.3(e). The provider organization will develop and maintain linkages with substance-abuse treatment providers to maintain continuity for patients with dual diagnoses of substance-use disorders and other mental disorders.

B.4.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.4.3.4(a). The provider organization will provide for methods to monitor for areas in need of improvement.

B.5. Oral Health Services

Origination: November 1996.
Revision: July 1997; ratified, October 1997.
Revision: July 1998; ratified, September 1998.
Revision: November 2000; ratified, December 2000.

B.5.1. Service Definition

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

As used herein, the term “client” encompasses the terms “patient” and “service consumer.”

B.5.2. Service Standards of Care

Care for persons with HIV disease should reflect competence and experience in the care and therapeutics known to be effective in the management of dental conditions of persons with HIV infection. Dental providers should educate patients to increase their awareness that good dental health is crucial to overall health.

B.5.2.1. Baseline Evaluation

A baseline dental evaluation should be performed and made available to the dental practitioner.

B.5.2.1(a). The following baseline medical information should be available to the dental provider at the point of referral or at the time of the initial patient visit from the primary medical care provider or referring entity:
(i). Complete blood count (CBC) with differential.
(ii). Chem 7 test results.
(iii). CD4 and viral load count.
(iv). PT and PPT tests (pre-extractions).
(v). Hepatitis B and C screening results.
(vi). List of current medications.

B.5.2.1(b). Dental providers may request other tests before initiating invasive treatments.

B.5.2.1(c). The initial dental evaluation (which may take up to two visits) should include:
(i). Comprehensive health history.

(ii). Continuation or initiation of antibiotic prophylaxis as needed according to the current American Heart Association (AHA) recommendations.
(iii). Hard and soft tissue examination.
(iv). X-rays of the teeth.
(v). Oral manifestations of HIV and treatment modalities. Refer to the guidelines in the most recent edition of *Medical Management of HIV Infection* (Bartlett and Gallant 2003:333-344).
(vi). Documentation of the examination results in a patient chart.
(vii). Development of a treatment plan that is discussed in detail with the patient. The plan should address: cavities, missing teeth, periodontal condition, extractions needed and needed replacement teeth.
(viii). Referral to primary-care facility or physician for medical care as needed.

B.5.2.2. Further or Continued Services

Implementation of the treatment plan should entail continuing education for the patient regarding oral hygiene, the importance of regular dental care and specific discussion of the individual's treatment plan, the treatments needed and the procedures to be used.

B.5.3. Administrative Standards of Care

Dental-health providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness and continuity of care; and (d) quality-of-care improvement efforts.

B.5.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.5.3.1(a). All dental practitioners must adhere to the Code of Maryland Regulations (COMAR).

B.5.3.1(b). There must be professional supervision of all staff and consultation when appropriate.

B.5.3.1(c). There must be staff training, continuing education and/or experience with dental health assessment and treatment of persons with HIV.

B.5.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.5.3.2(a). A written policy regarding: confidentiality of the patient's dental and/or medical information, the grievance or complaint process, and eligibility criteria for services.

B.5.3.2(b). An assurance of patient confidentiality with regard to medical information transmission, maintenance and security.

B.5.3.2(c). A statement of the patient's rights when seeking and receiving care and responsibilities when being treated.

B.5.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.5.3.3(a). Time-appropriate delivery of services.

B.5.3.3(b). A system for referral and follow up for urgent care evaluation and/or triage

B.5.3.3(c). Care services, which include individualized evaluation, diagnosis, and formulation and implementation of a treatment/therapy plan.

B.5.3.3(d). Continuity of care with the primary-care provider, care facility or case manager.

B.5.3.4. Quality Assurance

Providers and/or provider agencies should have a quality-improvement (-assurance) activity, which identifies areas for improvement and the subsequent actions taken for improvement of services or service delivery.

B.5.4. Summary

This subsection provides miscellaneous further information on this service.

B.5.4.1. Recommendations

None.

B.5.4.2. References and Further Sources

John G. Bartlett and Joel E. Gallant. 2001. *Medical Management of HIV Infection*, 2000-2001 ed. Baltimore, Md.: Johns Hopkins University.

_____. 2003. *Medical Management of HIV Infection*, 2003 ed. Baltimore, Md.: Johns Hopkins University.

B.5.4.3. Appendix

See following page.

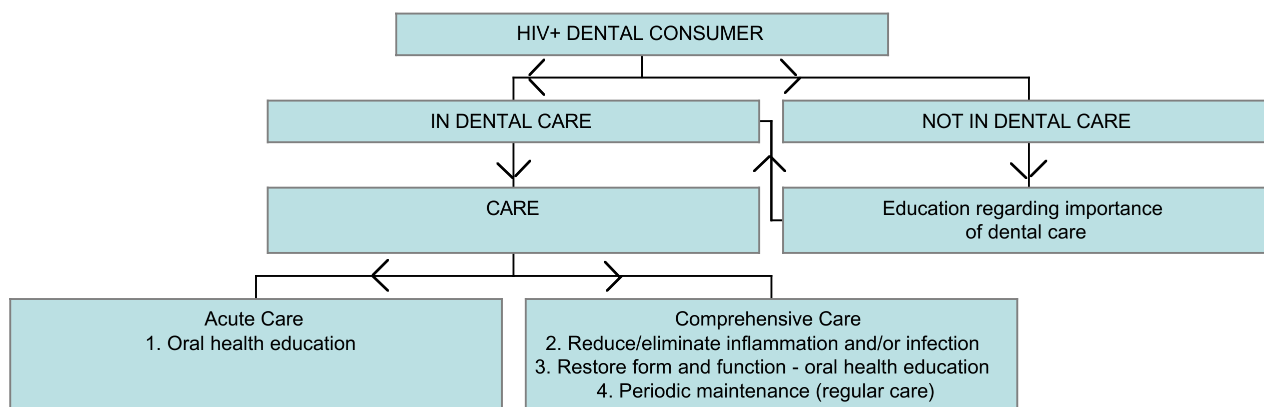
B.5.4.3(a). Outcomes for dental care — these a summarized in the flow chart below and must incorporate the following:

(i). Elimination or reduction in inflammatory periodontal and dental disease

(ii). Education on oral health care and adherence. Clients are maintained and must adhere to their treatment plans (i.e., there should be regular dental visits).

(iii). Restoration (form and function) of mouth (e.g., by means of dentures, extractions, etc.).

(iv). Maintenance of basic and preventive oral hygiene (resulting in a decrease in the number of patients who do not brush their teeth on a regular basis).



B.5.4.3(b). Oral manifestations of HIV and treatment modalities — these are summarized in Bartlett and Gallant, *Medical Management of HIV Infection* (2003 ed.), pages 333-344.

B.6. Home Health Services

Origination: November 1996 (ratified, September 1997).

Revision: July 1998; ratified, September 1998.

Revision: June 2001; ratified, July 2001.

B.6.1. Service Definition

There are three subfields of home health services, each of which is defined below.

B.6.1.1. Home Health: Para-professional Care

The provision of services in the home by a homemaker, home health aide, personal caretaker or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.

B.6.1.2. Home Health: Professional Care

The provision of services in the home by licensed health-care workers, such as nurses.

B.6.1.3. Home Health: Specialized Care

The provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other technology-based therapies.

As used herein, the term “client” encompasses the terms “patient” and “service consumer.”

B.6.2. Service Standards of Care

Home health services for persons with HIV disease should reflect competence and experience in evaluation, formulation and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.

B.6.2.1. Baseline Evaluation

A baseline evaluation should be performed; it should document the following matters.

B.6.2.1(a). An initial evaluation should be conducted prior to the initiation of any treatment.

B.6.2.1(b). This evaluation must be conducted by a licensed or certified professional working as part of an interdisciplinary team.

B.6.3. Administrative Standards of Care

Home health providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness and continuity of care; and (d) quality-of-care improvement efforts.

B.6.3.1. Licensing, Knowledge, Skills, and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.6.3.1(a). All care providers will be licensed/certified as required by the State of Maryland.

B.6.3.1(b). The nurse/case manager and other members of the care team shall possess the knowledge, skills and experience necessary to competently perform care or case-management activities.

B.6.3.1(c). Evidence of continuing education in the area of HIV disease is highly recommended.

B.6.3.1(d). Care providers are encouraged to contact the AIDS Education and Training Center (AETC) regarding on-going education.

(i). The Mid-Atlantic AETC is based at the University of Pittsburgh, as follows:

University of Pittsburgh
Graduate School of Public Health
Department of Infectious Diseases and Microbiology
130 DeSoto Street
Room G-15 Parran Hall
Pittsburgh, PA 15261
Tel.: (412) 624-1895
Fax: (412) 624-4767

(ii). One of the Mid-Atlantic AETC's local performance sites is at the University of Maryland, Baltimore, as follows:

University of Maryland, Baltimore
Institute of Human Virology
22 S. Greene Street, Box 175
Baltimore, MD 21201-1595
Tel.: (410) 328-8639
Fax: (410) 328-9106
Dental School
Tel.: (410) 706-7628
Fax: (410) 706-0519

(iii). The other Mid-Atlantic AETC local performance site is at the Johns Hopkins School of Medicine, Baltimore, as follows:

Johns Hopkins University School of Medicine
Division of Infectious Diseases
1830 E. Monument Street, 4th Floor
Baltimore, MD 21287-0003
Tel.: (410) 614-2234
Fax: (410) 955-0740

B.6.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.6.3.2(a). All staff will protect the rights and confidentiality of each patient. Each patient will sign a bill of rights, be advised of the grievance procedure, and be provided with a specific telephone number to call for complaints.

B.6.3.2(b). When patient records have been requested by another care provider, the release-of-information form will be kept on file.

B.6.3.2(c). There should be evidence of a discussion of advance directives with the patient and/or family unit.

B.6.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.6.3.3(a). Nursing and medical back up will be available to the patient on a 24-hour basis.

B.6.3.3(b). Medical records should reflect the initial care plan signed by the physician and appropriate timely updates.

B.6.3.3(c). The nurse/case manager will intervene at the patient level to monitor and coordinate symptom management and to assure continuity and consistency of care between care settings and providers.

B.6.3.3(d). The plan will be reviewed by the physician and the team member from each responsible discipline, including nursing, home health, social work, and therapy (speech, occupational and physical).

B.6.3.4. Quality Assurance

Quality improvement provisions should include:

B.6.3.4(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.6.3.4(b). Documentation of care-plan reviews, both peer and supervisory.

B.6.3.4(c). Documentation of utilization review.

B.6.3.4(d). Documentation of the most recent site visit by the administrative agency.

B.6.3.4(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.6.3.4(f). Documentation of periodic data and narrative reports to the administrative agency.

B.6.3.4(g). A process to solicit satisfaction with services at least annually.

B.6.3.4(h). Assurance that the provider agency meets the service category standards and/or any applicable professional or federal practice standards.

B.7. Hospice Services

Origination: November 1996 (ratified, September 1997).

Revision: July 1998; ratified, September 1998

Revision: June 2001; ratified, July 2001.

B.7.1. Service Definition

There is no HRSA HIV/AIDS Bureau definition for this service.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.7.2. Service Standards of Care

Hospice services for persons with HIV disease should reflect competence and experience in evaluation, formulation, diagnosis and evidence-based therapeutics, using contemporary practice guidelines where available.

B.7.2.1. Baseline Evaluation

An initial evaluation should be conducted prior to the initiation of any treatment. This evaluation must be conducted by a licensed or certified professional working as part of an interdisciplinary team.

B.7.3. Administrative Standards of Care

Hospice-care providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness and continuity of care; and (d) quality-of-care improvement efforts.

B.7.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.7.3.1(a). All care providers will be licensed/certified by the State of Maryland.

B.7.3.1(b). The nurse/case manager and other members of the care team shall possess the knowledge, skills and experience necessary to competently perform care or case-management activities.

B.7.3.1(c). Evidence of continuing education in the area of HIV disease is highly recommended.

B.7.3.1(d). Care providers are encouraged to contact the AETC regarding on-going education. See section B.6.3.1(d) hereof for AETC contact information.

B.7.3.1(e). Appropriate continuing education about terminal/palliative care must be available to all staff at least quarterly.

B.7.3.1(f). The hospice facility must be licensed as required.

B.7.1.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.7.3.2(a). All staff will protect the rights and confidentiality of each patient. Each patient will sign a bill of rights, be advised of the grievance procedure, and be provided with a specific telephone number to call for complaints.

B.7.3.2(b). When patient records have been requested by another care provider, the release of information form will be kept on file.

B.7.3.2(c). There should be evidence of a discussion of advance directives with the patient and/or family unit.

B.7.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.7.3.3(a). The inpatient unit should be handicapped accessible. Admission guidelines should assure no discrimination on any basis. There should be unrestricted access by family and friends, limited only by the wishes of the patient.

B.7.3.3(b). Medical records should reflect initial care plans signed by the physician and appropriate timely updates.

B.7.3.3(c). The plan of care should be discussed at least biweekly by an interdisciplinary team that reflects medical direction with equal participation by nurses, social workers, volunteers and spiritual/pastoral care. When needed, the physician will be contacted.

B.7.3.3(d). Volunteer services should be available to each patient, although some patients may not have a need for them.

B.7.3.3(e). The staffing ratio of the inpatient facility must be comparable to that found in an acute-care facility whenever possible. The program must be able to provide aggressive symptom management.

B.7.3.3(f). There should be at least one registered nurse per shift and other staffing appropriate to patient needs at the inpatient unit.

B.7.3.3(g). For patients in the program, bereavement services should be made available to their families or support persons.

B.7.3.4. Quality Assurance

Quality-improvement provisions should include:

B.6.3.4(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.6.3.4(b). Documentation of care-plan reviews, both peer and supervisory.

B.6.3.4(c). Documentation of utilization review.

B.6.3.4(d). Documentation of the most recent site visit by the administrative agency.

B.6.3.4(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.6.3.4(f). Documentation of periodic data and narrative reports to the administrative agency.

B.6.3.4(g). Documentation of a process to solicit satisfaction with services at least annually.

B.6.3.4(h). Documentation that the provider agency meets the service category standards and/or any applicable professional or federal practice standards.

B.8. Substance Abuse Treatment

Origination: October 1997.

Revision: August 2001; ratified, August 2001.

Revision: March 2003; ratified, April 2003.

B.8.1. Service Definition

There are two subfields of substance-abuse treatment, each of which is defined below.

B.8.1.1. Substance Abuse Services: Outpatient

This refers to the provision of medical treatment and/or counseling to address substance-abuse problems (i.e., alcohol and/or legal or illegal drugs), provided in an outpatient setting and rendered by a physician or under the supervision of a physician.

B.8.1.2 Substance Abuse Services: Residential

This refers to the provision of treatment to address substance-abuse problems (defined as at B.8.1.1), provided in an inpatient health-service setting (short-term).

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.8.2. Service Standards of Care

This subsection describes those standards necessary for the provision of clinical care. Substance-abuse treatment for persons with HIV disease should reflect competence and experience in evaluation, formulation, diagnosis and in evidence-based therapeutics, using contemporary practice guidelines where available. Agencies eligible for Ryan White Title I funding must be compliant with the current COMAR regulations. The standards apply for outpatient programs and inpatient programs.

B.8.2.1. Baseline Evaluation

A baseline evaluation should be performed, addressing and documenting the following matters.

B.8.2.1(a). Eligibility for all other funding resources must be assessed before Ryan White CARE Act, Title I funds can be used.

B.8.2.1(b). Documentation that demonstrates that the client was not eligible for any other funding resource to pay for services must be maintained in every client record.

B.8.2.1(c). Eligibility must be documented to ensure that the client is within the Ryan White income guidelines for the uninsured and underinsured.

B.8.2.1(d). For those with insurance that does not have substance-abuse coverage, documentation must show that the client (i) is HIV positive and (ii) has evidence that shows a medical or health-status report within the previous six months.

B.8.2.1(e). A statement of eligibility can be completed by the referring agency for each client.

B.8.2.1(f). The following components of evaluation and treatment should be standard practice with all clients and should be reflected in medical record documentation:

(i). An initial evaluation must be conducted prior to the initiation of any treatment.

(ii). Clinical staff knowledgeable about the full spectrum of alcohol and drug addiction must conduct this evaluation.

(iii). Clinical staff should be working in a substance-abuse program certified/licensed by the Maryland Office of Health Care Quality or hold current certification/licensure recognized by the Maryland Alcohol and Drug Abuse Administration for practice in Maryland.

(iv). The intake and assessment must meet the clinical requirements as outlined in COMAR regulations 10.47.01.04 (Clinical Requirements), 10.47.02.03 (Early Intervention), and 10.47.01.09 (Referral Agreements and Program Cooperation), as applicable.

B.8.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.8.2.2(a). For standards for delivery of outpatient services, refer to COMAR 10.47.02.04 (Outpatient Services), 10.47.02.05 (Intensive Outpatient and Partial Hospitalization Services), and 10.47.02.11 (Mediation-Assisted Treatment).

B.8.2.2(b). For standards for delivery of residential services, refer to COMAR 10.47.02.06 (Residential Services — Halfway Houses), 10.47.02.07 (Residential Services — Long Term Residential Care), 10.47.02.08 (Residential Services — Therapeutic Community), and 10.47.02.09 (Residential Services — Medically Monitored Intensive Inpatient Treatment).

B.8.2.2(c). For standards for delivery of detoxification services, refer to COMAR 0.47.02.10 (Detoxification Services).

B.8.2.2(d). For standards regarding agency responsibilities, refer to COMAR 10.47.01.03 (Governance) and 10.47.03.03 (Certification Required).

B.8.2.2(e). Residential service programs must also meet COMAR 10.47.01.05 requirements (Environmental Requirements).

B.8.2.2(f). Refer to COMAR sections for residential and outpatient services for requirements for monitoring on-going services (COMAR 10.47.02ff.).

B.8.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.8.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.8.3.1(a). Refer to COMAR 10.47.01.06 (Staff Requirements) for minimum qualifications for staff providing services.

B.8.3.1(b). Staff providing services must have both knowledge and experience in working with HIV-positive individuals as well as meeting the licensure or certification requirements.

B.8.3.1(c). The agency must encourage and allow continuing education and professional development opportunities to be pursued on an annual basis.

B.8.3.1(d). The agency is responsible for ensuring that each staff person attends training and educational opportunities related to HIV/AIDS and pertinent related topics.

B.8.3.1.(e). The agency is required to maintain documentation of staff attendance at continuing education, professional development opportunities for both HIV/AIDS topics and substance-abuse treatment or best practices.

B.8.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.8.3.2(a). Refer to COMAR 10.47.01.07 (Patient Rights and Grievance Procedures) and 10.47.01.08 (Records).

B.8.3.2(b). The agency must maintain documentation that copies of policies have been given to clients seeking services.

B.8.3.2(c). The agency shall have a consumer advisory board and maintain documentation of its meetings.

B.8.3.2(d). If a waiting list exists, the agency shall show evidence of a plan to attempt to communicate regularly with those clients on the list regarding waiting-list status.

B.8.3.2(e). The agency must have: written criteria for services; a fee structure; an intake process; and discharge, transfer and closing procedures. It must document that clients are informed of these.

B.8.3.3. Quality Assurance

The agency must show:

B.8.3.3(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.8.3.3(b). Documentation of care plan reviews, both peer and supervisory.

B.8.3.3(c). Documentation of utilization review.

B.8.3.3(d). Documentation of the most recent site visit by the administrative agency.

B.8.3.3(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.8.3.3(f). Documentation of periodic data and narrative reports to the administrative agency.

B.8.3.3(g). A process to solicit information about satisfaction with services at least annually.

B.8.3.3(h). Assurance that it meets the service category standards and/or any applicable professional or federal practice standards.

B.9. Case Management

Origination: October 1998 (ratified, November 1998).

Revision: October 2003; ratified, November 2003.

B.9.1. Service Definition

Case management is defined as a range of client-centered services that links clients with health-care, psychosocial and other services. Case management ensures timely and coordinated access to medically appropriate levels of health and support services and enhances continuity of care through on-going assessment of the client's and other key family members' needs and personal support systems. It also includes inpatient case-management services that prevent unnecessary hospitalization and that expedite discharge from an inpatient facility.

9.1.1.1. Key Services

Key activities:

9.1.1.1(a). Include initial assessment of service needs.

9.1.1.1(b). Include development of a comprehensive, individualized service plan.

9.1.1.1(c). Include coordination of services required to implement the plan.

9.1.1.1(d). Include client monitoring to assess the efficacy of the plan.

9.1.1.1(e). Include periodic reevaluation and adaptation of the plan as necessary over the life of the client.

9.1.1.1(f). May include client-specific advocacy and/or review of utilization of services.

B.9.1.2. Levels of Case Management

There are various levels of case management, defined as intensive, intermediate or periodic, and limited. Each is described below.

B.9.1.2(a). *Intensive* case management has the following characteristics:

- (i). The duration of the case-management relationship is expected to last as long as the client wishes it or is in need of service.
- (ii). Significant involvement in coordinating services to the client and/or family and household members is expected.
- (iii). Problem solving spans medical services, mental-health and/or substance-abuse services, social services, and support services. Follow up on referrals is required and must be in compliance with section B.9.2.2 hereof.

(iv). The client will receive a minimum of one face-to-face contact per month from the case manager. If the client does not follow through with scheduled appointments, the case manager will initiate contact.
(v). Each client will have an initial plan of care written up. This care plan will be arrived at by mutual agreement during the assessment phase of service. The plan must be completed within two months of the first interview. Written reevaluation of the care plan will occur once every six months. The agency will continue with the current client plan for one year if the client's needs have not changed.

B.9.1.2(b). *Intermediate or periodic* case management has the following characteristics:
(i). The duration of the relationship is expected to last as long as program participation.
(ii). The level of the case manager's involvement in coordinating services to the client and/or family and household members will be determined by the client's needs for intervention. Follow up by case managers on referrals will be determined by the client's needs for such intervention.
(iii). The case manager will initiate contact with the client at least every three months, with at least one face-to-face contact every six months.
(iv). Each client will have a written initial plan of care, which will be reevaluated at least annually.

B.9.1.2(c). *Limited or one-time intervention* case management has the following characteristics:
(i). Clients receive a mini-assessment specific to the client-identified problem; other issues and problems may be identified at this point.
(ii). The duration of the relationship may be limited to specific issues.
(iii). Problem solving is limited to resource identification.
(iv). The case manager is expected to have no more than two contacts per year. If more follow ups are necessary within a 90-day period from the initial contact, the case manager will reassess the level of case management for appropriateness.
(v). A plan of care is necessary.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.9.2. Service Standards of Care

Case-management services are directed toward ensuring the timely and coordinated access to medically necessary and appropriate levels of care and support services that enhance continuity of care across the continuum of service providers. The following are the minimum standards for the provision of case-management services. Agencies and individuals may exceed these minimum standards. The level of case-management service is determined by the case manager and the client, beginning at assessment, and should be changed, as needs change.

B.9.2.1. Baseline Evaluation

The baseline-evaluation period has four principal phases, as follows: identification, intake, psychosocial needs assessment and care-plan development.

B.9.2.1(a). *Identification* is defined as the process used to determine if an individual is eligible for services by virtue of pre-established criteria developed by the service provider.

(i). The agency shall screen all the individuals who call, walk in or schedule an appointment for case-management services to determine the appropriateness for agency services, including verification of HIV status.

(ii). The agency shall make suitable referrals for those individuals who are not appropriate for agency case management, but who are in need of services.

(iii). The agency shall assess individuals in crisis to determine what agency interventions are appropriate.

(iv). The agency shall assign a case manager to eligible clients within five business days of the completion of the initial screening.

B.9.2.1(b). *Intake* is defined as the process used to formally enter an eligible client into the system for further assessment and the development of the client's plan of care; it is necessary to collect all information about the client for subsequent planning, intervention and/or intake.

(i). The agency shall complete an initial assessment of each eligible client at the time of intake, collecting all information as outlined on the service provider's intake forms within two business days. Completion of these forms is required for all levels of case management.

(ii). Eligible clients presenting with emergency needs should have these needs addressed by the conclusion of the intake appointment. Emergency needs are defined as needs that will have serious immediate consequences for the client unless these needs are met.

(iii). Clients will be seen for the first case-management appointment within five working days after assignment to a case manager. Individuals requiring an off-site visit must be seen within 10 working days after assignment to a case manager. Exceptions are made if clients initiate cancellations.

(iv). The agency shall assist clients in identifying and making appointments with medical providers as early as possible during the initial intake or the case-management intake appointment for those clients not already connected to a primary medical care provider. Clients are to schedule their own appointments if they are able.

B.9.2.1(c). After intake, agencies must provide a *psychosocial needs assessment* in the following manner:

(i). The case manager shall complete a comprehensive written psychosocial needs assessment for each client within 30 days or by the conclusion of the third case-management appointment, which ever comes first. This needs assessment shall include a medical/psychosocial history and shall be included in the record; this history is required for all levels.

(ii). Areas to be covered in the psychosocial assessment:

- Presenting problem(s).
- Living situation.
- Nutritional status history.
- Spirituality issues.

- Social community supports.
- Emotional/behavioral status.
- Financial status/entitlements.
- Health insurance/prescription plans.
- Sexuality issues.
- Awareness of safe sex practices.
- Current health status.
- Health symptoms.
- Medical history.
- Family composition.
- Psychiatric/mental health.
- Recreational/social activities.
- Employment history.
- Substance-abuse history.
- Current medications.

Note that it is recommended that children, ages 13 and under, be tested for HIV if either parent is HIV positive.

(iii). The case manager shall ensure that each chart contains complete written indications that the current needs have been discussed and/or identified at the time of the psychosocial needs assessment. Case managers should review the listed areas of needs when performing the psychosocial needs assessment.

(iv). The agency should ensure that a mini-assessment specific to the identified problems is completed for any individuals requesting limited or one-time interventions.

B.9.2.1(d). Once the needs assessment has been completed, there follows the *development of the care plan*.

(i). With the active participation of the client and possibly others (e.g., partners, parents, guardians and medical-care givers), the case manager shall develop an appropriate course of action to access the identified resources required to meet the needs and resolve the problems.

(ii). The case manager shall, with the active participation of the client, identify which needs are to be addressed through the development of goals and objectives. Time frames for meeting the goals and resolving the problems should be established. These written objectives and goals are to be incorporated into the plan of care, which is a permanent part of the client's chart. Development of the plan of care shall be started by the third case-management appointment or within 30 working days of the date of the assignment to a case manager. All plans of care should be signed and dated by the client and the case manager.

(iii). The agency shall, together with the client, identify the appropriate resources needed to attain the stated goals and objectives. This resource identification shall be written in the plan of care.

(iv). The agency shall provide written verification that the client is either in agreement or disagreement with the goals and objectives contained in the plan of care.

B.9.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.9.2.2(a). *Implementation and coordination of the plan of care* should be conducted in the following manner.

(i). The case manager shall provide support, advocacy, consultation and crisis intervention to the client and others involved in the implementation of the plan.

(ii). The case manager shall proactively attempt to contact the client after the development of the plan to implement those parts that were not executed at the time of the plan development. The plan will establish priorities among the identified needs.

(iii). The case manager shall advise the client on making arrangements with service providers selected and on ways of gaining access to those services. The case manager will assist clients who cannot successfully access services on their own.

(iv). The case manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client and other identified people and the outcomes resulting from these actions shall also be incorporated in the record one week after the referral or appointment.

(v). The case manager shall be in communication with the client during the intensive level of case management, a minimum of one contact per month to provide support, advocacy, consultation and crisis intervention throughout implementation of the client plan. For intermediate case management, the case manager shall be in communication with the client at minimum once every three months. There shall be at least one face-to-face contact and communication as necessary for clients at the limited level of intervention, one face-to-face contact every six months for the intermediate case management level, and one face-to-face contact every six months at the intensive level.

B.9.2.2(b). *Monitoring of the plan of care* shall continue after the plan has been developed and implemented.

(i). Monitoring is performed to routinely review the success in achieving services as outlined in the care plan, to measure progress in meeting goals and objectives, to intervene as appropriate and to revise the plan as necessary.

(ii). The case manager shall monitor the goals and objectives contained in the plan, as the needs of the client require, to decide what steps need to take, if any. Documentation of the monitoring process shall be recorded in the record. This monitoring shall occur a minimum of the following:

- *Intensive:* Each client shall receive a minimum of one contact per month from the case manager; as part of this, there shall be one face-to-face contact every six months.
- *Intermediate or Periodic*: Contact can be initiated by the case manager or the client at least every three months; as part of this, there shall be one face-to-face contact every six months.
- *Limited:* The case manager is involved in no more than two intervention contacts, these being limited to particular issues.

(iii). If a client cannot be located, after several attempts to reach him or her by telephone and/or letter for two months, a referral shall be made to case finding (if available) to assist in locating

the client. If the case finder cannot locate the client within 90 days, the case-management record shall be closed.

(iv). The case manager shall monitor the referral services provided and the service delivery to verify that the services are being received and are of sufficient quality and quantity.

(v). The case manager shall provide written documentation in the progress notes of difficulties encountered in achieving the goals and objectives and provide strategies in writing for resolving the difficulties.

(vi). The agency shall make available professional supervision or consultation to all case managers while the care plan is being monitored. A minimum of one hour of formal supervision once a month is required per case manager, with additional case consultations on an as-needed basis.

B.9.2.2(c). *Reevaluation of the plan of care* will occur periodically.

(i). The purpose of reevaluating the plan of care is to review the success of the implementation of the care plan and to determine if the client's needs have significantly changed since the previous needs assessment. If the needs have changed, then a new plan should be developed. If the needs are the same, then the current plan shall be continued for one year.

(ii). Each agency shall assess the client's records a minimum of once every six months to determine the client's status and progress and to ascertain if any revision is needed in the care plan or in the provision of services. This review shall be recorded in the progress notes. The case manager supervisor, peer review or formal audit personnel may undertake the record review.

(iii). The case manager shall develop, with the active participation of the client, new goals and objectives if the client's needs have changed since the previous needs assessment.

B.9.2.2(d). The process for *case closure* shall be as follows:

(i). Closure of the case may occur at the request of the client, at the request of the agency (provided that the pre-established procedures are followed), or due to death.

(ii). Prior to closure (with the exception of death), the agency shall attempt to inform the client of the reentry requirements into the system, and make explicit what case closing means to the client.

(iii). The agency shall close a client's file according to the written procedures established by the agency, including, but not limited to: death, relocation, transition to another provider or at the request of the client.

(iv). In Maryland, adult records will be kept for a minimum of 10 years after the last entry (that is, records of those over 18 years of age). For children (those aged 18 and under), records must be archived either until the child reaches the age of 24 or for six years after death, whichever occurs sooner.

B.9.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.9.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.9.3.1(a). The agency/organization will show evidence of being licensed by an appropriate body.

B.9.3.1(b). Licenses must be current and available.

B.9.3.1(c). Where applicable, staff will have licenses that are current and appropriate for providing case-management services.

B.9.3.1(d). The agency will:
(i). Maintain documentation that demonstrates that case-management services are provided directly by, or under the supervision of, or in consultation with, a licensed social worker and/or registered nurse case manager. The minimum set of qualifications for supervision of case managers shall be: registered nurse or licensed certified social worker status, with a minimum of three years' experience. One year of experience may be substituted by an equivalent in additional academic preparation.
(ii). Maintain documentation for each staff person of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS.
(iii). Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.
(iv). Create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

B.9.3.2. Patient Rights and Confidentiality and Agency Responsibilities

Providers should be able to document the following in terms of clients' rights and confidentiality:

B.9.3.2(a). The agency shall have policies and procedures that protect the rights and outline the responsibilities of the clients and the agency.

B.9.3.2(b). The agency shall have policies and procedures that include these provisions:
(i). The agency shall have written policies regarding eligibility, confidentiality, grievance procedures, rights and responsibilities of clients, referral and linkage, agency expectations of clients, and termination policies.
(ii). The agency shall have documentation, with client signature, that such policies have been offered/read and explained to the client seeking service.
(iii). The agency shall have a system for ensuring that case-management records are protected and secured.
(iv). The agency shall have a written, informed, signed consent for the delivery of case-management services.
(v). The agency shall ensure that, when appropriate, agency staff will refer and link clients with other needed services.
(vi). The agency shall ensure that each client has received an intake screening, an eligibility determination and, for eligible clients, an initial assessment.

(vii). The agency shall have documentation of the provision of information and referrals to clients as necessary when case-management services are not available. If a waiting list exists, the agency must show evidence of a plan to communicate on a regular basis with the client regarding waiting-list status.

(viii). The agency shall have evidence of referrals to other resources and information, based on client need.

(ix). The agency shall have documentation of mutual goal setting between the client and the case manager delivering the service.

(x). The agency shall have evidence of client progress toward meeting established goals by documentation of activity through the case-management plan of care.

(xi). The agency shall have evidence of a monitoring process, to reflect that:

- The plan of care should be monitored and revised, as necessary, on a periodic basis, at least every six months, with the client, to determine whether client and agency service goals are being met.
- Services should be reviewed periodically, at least annually, to ensure that information given to the client is current.

(xii). The agency shall have documentation of a formal review instrument, and evidence that the record has been reviewed by a supervisor, peer reviewer or formal audit.

(xiii). The agency shall have documentation of written criteria for services, fee structure as defined within the CARE Act, intake process, discharge, transfer and closing procedures.

(xiv). The agency shall have evidence of orientation for new staff; documentation of on-going continuing education for staff.

(xv). The agency shall have a written process for supervision of case managers.

B.9.3.3. Quality Assurance

Quality assurance is described below.

B.9.3.3(a). There must be a quality-improvement or -assurance plan designed to monitor both the appropriateness and effectiveness of all services delivered.

B.9.3.3(b). The delivery of direct services must be monitored and documented for professional accountability through the following: regular and on-going team meetings, case conferences at least monthly; individual professional evaluations at least annually, and formal supervision (which may be peer supervised).

B.9.3.3(c). There must be a formal written grievance or appeal process for clients.

B.9.3.3(d). Agency policies should be given to all enrolled clients.

B.9.3.3(e). There must be a process for identifying clients who qualify for case-management services

B.9.3.3(f). There must be documentation of the existence and meeting of a formal advisory board held at least quarterly made of agency clients.

B.9.3.3(g). There must be a process to solicit client satisfaction at annually.

B.9.3.3(h). There must be documentation of periodic site visits by the administrative agent, BCHD or a designee.

B.10. Client Advocacy

Origination: October 1998.

B.10.1. Service Definition

Client advocacy is the provision of advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Advocacy does not involve coordination and follow up on medical treatments, as case management does.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.10.2. Service Standards of Care.

Client-advocacy services provide assessment of individual needs as well as advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Services focus on continuity of care and ensuring that consumers have access to special HIV resources. The following are minimum standards for the provision of client-advocacy services. Agencies and individuals may exceed these minimum standards. The services are determined by the assessment that the client advocate makes in discussions with the client.

B.10.2.1. Baseline Evaluation

An initial evaluation process should be performed, consisting of two components (identification and, if warranted, intake), as follows:

B.10.2.1(a). *Identification*: To determine if an individual is eligible for services, by the pre-established criteria developed by the service provider:
- (i). The agency shall screen all individuals who call, walk in or are referred for client-advocacy services. Verification of HIV status and eligibility for the services is required.
- (ii). The agency shall make suitable referrals for those individuals who are not appropriate for the client advocacy.
- (iii). The agency shall assess individuals in crisis to determine the immediate interventions that are appropriate.
- (iv). The agency may assign a client advocate to provide on-going services.

B.10.2.1(b). *Intake:* The intake phase should be completed within two visits for clients who will be receiving on-going services. The initial assessment will cover the following topics:
- (i). Presenting problem.
- (ii). Living situation.
- (iii.) Financial entitlement.

(iv.). Health insurance.
(v). Substance abuse and mental health history.

B.10.2.1(c). A written action plan will be developed with the client.

B.10.2.1(d). Signed consent will be obtained to discuss the action plan, if appropriate, with other service providers' case managers and to develop a collaborative relationship with those entities on behalf of the client.

B.10.2.1(e). Completion of all agency intake forms and discussions with clients will take place regarding grievance, confidentiality, client rights, client responsibilities and agency services.

B.10.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.10.2.2(a). The action plan will be implemented as follows:
(i). The client advocate will provide advice, referrals and other assistance necessary to carry out the action plan.
(ii). The client advocate — through office visits, home visits and phone calls — will proactively work with the client to obtain the services or information necessary to make referrals for services.
(iii). The client advocate will follow up and, if necessary, coordinate referrals to ensure a continuity of care.
(iv). The client advocate will intercede on behalf of the client with other agencies when necessary.
(v). The client advocate will maintain documentation of all contacts with or on behalf of the client.

B.10.2.2(b). The action plan will be monitored as follows:
(i). The client advocate will review the action plan at least every six months with the client.
(ii). The client advocate will monitor the services provided and act as an advocate for the client when necessary.

B.10.2.2(c). The client's case will be closed in the following manner:
(i). Closure of the case may occur at the request of the client, at the request of the agency (provided that pre-established procedures are followed), or due to death of the client.
(ii). Prior to closure (with the exception of death), the agency shall attempt to inform the client of the reentry requirements into the system and make explicit what case closing means to the client.
(iii). The agency shall close a client's file according to the procedures established by the agency. In Maryland, adult records will be kept for a minimum of 10 years after the last entry (that is, records of those over 18 years of age). For children (those aged 18 and under), records must be archived either until the child reaches the age of 24 or for six years after death, whichever occurs sooner.

B.10.3. Administrative Standards of Care

In addition to demonstrating competency in the provision of client-advocacy services, programs must show evidence that their performance follows administrative norms for such services.

B.10.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.10.3.1(a). Licensing standards are these:
(i). The agency/organization will show evidence of being licensed by an appropriate body.
(ii). Licenses must be current and available.
(iii). Where applicable, staff will have licenses that are current and appropriate for providing client-advocacy services.
(iv). Supervisors of client advocates shall be licensed social workers or registered nurse case managers.

B.10.3.1(b). Training and supervision standards are these:
- (i). The agency will provide adequate training and supervision for all client advocates.
- (ii). The agency will maintain documentation that demonstrates that client-advocate services were provided directly by, or under the supervision of, or in consultation with, a licensed social worker and/or registered nurse case manager.
- (iii). The agency will maintain documentation for each client advocate of in-service and/or specialized training given or taken on pertinent topics related to HIV/AIDS.
- (iv). The agency will have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.
- (v). The agency will create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

B.10.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of patients' rights and confidentiality.

B.10.3.2(a). The agency shall have policies and procedures that protect the rights, and outline the responsibilities, of the client and the agency.

B.10.3.2(b). These policies and procedures shall include:
- (i). A written agency policy on client confidentiality.
- (ii). A statement signed by the client stating that existing policies and procedures regarding confidentiality, grievances, eligibility and services have been explained to the client. (Copies of eligibility criteria and lists of services available should be given to each client requesting services.)
- (iii). A system for ensuring that case records are protected and secured.

(iv). A written, signed consent for the release of information that pertains to establishing eligibility for agency services.
(v). A written grievance procedure.
(vi). A statement of rights as well as responsibilities or agency expectations of each client.
(vii). A statement that outlines the process for both voluntary and involuntary disengagement from services.

B.10.3.4. Quality Assurance

The agency shall provide:

B.10.3.3(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.10.3.3(b). Documentation of care plan reviews, both peer and supervisory.

B.10.3.3(c). Documentation of utilization review.

B.10.3.3(d). Documentation of the most recent site visit by the administrative agency.

B.10.3.3(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.10.3.3(f). Documentation of periodic data and narrative reports to the administrative agency.

B.10.3.3(g). Documentation of a process to solicit client satisfaction with services at least annually.

B.10.3.3(h). Assurances that it meets the service category standards and/or any applicable professional or federal practice standards.

B.11. Psychosocial Support Services

Origination: March 2003 (ratified, April 2003).

B.11.1. Service Definition

"Psychosocial support" refers to the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, play and other rehabilitation services), child-abuse and -neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support and bereavement counseling. Psychosocial support also includes other services not included in mental-health or substance-abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and are focused on HIV-related problems.

B.11.1.1. Key Services

Key services include:

B.11.1.1(a). Individual counseling.

B.11.1.1(b). Peer counseling or peer support groups offered by HIV-positive individuals or those with similar life experiences who are knowledgeable about HIV and are culturally sensitive to the special populations.

B.11.1.1(c). Caregiver support or bereavement counseling.

B.11.1.1(d). Drop-in counseling.

B.11.1.1(e). Benefits counseling.

B.11.1.1(f). Nutritional services that include the provision of education.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.11.2. Service Standards of Care

This section describes those service standards necessary for the provision of care under this category.

B.11.2.2. Baseline Evaluation

An initial evaluation process should be performed, consisting of two components (intake and assessment), as follows:

B.11.2.2(a). *Intake:* This includes:
(i). Completion of agency-required intake forms.
(ii). Collection of demographic information, where relevant.
(iii). Documentation of services provided to the client. This should be maintained by the agency.
(iv). Documentation of eligibility to ensure that the client is within Ryan White income guidelines for the uninsured and underinsured.
(v). Documentation that the client is HIV positive or, if not, is directly affected by HIV (such definition to include household family members or caretakers of those who are HIV infected).
(vi). If the client is HIV affected, not HIV infected, documentation that shows the relationship of the affected person to an HIV-positive individual.
(vii). A statement of eligibility, which can be completed by the referring agency.

B.11.2.2(b). *Assessment:* This includes:
(i). Review of services offered and discussion with the client of his or her needs.
(ii). Determination of those psychosocial support services that are appropriate.
(iii). Collection of demographic information, if relevant.
(iv). Documentation of services provided to the client.

B.11.2.3. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.11.2.3(a). The agency will ensure that direct services are monitored for accountability through regular and on-going team/staff meetings, individual evaluations (at least annually), and supervision as necessary.

B.11.2.3(b). The agency will also provide:
(i). Evidence of an initial eligibility screening and initial assessment.
(ii). Evidence of client progress toward meeting established goals through documentation of activity; such documentation includes sign-in sheets, case notes, etc.
(iii). Evidence of the existence and meeting of an advisory board at least quarterly, with representation from the HIV/AIDS community.
(iv). Evidence of a reasonable caseload standard or ratio by service providers with a priority system for acceptance of cases.
(v). Evidence that information and referrals are provided to clients when psychosocial support services are not available. If a waiting list exists, the agency must show evidence of a plan to communicate regularly with clients regarding waiting-list status.
(vi). Evidence of referrals to other resources and information, as appropriate.
(vii). Evidence of written criteria for services, fee structure, intake process, discharge, transfer and closing procedures.

B.11.2.3(c). On-going counseling should be monitored on a periodic basis, at least once every six months, to determine whether the client and/or the agency's service goals are being met.

B.11.2.3(d). Each client receiving services from a psychosocial-support provider must have an annual reassessment of service needs where appropriate.

B.11.2.3(e). Documentation of any reassessment must be maintained in files.

B.11.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.11.3.1. Licensing, Knowledge, Skills And Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.11.3.1(a). Psychosocial-support service providers will possess the knowledge, skills and experience necessary to competently perform expected services.

B.11.3.1(b). Staff will possess the knowledge (including cultural sensitivity to the population served), skills and experience necessary to competently perform expected services.

B.11.3.1(c). Staff will have experience and knowledge of HIV-related issues.

B.11.3.1(d). The agency is responsible for ensuring that staff providing psychosocial support is overseen by a licensed or certified professional and/or that staff members consult with practitioners who have extensive HIV experience.

B.11.3.1(e). The agency will show evidence of being a legal entity, able to do business in psychosocial support in Maryland.

B.11.3.1(f). Certification must be current and displayed.

B.11.3.1(g). The agency will have a training program for all staff and volunteers who will be responsible for services to clients.

B.11.3.1(h). The agency must show evidence that all staff and volunteers attend in-service specialized training on HIV and related topics.

B.11.3.1(i). For those staff members who have special expertise, such as counselors, the agency should show that staff have the opportunity to attend training sessions regarding the provision of services to the HIV-infected and HIV-affected populations within the staff areas of specialization.

B.11.3.2. Client Rights and Confidentiality

Agencies must ensure that there are policies and procedures on the protection of the rights and confidentiality of each client by:

B.11.3.2(a). Showing evidence of a written agency policy on client confidentiality.

B.11.3.2(b). Showing evidence in existing records/files of client knowledge of policies and procedures for maintaining confidentiality.

B.11.3.2(c). Showing evidence that existing records/files containing client information are secured and protected.

B.11.3.2(d). Showing evidence in existing records of clients' consent for release of information to other service providers and, if appropriate, release forms authorizing information to be requested from other providers.

B.11.3.2(e). Showing evidence that clients have been given copies of the agency grievance policy and procedures.

B.11.3.3. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken. The agency must show:

B.11.3.3(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.11.3.3(b). Documentation of care plan reviews, both peer and supervisory.

B.11.3.3(c). Documentation of utilization review.

B.11.3.3(d). Documentation of the most recent site visit by the administrative agency.

B.11.3.3(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.11.3.3(f). Documentation of periodic data and narrative reports to the administrative agency.

B.11.3.3(g). Evidence of a process to solicit satisfaction with services at least annually.

B.11.3.3(h). Evidence that it meets the service category standards and/or any applicable professional or federal practice standards.

B.12. Day and Respite Care: Children

Origination: November 1996.

Revision: August 1999; ratified, September 1999.

B.12.1. Service Definition

Day and respite care is designed to offer day care or residential or home-based assistance to relieve the primary caregiver responsible for providing day-to-day care to the client or the client's children.

B.12.1.1. Key Services

Key day- and respite-care services include:

B.12.1.1(a). Supporting the development of child day care for HIV-infected children.

B.12.1.1(b). Supporting the development of day care for children to enhance the ability of the individuals with HIV infection to obtain health and social services.

B.12.1.1(c). Supporting the development of respite care for individuals with HIV infection in order to provide relief to caregivers.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.12.2. Service Standards of Care

The following are minimum standards for the provision of day- and respite-care services. Agencies and individuals may exceed these standards.

B.12.2.1. Baseline Evaluation

A baseline evaluation should be performed, including the following elements:

B.12.2.1(a). The agency must determine and document the HIV status of the parent/caretaker or child.

B.12.2.1(b). The agency must comply with state regulations concerning acquisition of proper licenses for serving appropriate age groups. Documentation of ages of children must be in the files.

B.12.2.1(c). The agency must establish and document income eligibility for services.

B.12.2.1(d). The agency may accept self- or client referrals for services.

B.12.2.1(e). The agency will meet with the client or caretaker for a screening interview, during which:
(i). The agency will discuss general needs for day and respite care.
(ii). The agency will discuss any special day-care requirements.
(iii). The applicant will identify his or her current primary medical care physician and sign a release form to secure medical information on the HIV-positive parent or child.

B.12.2.1(f). If the applicant does not have a primary medical care provider, the agency will make a referral to medical services.

B.12.2.1(g). If the client is referred from an agency for day and respite care, the referring agency will send documentation regarding:
(i). Physical examinations within the past 12 months for any HIV-positive clients and children entering the program.
(ii). Day- and respite-care needs of the family or caretaker and adult HIV-positive client.
(iii). Special instructions about the care of children and/or adult HIV-positive service recipients entering the program.
(iv). Medication regimens, dosing schedules and/or special medication instructions.
(v). Mental, developmental or special educational needs or issues.
(vi). For children, certification that the state-required minimal baseline inoculations have been received.
(vii). The most current CD4 and viral load test results.

If self-referring, the client must provide this same documentation.

B.12.2.1(h). The day- and respite-care agency will maintain copies of all birth certificates and Social Security numbers for children entering program.

B.12.2.1(i). The agency will document the type of health insurance, if any.

B.12.2.1(j). The agency will maintain copies of any custody documents for caretakers of children.

B.12.2.1(k). The agency will identify other agencies that are working with the client or caretaker and record contact names and telephone numbers in the files.

B.12.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.12.2.2(a). The agency will develop a care plan and implement it as follows:
(i). The agency will work with the caretaker or HIV-positive adult client to develop a day- and respite-care plan.
(ii). Client rights and responsibilities should be outlined.
(iii) Program services should be described and expectations of clients for particular services should be discussed.
(iv). State and local regulations for day-care programs should be discussed.

(v). Agency policies regarding grievances, confidentiality of client's and/or children's information, and safety procedures should be discussed.
(vi). The care plan should include self-care goals decided by each HIV-positive adult client and caretaker.
(vii). The care plan should include goals identified by the adult client or caretaker for children receiving day care services.
(viii). The agency should work toward a multidisciplinary team approach for each client or child, utilizing other agencies and services, and working with the client or family.
(ix). The agency should incorporate or develop transition plans for the point at which the client and/or children are no longer eligible for the service.

B.12.2.2(b). The agency will monitor plans as follows:
(i). Each care plan should be reviewed at least once annually.
(ii). Eligibility for continuing services should be part of the review process.
(iii). Care plans should be revised as the needs of clients, caretakers or children change.

B.12.2.2(c). In regard to closure, services may be ended for any of the following reasons:
(i) Death of eligible HIV-infected person.
(ii) Choice of the client or caretaker to discontinue services.
(iii). Age of the child or children.
(iv). Change in health status, requiring services beyond the agency's program.
(v) Failure of the client or caretaker to appropriately utilize services.

B.12.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.12.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.12.3.1(a). The agency will show evidence of being licensed by all the appropriate state and/or local regulatory agencies.

B.12.3.1(b). The agency will show evidence that its license is current and available for review, where applicable.

B. 12.3.1(c). Program staff will possess the knowledge, skills and experience necessary to competently perform expected services. Specifically, the agency should show evidence that:
(i). Staff members are trained and knowledgeable regarding HIV/AIDS, the affected community, and child-abuse and -neglect issues.
(ii). The day- and respite-care facility and service meets health, fire and state safety standards.
(iii). The personnel employed to deliver the service are licensed and certified, as applicable.

(iv). Each staff member or volunteer working directly with children has passed a criminal background check.
(v). Each staff member or volunteer having direct contract with clients or children has had a physical examination within the past 12 months.
(vi). Staff members have been trained and, where applicable, are certified in CPR and first aid.

B.12.3.2(d). The agency is responsible for ensuring that any staff person dispensing medications is properly licensed or certified to perform this function.

B.12.3.2(e). The agency will have a training program for all staff and volunteers who will be responsible for services to consumers/clients.

B.12.3.2(f). The agency will provide evidence that all provider staff attend in-service and specialized training on topics related to the services delivered and to the special populations with which the agency works.

B.12.3.2. Client Rights and Confidentiality

The agency should establish and maintain policies and procedures for the protection of the rights and confidentiality of each client. Specifically, the agency should show evidence:

B.12.3.2(a). Of a written agency policy on client confidentiality.

B.12.3.2(b). Of client knowledge of policies and procedures in existing records and files.

B.12.3.2(c). That existing records and files containing client information are secured and protected.

B.12.3.2(d). That the agency has been licensed or approved and meets or exceeds all local or state health department or other regulatory body requirements for food handling, preparation or serving.

B.12.3.2(e). That in dispensing medications, the agency adheres to state or local health department or child-care administration guidelines and regulations for disbursing medications.

B.12.3.3. Quality Assurance

The agency must have a quality-assurance plan designed to monitor both appropriateness and effectiveness of all services delivered. Specifically, the agency must:

B.12.3.3(a). Show evidence of an application and assessment process that includes, but is not limited to, written applications criteria for acceptance/rejection; ranking criteria utilized for eligible applications when waiting lists exist; formal grievance process; and termination processes.

B.12.3.3(b). Show evidence that program policies are understood and signed by all clients.

B.12.3.3(c). Show evidence of a structured referral process if clients require assistance with other social services.

B.12.3.3(d). Show evidence of the existence of an active advisory board with representation from the client population.

B.12.3.3(e). Show evidence that space and staffing ratios are in compliance with agency guidelines and any other pertinent regulatory body's requirements.

B.12.3.3(f). Show evidence of emergency procedures for children who are abandoned or who have parents that require overnight hospital care.

B.13. Emergency Financial Assistance

Origination: November 1996.

Revision: February 2000; ratified, March 2000.

B.13.1. Service Definition

Emergency financial assistance (EFA) is the provision of short-term payments for food, essential utilities or medication assistance that planning councils may allocate and which must be carefully monitored to assure limited amounts, limited use and limited duration of time.

13.1.1. Key Services

Emergency financial assistance may include:

13.1.1(a). Food, nutritional supplements and basic staples on an emergency basis.

13.1.1(b). Maintenance of essential utilities and other critical needs on an emergency basis.

13.1.1(c). Paying for emergency medicine pharmacy assistance for clients until their Medicaid, MADAP or other medical assistance is approved.

13.1.1(d). Paying for meals for an HIV-affected family while members are temporarily sheltered in transitional housing.

13.1.1(e). Medication, laboratory work, medical care, medical supplies and other critical needs for which there is no other payment available on a short-term basis, including coverage for co-payments.

13.1.1(f). Other emergency needs as deemed appropriate by the agency.

As used herein, the term “client” encompasses the terms “patient” and “service consumer.”

B.13.2. Service Standards of Care

The following are minimum standards for the provision of EFA services, commonly called “vouchers.” Agencies and individuals may exceed these standards.

B.13.2.1. Baseline Evaluation

The baseline-evaluation period has three phases, as follows: eligibility determination, needs assessment and intake.

B.13.2.1(a). To determine *eligibility* for EFA, agencies should:
(i). Collect documentation that establishes HIV status.
(ii). Determine income eligibility for Ryan White Title I.
(iii). Review eligibility based on agency policy regarding caps on the amount of EFA clients may receive during any given time period.

B.13.2.1(b). To conduct an *assessment* of the need for EFA, agencies should:
(i). Establish with the client that the request is of an emergency nature.
(ii). Maintain documentation that supports the emergency need.
(iii). Determine necessary linkages and/or referrals to address emergency.

B.13.2.1(c). To facilitate the *intake* of clients into EFA, agencies should:
(i). Complete the agency intake forms and process.
(ii). Where possible, develop a longer-range strategy with the client to avoid future emergencies of the same nature.
(iii). Maintain documentation of services provided.

B.13.2.1(d). The agency must have written policies including services descriptions, eligibility criteria, confidentiality provisions, grievance procedures, referral and linkage mechanisms, and agency expectations of clients.

B.13.2.1(e). The agency must maintain documentation that shows that policies were provided to clients.

B.13.2.1(f). When appropriate, the agency will link clients with other needed services.

B.13.2.1(g). The agency must maintain documentation of EFA services provided to each client.

B.13.2.1(h). The agency must have written guidelines so that EFA services are provided uniformly to eligible clients, without discrimination, according to Ryan White regulations, as funding of last resort and according to criteria that establish the nature or level of the emergency.

B.13.2.1(i). The agency must have a system for securing vouchers, ensuring the proper authorization for their use and for monitoring the use of vouchers.

B.13.2.1(j). The agency will ensure that no cash assistance can be provided to clients.

B.13.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.13.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.13.3.1(a). The agency will show evidence of being licensed by an appropriate body, where applicable.

B.13.3.1(b). The agency will show evidence that the license of the organization is current and available, if applicable.

B.13.3.1(c). Program staff will possess the knowledge, skills, and experience necessary to competently deliver expected services.

B.13.3.1(d). The agency will show evidence that staff and volunteers are trained and knowledgeable regarding HIV/AIDS in the community.

B.13.3.1(e). The agency will show evidence that an intake mechanism is in place to deal with emergency financial assistance requests; that there is a system in place to process the request; that a decision-making body reviews the request; and that there is an accounting mechanism whereby authorization is given to pay a written bill or issue a check on behalf of the client.

B.13.3.1(f). The agency will show evidence that no cash assistance is given to clients and that, for each payment, there is written documentation supporting the request, along with documentation of the client's HIV status in the client's file.

B.13.3.1(g). The agency will show evidence that the personnel authorized to deliver the service are certified and licensed, if licensure is applicable.

B.13.3.1(h). The agency will have a training program for all staff and volunteers who are or will be responsible for services to clients.

B.13.3.1(i). The agency will show evidence that all provider staff attend in-service and specialized training on related topics.

B.13.3.2. Client Rights and Confidentiality

The agency must have policies and procedures for the protection of the rights and confidentiality of each client. Specifically, the agency must show evidence:

B.13.3.2(a). Of a written agency policy on client confidentiality.

B.13.3.2(b). Of client consent for release of client information pertaining to eligibility criteria, in existing files.

B.13.3.2(c). That existing records or files containing client information are secured and protected.

B.13.3.2(d). That client confidentiality is protected by ensuring that vouchers used for medications, transportation and utilities do not reveal that the agency provides HIV-related services.

B.13.3.3. Quality Assurance

There must be a quality-assurance plan designed to monitor both appropriateness and effectiveness of all services delivered. Specifically, the agency must show evidence:

B.13.3.3(a). Of the application and assessment process including, written criteria for eligibility for the program, criteria for acceptance or rejection, and grievance procedures.

B.13.3.3(b). That program policies are understood and signed by all clients.

B.13.3.3(c). That clients receive assistance with social-services needs and that appropriate referrals are made for other related services and for help with financial assistance from other agencies or programs when clients do not meet the particular agency's eligibility criteria for EFA.

B.13.3.3(d). Of the existence of a formal advisory board which meets quarterly with representation from the HIV/AIDS community.

B.13.3.3(e). That policies/procedures exist to assure equity in the distribution of funds among all eligible applicants.

B.14. Food Bank and Home Delivered Meals

Origination: November 1996.

Revision: July 1999; ratified, August 1999.

B.14.1. Service Definition

The food bank and home-delivered meals category pertains to the provision of actual food, meals or nutritional supplements. The service does not include finances to purchase food or meals, and nor nutritional-counseling services. Nutritional services may be integrated with outpatient HIV primary medical care programs.

B.14.1.1. Key Services

Food and nutrition services include:

B.14.1.1(a). The provision of food, home-delivered meals, groceries and nutritional supplements.

B.14.1.1(b). Meal plans developed under the supervision of a licensed nutritionist/dietitian.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.14.2. Service Standards of Care

The following are minimum standards for the provision of food services. Agencies and individuals may exceed these standards.

B.14.2.1. Baseline Evaluation

The baseline-evaluation period has three principal phases, as follows: eligibility determination, needs assessment and intake.

B.14.2.1(a). Referral from an HIV service provider must be accompanied by documentation from the client's primary medical care provider that establishes the need for services.

B.14.2.1(b). *Eligibility* determination will include:
- (i). Documentation of HIV status.
- (ii). Documentation of Ryan White eligibility.
- (iii). Documentation of family composition/nuclear family.
- (iv). Documentation that consumer is homebound or medically fragile.

B.14.2.1(c). *Assessment* will include:
(i). Medical considerations (HIV and other conditions).
(ii). Food allergies.
(iii). Medicine and food interactions.
(iv). Dietary restrictions.
(v). Food preferences.
(vi). Nutritional supplements.
(vii). Food preparation capacity, the latter to include determination of the possession of:
- Microwave.
- Stove.
- Refrigerator.
- Utensils.
- Working utilities.
- Cooking skills.

B.14.2.1(d). During *intake*, the provider should:
(i). Complete all agency intake forms and processes.
(ii). Provide the client with agency eligibility criteria; the grievance process; and information about client rights, confidentiality protections, client responsibilities and agency services.

B.14.2.1(e). Working with the client or guardian, the provider should develop a written plan of service. A nutritionist/dietitian should have input into this plan. The plan should include at a minimum:
(i). The level or type of service (e.g., grocery only, home-delivered meals, etc.).
(ii). Documentation that the plan meets USRDA guidelines.
(iii). Assurance from the provider that the plan meets the special dietary needs of HIV disease.
(iv). A signed consent form authorizing the provider to discuss the plan with other service providers as appropriate.

B.14.2.1(f). The provider should maintain documentation of all services delivered and contacts with or made on behalf of the client.

B.14.2.1(g). The provider should ensure that a system is in place to get meals in to a bed-ridden client.

B.14.2.1(h). The provider should develop a logistical plan for the delivery of meals or groceries.

B .14.2.1(i). Food preparation must meet HACCPS (hazard analysis critical control point standards).

14.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.14.2.2(a). The plan must be reevaluated at least every six months, more often depending on the health status of the client.

B.14.2.2(b). The provider is responsible for ensuring that clients receive all deliveries of meals or groceries.

B.14.2.2(c). The delivery staff is responsible for reporting to the agency any changes in service delivery plans (e.g., if they are unable to deliver three meals).

B.14.2.2(d). The provider should follow up with the client and/or referring agency to determine next steps regarding any change in the service plan.

B.14.2.2(e). In regard to closure, the provider should develop procedures to close consumer files. Reasons a file might be closed include:
(i). The HIV-positive individual who is the eligible client has died.
(ii). The client is relocating out of the service area.
(iii). The client is no longer in need of service.
(iv). The client elects to discontinue receiving service.
(v). The client is not utilizing services appropriately.

B.14.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.14.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.14.3.1(a). The agency will show evidence of being licensed by an appropriate body.

B.14.3.1(b). The agency will show evidence that the license of the organization is current and available, if applicable.

B.14.3.1(c). The agency will meet HACCP guidelines for food handling and preparation.

B.14.3.1(d). The agency will meet all applicable federal, state and local regulations.

B.14.3.1(e). The agency will show evidence that staff and volunteers are trained and knowledgeable about HIV/AIDS in the community.

B.14.3.1(f). The agency will show evidence that any nutritionist/dietitian is licensed in Maryland, and that the license is current and available.

B.14.3.1(g). Agency supervisors working with food handling and preparation staff, must be graduates of an accredited culinary school.

B.14.3.1(h). The agency will have a training program for all staff and volunteers responsible for services to clients.

B.14.3.1(i). The agency will show evidence that direct client service staff making assessments and referrals attend in-service and specialized training on pertinent HIV topics.

B.14.3.1(j). Professional nutritionists and dietitians and other provider staff will attend seminars and supplemental courses to remain informed of the most current nutritional care for persons with HIV and, where appropriate, meet any continuing education requirements to maintain a license.

B.14.3.2. Client's Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.14.3.2(a). Providers must ensure that they have policies and procedures for the protection of the rights and confidentiality of each client.

B.14.3.2(b). Providers must show evidence of a written agency policy on the protection of client confidentiality.

B.14.3.2(c). Providers must show evidence in existing files of client knowledge of existing policies and procedures on confidentiality.

B.14.3.2(d). Providers must show evidence that existing files containing client information are secured and protected.

B.14.3.2(e). Providers must ensure that only appropriate staff members have access to client files.

B.14.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.14.3.4(a). Each provider must ensure that a quality-assurance plan is designed to monitor both appropriateness and effectiveness of all services delivered.

B.14.3.4(b). The provider will show evidence that the application and assessment process include: a written application; criteria for acceptance or rejection; ranking criteria utilized for eligible applications when waiting lists exist; a formal grievance process; and a termination process.

B.14.3.4(c). The provider will show evidence that program policies are understood and signed by all clients.

B.14.3.4(d). The provider will show evidence that clients receive assistance with other social-services needs and that appropriate referrals are made for other related services.

B.14.3.4(e). The provider will show evidence of the existence and meeting of a formal advisory board with representation from the HIV/AIDS community.

B.14.3.4(f). The provider will show evidence that, whenever necessary, home-delivered meals and liquid food supplements to persons with HIV include: soft, liquid foods with extra portions; special diets for diagnostic testing; extra fluid requirements to avoid dehydration and diarrhea; and supplements for wasting syndrome, if applicable.

B.14.3.4(g). The provider will show evidence that the meal plan is developed under the supervision of a licensed nutritionist/dietitian.

B.14.3.4(h). The provider will show evidence that plans are coordinated with the client's case manager or primary medical care provider.

B.15. Housing Assistance Services

Origination: November 1996.

Revision: July 1999, ratified, October 1999.

B.15.1. Service Definition

All housing services funded by the Ryan White CARE Act are to ensure that eligible HIV-positive individuals and/or families gain and maintain access to medical care. There are two subfields within this category, each of which is defined below.

B.15.1.1. Housing Assistance

Housing assistance is short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of funds must be linked to medical or supportive services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment. Emergency rental assistance services can be provided under housing assistance.

B.15.1.2. Housing-related Services

Housing-related services include assessment, search, placement and advocacy services provided by professionals who possess an extensive knowledge of local, state and federal housing programs and how to access them.

B.15.1.3. Key Services

Services may include:

B.15.1.3(a). Assistance in locating and obtaining suitable on-going transitional shelter and residential housing services that provide housing assistance in a group-home setting.

B.15.1.3(b). Bed nights or temporary housing.

B.15.1.3(c). Support services necessary to promote the transition of clients across the continuum of housing needs.

B.15.1.3(d). Emergency rental assistance to prevent eviction or similar service intervention for preventing clients from becoming homeless.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.15.2. Service Standards of Care

The following are minimum standards for the provision of housing assistance and housing-related services. Agencies and individuals may exceed these standards.

B.15.2.1. Baseline Evaluation

The baseline-evaluation period has two principal phases, as follows: eligibility determination and needs assessment.

B. 15.2.1(a). There should be an initial eligibility determination. Documentation to support this process must be maintained in agency files and should:
(i). Document the clients' HIV-positive status.
(ii). Establish the client's homelessness, being "at risk" of becoming homeless, or living in temporary or transitional housing.
(iii). Establish and document the client's financial eligibility for service.

B. 15.2.1(b). There should also be an initial assessment of the client's health and background. Documentation supporting this process must be maintained in the files, and must include the following client information:
(i). Age.
(ii). Health status.
(iii). Family composition.
(iv). Special temporary or transitional housing needs, or special permanent housing needs.
(v). Level of independence/level of personal resources to solve problems.
(vi). Co-morbidity factors.

B.15.2.2. Action Plan For Transitional Housing (Bed Nights)

In collaboration with the consumer, the housing-assistance agency staff and, in some instances, an on-going case manager will develop the housing action plan for transitional housing ("bed nights"). Housing-assistance staff will maintain regular contact, at least monthly, with the client during the transitional housing period and document all contacts with and on behalf of the client. The housing-assistance agency is responsible for maintaining documentation that supports its services to clients, which include:

B.15.2.2(a). Reviewing the client's need for immediate transitional housing.

B.15.2.2(b). Making referrals or assisting with placement into transitional housing.

B.15.2.2(c). Ensuring that the client has assistance in developing a plan for transfer to permanent housing.

B.15.2.2(d). Ensuring that the client receives assistance in clarifying the type of housing needed, the location and any special housing needs.

B.15.2.2(e). Ensuring that there is case-management assistance to develop a plan for providing life-skills training, if appropriate.

B.15.2.2(f). Ensuring that the client has access to assistance that explores present and intermediate financial status, especially entitlements.

B.15.2.2(g). Developing a plan to pay for interim housing, through referral, linkage or direct payment to a housing agency.

B.15.2.2(h). Ensuring that the client has assistance in developing a plan for referral to services that provides long-term financial stability.

B.15.2.2(i). Ensuring that the client is linked with services that assist in locating permanent housing that meets his or her needs, including arranging for an inspection of the unit by a licensed inspector before any lease arrangement is completed.

B.15.2.2(j). Following up with the client and any housing case manager at three months after the client is in permanent housing.

B.15.2.2(k). Showing evidence that the agency has discussed with the client its: services, eligibility criteria, grievance policy, confidentiality policy, safeguards for client rights and responsibilities, agency expectations of clients, and limits on financial assistance for temporary or transitional housing.

B.15.2.2(l). Providing emergency rental assistance services to prevent clients from becoming evicted and/or homeless or ensuring that such assistance is available.

B.15.2.3. Action Plan for Housing-related Services

Working with the consumer, the agency staff will develop an action plan for housing-related services that includes a plan review and revaluation schedule. Staff will maintain regular contact with the client, including at least one face-to-face contact every three months during the first six months of service. Staff will document all contacts with and on behalf of the consumer, and will:

B.15.2.3(a). Review the client's present housing situation.

B.15.2.3(b). Identify the specialized services needed to maintain the consumer in permanent housing and to access and adhere to primary medical care services.

B.15.2.3(c). Develop a plan for assisting the client to secure permanent housing.

B.15.2.3(c). Provide life-skills training, if appropriate.

B.15.2.3(e). Make referrals and linkages for specialized services, such as on-going case-management services.

B.15.2.3(f). Assess the client's present and intermediate financial status, especially entitlements.

B.15.2.3(g). Develop a plan for referral to services that ensure long-term financial stability.

B.15.2.3(h). Follow up with the client and any assigned case manager three months after the client has secured permanent housing.

B.15.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.15.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.15.3.1(a). The agency will show evidence of being licensed by an appropriate body where applicable.

B.15.3.1(b). The agency will show evidence that its license is current and available for inspection, if applicable.

B.15.3.1(c). Housing providers will deliver safe, secure and decent housing services and will possess the knowledge, skills and experience necessary to deliver housing-related services.

B.15.3.1(d). The agency will show evidence that the housing provider who enters into a tenant/landlord relationship with the client has executed a lease.

B.15.3.1(e). The agency will show evidence that any housing it arranges meets health, fire and safety standards.

B.15.3.1(f). The agency will show evidence that bed and board, domiciliary or adult foster-care providers are registered, licensed or certified.

B.15.3.1(g). The agency will show evidence that housing-related services provided by a housing provider are competently performed and meet health, social and/or other supportive services standards.

B.15.3.1(h). The agency will show evidence that staff offering housing-related services are professionals with extensive knowledge and experience with all housing programs in the region.

B.15.3.1(i). The housing provider will have a training program for all staff members that deliver housing-related services.

B.15.3.1(j). The agency will show evidence that staff members attend in-service and specialized training on HIV and housing-related topics.

B.15.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.15.3.2(a). The agency must have policies and procedures on the protection of the rights and confidentiality of each client.

B.15.3.2(b). The agency must show evidence of a written agency policy on client confidentiality.

B.15.3.2(c). The agency must show evidence in existing files of client knowledge of agency policies and procedures on confidentiality.

B.15.3.2(d). The agency must show evidence that residential and transitional housing provider staff members are knowledgeable of agency confidentiality policies.

B.15.3.2(e). The agency must show evidence that existing records and files containing client information are secured and protected.

B.15.3.3. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.15.3.3(a). The agency will have a quality-assurance plan designed to monitor both appropriateness and effectiveness of all services delivered.

B.15.3.3(b). The agency will show evidence that housing-eligibility requirements are clearly defined in written form for client applicants.

B.15.3.3(c). The agency will show evidence of an application and assessment process including: a written application; criteria for acceptance or rejection; ranking criteria utilized for eligible applicants when waiting lists exist; a formal grievance process; and termination policy.

B.15.3.3(d). The agency will show evidence that housing is appropriately utilized by the target population.

B.15.3.3(e). The agency will show evidence that housing-related services are evaluated by clients.

B.15.3.3(f). The agency will show evidence of the existence of, and meeting minutes from, a formal advisory board with representation from the HIV/AIDS community.

B.15.3.3(g). The agency will show evidence that clients receive housing-related services, when they are provided by a housing provider.

B.15.3.3(h). The agency will show evidence that client eligibility for continued housing or related services is reevaluated periodically.

B.15.3.3(i). The agency will show evidence that care needs are assessed before placement and that the housing is safe for the client's condition.

B.15.3.3(j). The agency will show evidence that agencies offering only financial assistance have clearly stated policies regarding any caps on the amount of funds that will be expended on any one client and over what amount of time.

B.15.3.3(k). The agency will show evidence that the agency offering only financial assistance has a clear system for disbursing and accounting for its funds.

B.15.3.3(l). The agency will ensure that all clients receiving housing assistance or housing-related services have a linkage with a medical care provider and other support services as necessary to assist the clients in maintaining themselves in medical care.

B.16. Legal Services

Origination: November 1996.

Review: March 2000.

Revision: March 2003; ratified, April 2003.

B.16.1. Service Definition

There are two subfields within this category, legal services *per se* and entitlement services, each of which is defined below.

B.16.1.1. Legal Services

Legal services comprise the provision of advocacy and expert legal representation with respect to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings and interventions necessary to ensure access to benefits to which the client is entitled, including discrimination or breach-of-confidentiality litigation as pertaining to services eligible for funding under the Ryan White CARE Act.

B.16.1.2. Entitlement Services

The term "Social Security entitlement services" (SSES) refers to the provision of assistance to HIV-positive consumers, eligible under Title I, in applying for any of the Social Security entitlement programs including: Survivor's Benefits, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

B.16.1.3. Key Services

Key services include legal intervention involving:

B.16.1.3(a) Income-maintenance SSES assistance, including: applications, document collection, filing applications for Social Security entitlements, referral for other services, and follow up.

B.16.1.3(b). Legal services assistance, including: durable powers of attorney for health care, financial affairs, living wills, and last wills and testaments.

B.16.1.3(c). Contingency planning for care of minor children when parent is unable to care for them, including standby guardianships and limited powers of attorney.

B.16.1.3(d). Consumer issues, such as debtor/creditor issues, creditor workouts, bankruptcy ("Chapter 7" bankruptcy).

B.16.1.3(e). Income-maintenance assistance, including: appeals of denials for all types of benefits such as Veterans' Administration aid, temporary cash assistance, SSDI, SSI, short-term disability payments, and other forms of income maintenance.

B.16.1.3(f). Discrimination matters, including discrimination in employment, housing, schools, and public accommodations.

B.16.1.3(g). Housing issues concerned with the federal Housing Opportunities for People with AIDS (HOPWA) program.

B.16.1.3(h). Welfare support; leave from work and disability coverage, while caring for ill children.

B.16.1.3(i). Issues relating to breach of the client confidentiality.

B.16.1.4. Excluded Services

Legal services do not include:

B.16.1.4(a). Torts, such as when the client wishes to sue someone because he/she has suffered an injury.

B.16.1.4(b). Criminal cases, specifically when the issue is not related to HIV. In such instances, the agency should refer the client to the public defender and/or a private attorney.

B.16.1.4(c). Complex litigation, that is, expensive and time-consuming legal issues. In such instances, the agency should refer the client to a private attorney.

B.16.1.4(d). Permanency planning, for example, guardianship or adoption after the death of the usual care giver.

B.16.1.4(e). Fee-generating cases. In such instances, the agency should refer the client to the private bar association.

B.16.1.4(f). Civil cases unrelated to HIV status (e.g., divorces, will disputes, etc.).

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.16.2. Service Standards of Care

Legal services for persons with HIV disease should reflect sensitivity to the client's disease and its impact on him or her, and should be based on competence in evaluating the client's legal issues in determining the proper course of action with the client's approval. Representation of and advocacy on behalf of the client shall by governed by the *Maryland Lawyers' Rules of Professional Conduct* (CA 2003). The following are minimum standards for the provision of legal services and Social Security entitlement services. Agencies and individuals may exceed these standards.

B.16.2.1. Baseline Evaluation

The baseline-evaluation period has two principal phases, as follows: eligibility determination and intake.

B.16.2.1.(a). In regard to *eligibility* for *legal* services,

(i). The agency shall screen all individuals who call, walk in or schedule an appointment for legal services to determine their appropriateness for legal services, this screening to include a determination of HIV status, the type of legal issue, financial eligibility, and the client's place of residence.

(ii). The agency shall make suitable referrals to other departments, agencies or legal-service providers for those individuals who are not appropriate for the agency's services but who are in need of services.

(iii). The agency shall perform a legal assessment of the individual's situation to determine what agency interventions are appropriate.

(iv). The agency shall complete an intake form for all clients receiving legal services. In most instances, the intake should be completed within 30 days; it should not take longer than 45 days.

(v). The agency may assign an attorney to eligible clients at the time of initial intake.

B.16.2.1(b). In regard to *eligibility* for *entitlement* services,

(i). The agency shall refer all HIV-positive clients who meet general agency criteria for services to the entitlement specialist for actual eligibility screening.

(ii). The entitlement specialist shall make suitable referrals for those individuals who are not appropriate for department's services but who are in need of services.

B.16.2.1(c). In regard to *intake* for *legal* services,

(i). To formally enter an eligible client into the system for further evaluation and to develop a course of action, it is necessary to collect all information about the client, the legal issue and the adverse parties.

(ii). If a deadline is approaching, the agency representative may assist the client in completing paperwork to preserve legal rights, while not entering an appearance in the case until determination as to the client's eligibility is completed.

(iii). If a paralegal or administrative aide conducts the intake, an attorney will make the determination as to acceptance or refusal of a client's case and the course of action.

(iv). If the client is homebound or hospitalized, a staff member will visit the client at the bedside.

(v). Requests for assistance for bedridden clients will be answered within 24 hours and the visit made within 24 hours of contact.

(vi). Work on hospitalized or bedridden clients' cases may begin prior to the completion of intake.

(vii). The client shall sign a general release form at the time of intake to authorize contact with other agencies, attorneys and adverse parties.

B.16.2.1(d). In regard to *intake* for *entitlement* services,

(i). The entitlement specialist shall complete an initial assessment on eligible clients and begin collecting all information as outlined on the service provider's intake forms.

(ii). The entitlement specialist shall have the client sign a release form authorizing contact with other agencies to gather necessary documents to complete the Social Security application.

B.16.2.2. Development of the Proposed Course of Action

The staff member, with the active participation of the client, shall determine the course of action for each of the client's legal issues or for the appropriate Social Security Title II and XVI application(s).

B.16.2.3. Implementation of the Course of Action

The determined course of action will be implemented as follows:

B.16.2.3(a). The legal representative will provide the advice, representation and advocacy necessary to accomplish the client's goals.

B.16.2.3(b). The entitlement specialist will help the client file the appropriate application(s) and all supporting documents required by the U.S. Social Security Administration.

B.16.2.3(c). It is the client's responsibility to keep the pertinent staff member informed of any communications with other agencies and adverse parties relevant to the client's case or to the Social Security application.

B.16.2.3(d). The client shall keep the staff member informed of any change in circumstances, such as adverse party, housing, telephone number, hospitalization and health condition (if relevant to the legal issue or the Social Security application), etc.

B.16.2.3(e). The client's legal representative (by use of letters, phone calls, court and agency visits) shall represent, advocate and negotiate on the client's behalf.

B.16.2.3(f). The entitlement specialist shall advocate and follow up to ensure that the client's application is being processed through the Social Security system.

B.16.2.3(g). If the client's application is rejected, the entitlement specialist will refer the client to an agency that provides legal representation.

B.16.2.3(h). All contacts made on the client's behalf are to be documented (electronically on a computer or by means of handwritten notes in the client's file).

B.16.2.3(i). Each client's case shall have a "tickler," or another method to remind the representative of upcoming deadlines in each of the client's active cases.

B.16.2.3(j). Each written communication (letter or fax) sent on the client's behalf shall be copied photostatically and kept in the client's paper file.

B.16.2.4. Monitoring of the Client's Case

Legal and entitlement cases will be monitored in the following manner:

B.16.2.4(a). In regard to the monitoring of *legal* cases,
(i). The supervising attorney will monitor the progress of client cases.
(ii). The supervising attorney will monitor the work of all non-professional staff members with the assistance of other staff attorneys.
(iii). The supervising attorney will document acceptance of new cases and approve the proposed course of action after discussion with the client's non-professional representative.
(iv). At biweekly meetings, staff will discuss problematic client cases.

B.16.2.4(b). In regard to the monitoring of *entitlement* cases,
(i). The supervisor assigned to oversee entitlement services will monitor the progress of each case of a client seeking assistance with the Social Security application process.
(ii). The supervisor will hold weekly meetings with entitlement staff to review all active cases, to provide guidance or assistance, and to approve all closures or referrals to legal services for applications that have received denials.

B.16.2.5. Closure of the Client's Case

Cases will be closed in this manner:

B.16.2.5(a). Documentation of closed cases with reasons for closure shall be maintained by the agency in the client file.

B.16.2.5(b). In regard to *legal* cases,
(i). When a client's legal issue has been resolved, the client's case shall be closed.
(ii). If there has been no contact with a client for six months, and if three attempts at contact by telephone call and/or letter to the client at the last known address elicit no response, the case shall be closed.
(iii), Notice of the client's death shall result in case closure, unless the case can be pursued on behalf of another to achieve the client's legal goal.
(iv). If the client requests that the case be closed, or has other legal representation, the case shall be closed.

B.16.2.5(c). In regard to *entitlement* cases,
(i). If the Social Security application is successful and the client is receiving benefits, the case shall be closed.
(ii). If the client has been denied benefits but the case has been referred to legal services for intervention, the entitlement case shall be closed.
(iii). If the client cannot be found and no contact has been made by the client for six months, the case shall be closed.
(iv). If the client requests termination of services, the case shall be closed.
(v). If the client dies, the case shall be closed.

B.16.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.16.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.16.3.1(a). Any attorney providing or supervising the provision of legal services must be admitted to practice before the Maryland Court of Appeals.

B.16.3.1(b). Any attorney providing or supervising the provision of legal services must be admitted to practice before the United States District Court for Maryland.

B.16.3.1(c). Entitlement services may be supervised by an attorney working in the legal-services unit or by a licensed, master's-level social worker or nurse case manager.

B.16.3.1(d). An entitlement specialist must have a high school diploma or general equivalency certificate.

B.16.3.1(e). Legal-services providers will possess the knowledge, skills and experience necessary to competently perform expected legal services. All work will be supervised by an attorney who is admitted to practice by the Maryland Court of Appeals.

B.16.3.1(e). The agency shall show evidence that any attorney providing or supervising legal services has a J.D. degree from an accredited law school.

B.16.3.1(f). The agency shall show evidence that any attorney providing or supervising the provision of legal services by a non-professional is admitted to practice before the Maryland Court of Appeals.

B.16.3.1(g). The agency shall show evidence that any attorney or other person providing services to persons with HIV/AIDS has the experience and education to competently represent clients before the Social Security Administration, the Maryland State Office of Hearings and Appeals and other state agencies, district and circuit courts of Maryland, the U.S. District Court for Maryland, and the U.S. Bankruptcy Court.

B.16.3.1(h). Entitlement specialists must have at least one year's experience working with HIV clients or have two years' experience working with Social Security applications. Experience working with applications for managed care may be substituted for one year of Social Security experience.

B.16.3.1(i). Entitlement specialists will possess the knowledge, including cultural sensitivity to the populations served, and the skills necessary to competently perform the services.

B.16.3.2. Client Rights and Responsibilities

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.16.3.2(a). All client files shall be kept in locked storage.

B.16.3.2(b). For both legal and entitlement services, clients shall be given the opportunity to take their personal papers and health records with them at the time of case completion.

B.16.3.2(c). The agency must have written policies regarding eligibility, confidentiality, grievance procedures, referral and linkage, agency expectations of clients, and termination policies.

B.16.3.2(d). The agency must maintain documentation that copies of policies have been given to the clients seeking services.

B.16.3.2(e). The agency must ensure that each client receives an intake screening, an eligibility determination and, for eligible clients, an initial assessment.

B.16.3.2(f). When appropriate, the agency staff shall refer and link clients to other needed services.

B.16.3.2(g). The agency shall maintain documentation of client participation in setting goals or developing a service plan.

B.16.3.2(h). The agency shall maintain documentation of the client's progress toward meeting established goals.

B.16.3.2(i). The agency shall ensure that the delivery of direct services is monitored for professional accountability through the following means: regular and on-going team meetings or case conferences at least monthly; individual professional evaluations at least annually; and formal supervision (which may be peer supervised).

B.16.3.2(j). The agency shall have a consumer advisory board and maintain documentation of its meetings.

B.16.3.2(k). The consumer advisory board shall meet at least quarterly and be made up of agency clients.

B.16.3.2(l). The agency must develop reasonable caseload standards or ratios and establish a priority system for acceptance of new cases. If a waiting list exists, the agency must show evidence of a plan to attempt to communicate regularly with those clients on the list regarding waiting-list status.

B.16.3.2(m). The agency must have written criteria for services, fee structure, intake process, discharge, transfer and closing procedures and document that clients are informed of such.

B.16.3.2(n). The agency shall provide written policies and procedures that protect the rights and outline the responsibilities of the clients and the agency, such policies and procedures to include:

(i). A written policy on protection of client rights and confidentiality of each client.

(ii). A statement signed by the client that states that existing policies and procedures regarding confidentiality and grievance procedures have been explained to the client and that he or she has received copies.

(iii). A system for ensuring that client files are protected and secured.
(iv). A written, signed consent for the release of client information to other service providers, agencies, opposing attorneys and adverse parties involved in the client's case.
(v). A written grievance procedure.
(vi) A signed retainer agreement for legal services, which states the scope of representation.
(vii). A statement outlining the client's rights as well as responsibilities, and the agency's expectations of each client.

B.16.3.3. Quality Assurance

The agency must show:

B.16.3.3(a). An overall mechanism, or quality-assurance plan, designed to monitor both appropriateness and effectiveness of all services provided.

B.16.3.3(b). Documentation of record reviews, both peer and supervisory.

B.16.3.3(c). Documentation of utilization review.

B.16.3.3(d). Documentation of the most recent site visit by the administrative agency.

B.16.3.3(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.16.3.3(f). Documentation of periodic data and narrative reports to the administrative agency.

B.16.3.3(g). Documentation of a process to solicit client satisfaction with services (at least annually).

B.16.3.3(h). Evidence of compliance with the service category standards and/or any applicable professional or federal practice standards.

B.16.4. Summary

This subsection provides miscellaneous further information on this service.

B.16.4.1. Recommendations

None.

B.16.4.2. References and Further Sources

State of Maryland, Court of Appeals. 2003. *Maryland Lawyers' Rules of Professional Conduct*. Available at Internet site (http://www.courts.state.md.us/lawyersropc.pdf), downloaded October 11, 2003.

B.17. Minority AIDS Initiative: Outreach/Linkage to Care

Origination: June 2000.

B.17.1. Service Definition

The terms "outreach" and "linkage to care" refer to those activities that promote the access to, and continuation of, appropriate services at the earliest possible stage of HIV disease by addressing the multitude of issues and service barriers that impact upon the individual. Services may be provided on the streets in areas where there is a demonstrably high incidence of HIV infection, in non-traditional HIV service settings and facilities, and within the traditional HIV health-care system.

This program used to be known as the "Congressional Black Caucus Initiative." As used herein, the term "client" encompasses the terms "patient" and "service consumer." The term "provider agency" refers to organizations providing outreach services as described herein; the term "host agency" refers to those other organizations that permit provider agencies' outreach workers to station themselves on the host agency's premises to conduct outreach activities.

B.17.2. Service Standards of Care

The following are minimum Congressional Black Caucus (CBC) standards for the provision of outreach/linkage to care services in the Baltimore EMA. All standards should be followed during the funding period. Agencies and individuals may exceed these standards.

B.17.2.1. Baseline Evaluation

Baseline-evaluation activities differ somewhat for each of the three types of outreach services, namely, street outreach, on-site recruitment at non-traditional HIV intake locations, and on-site recruitment at traditional HIV intake locations.

B.17.2.1(a). *Street Outreach Services*: Street outreach services are performed in areas where there is a documented high incidence of HIV and/or a discrete population that has a high rate of HIV infection. Initial activities should be as follows:

- (i). The provider agency should supply outreach workers with an identification card or other identification that establishes the workers' official relationship as employees of the provider agency.
- (ii). Outreach workers will distribute general literature about HIV and Ryan White services and/or make presentations to groups about HIV and Ryan White services.
- (iii). Outreach workers will make an assessment of an individual or group while answering questions.

(iv). Based upon a general assessment and information from the individual, outreach workers will make appropriate referrals for HIV services, especially case management and any primary medical care that the individual needs.
(v). The outreach worker should determine the level of assistance the individual needs to successfully access HIV services.
(vi). The outreach worker will make a plan to directly assist with linkages/referrals and will follow up with the individual client regarding referral.
(vii). The outreach worker will document the name (or other identifier, if anonymity is required) of the individual client, list the areas in which the individual needs help, identify the immediate plan for assistance (such as referral or follow-up meetings), write the name(s) of places where formal referrals are made, and make a follow-up plan. (See the sample outreach encounter/contact form at the end of this section.)
(viii). When performing services for a person who has dropped out of the care system, the outreach worker should attempt to reconnect the person with his or her former care facility. (This service is mostly performed for primary medical care locations.)
(ix). The outreach worker should report and document success or failure in reconnecting the client to his or her former care facility.
(x). For clients who do not wish to resume services with their former care facility, the outreach worker should refer them to another agency.
(xi). For clients who do not wish to resume care at this point, the outreach worker should add or retain them to his or her caseload file and later offer services when the client is ready to engage in services. At that point, the outreach worker will make a referral and follow up to ensure that the client kept the appointment.

B.17.2.1(b). *Outreach in Site-based, Non-Ryan White-funded Locations:* The outreach worker is an integral part of the structure of the host agency or facility offering non-traditional HIV services or even services unrelated to HIV, even though he or she may be an employee of another HIV service provider (i.e., the provider agency).
(i). The host agency (i.e., the non-traditional HIV intake site) will provide all of its clients with information about the services available from HIV outreach workers.
(ii). The host agency staff will refer identified HIV-positive individuals to the HIV outreach worker. If the host agency has documentation of a client's HIV status, this information must accompany the referral for outreach services.
(iii). The outreach worker will assist the client in establishing preliminary eligibility for Ryan White services.
(iv). For individuals who are not eligible for Ryan White services, the outreach worker will make appropriate referrals for other HIV services.
(v). The outreach worker will assist the client in identifying his or her immediate HIV service needs and, with the client, set goals for addressing those needs; generally, the goals will be to access primary medical care and/or case-management services.
(vi). The outreach worker will determine the level of direct assistance the client needs to implement the mutually developed goals.
(vii). When necessary, the outreach worker will directly assist the client in meeting these goals.
(viii). The outreach worker will complete the intake and assessment form(s) developed by the provider agency and open a client folder.

(ix). The outreach worker will complete any referral documents for the client and retain a copy of the referral documents in the client's folder.
(x). The outreach worker will follow up with the client and/or with the third-party HIV agency to which the individual was referred.
(xi). The outreach worker will continue follow-up activities regarding the client's progress in accessing and staying in primary medical care.
(xii). The outreach worker will be responsible for tracking and reporting outcomes for each individual in his or her caseload.
(xiii). Documentation of follow-up activities must be kept in the client folder.

B.17.2.1(c). *Outreach within the Traditional HIV Health Care System:* This service is primarily focused upon reengaging clients into a provider agency's own services (such services being other HIV services provided by the agency in question). This may be a stand-alone service performed by outreach workers or a function incorporated into existing case-management systems.
(i). The provider agency will identify clients who have missed appointments and send their (the clients') basic identifying information to the in-house outreach worker.
(ii). The outreach worker will follow up to locate each of the individuals.
(iii). The outreach worker will record all contacts with or on behalf of the client in the client folder.
(iv). Upon making contact with the client, the outreach worker will assess the barriers to the individual client's making or keeping a new appointment.
(v). The outreach worker and the client will make a plan to address any barriers.
(vi). The outreach worker and the client will implement the plan.
(vii). The outreach worker will follow agency procedures in making a new appointment for the client.
(viii). The outreach worker will close out his or her service when the client has kept two regularly scheduled appointments and is engaged in on-going services.

B.17.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.17.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.17.3.1(a). All programs and their staff will show evidence:
(i). Of possessing a background (indigenous/peer) of cultural competence with respect to diverse populations (including people of color, gays, bisexuals, transgendered persons, adolescents, women of childbearing age, injection-drug users and their partners, commercial sex workers and other groups that are at high risk for HIV infection).

(ii). That staff is knowledgeable about HIV and Ryan White programs and trained as specified in section B.17.3.1(b) hereof.
(iii). Of knowledge about accessing venues of at-risk populations (family-planning clinics, substance-abuse treatment programs, penal and drug-treatment transition houses, shelters, soup kitchens, bars, social clubs, open air drug markets, etc.).
(iv) Of staff's knowledge of available resources, access issues and the capacity to direct clients to primary-medical, support and ancillary services.

B.17.3.1(b). All staff of Title I-funded outreach services will attend a minimum of one professional-development training course or seminar annually. The course work must include one or more of the following areas:
(i). Quality assurance standards as specified below in Section B.17.3.3.
(ii). The Maryland AIDS Administration's "HIV Counseling Skills — Level I" training or a comparable course.
(iii). The American Red Cross "African-American HIV Instructor Training" course.
(iv). The Baltimore City Health Department's HIV training curriculum.
(v). Baltimore Trials, Inc.'s and Johns Hopkins University's training programs on clinical trials/vaccines.
(vi). A certified program on substance abuse and treatment, e.g., Critical Appraisal Skills Program (CASP), National Institute on Drug Abuse (NIDA), Office of Education and Training for Addictions (OETAS), Baltimore Substance Abuse Systems (BSAS), etc.
(vii). The Maryland AIDS Administration's case-management training course titled, "Working Effectively with Special Populations."

B.17.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.17.3.2(a). Provider agencies offering these outreach services must show that they have policies and procedures on the protection of the rights and confidentiality of each client.

B.17.3.2(b). Agencies offering these services must show evidence of a written policy on client confidentiality.

B.17.3.2(c). Agencies offering these services must show evidence that client encounter forms and files are secured and protected, especially when completing any forms while working on the streets.

B.17.3.2(d). Agencies offering these services must show evidence that there is a client grievance policy/procedure and that it has been shared with consumers/clients in site-based settings.

B. 17.3.3. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken. All recipients of Title I funds providing outreach services will do the following:

B.17.3.3(a). Utilize an outreach assessment and intake form or encounter forms with required demographic, referral and follow-up documentation for each client seen. See section B.17.4.3(a) hereof.

B.17.3.3(b). Conduct a client satisfaction survey for site-based services.

B.17.3.3(c). Show evidence that outreach activities are monitored for appropriateness, accountability and effectiveness (through on-site observation, monitoring, individual supervision and evaluations, etc.).

B.17.3.3(d). Conduct in-service training for all new staff hired to perform outreach/advocacy functions pertaining to: HIV, substance-abuse and drug-treatment services, mental health, domestic violence, clinical trials/protocols/vaccines, tuberculosis, sexually transmitted diseases, partner notification, bereavement, cultural competence, nutrition, housing services, suicide, adolescent health issues, communication, opportunistic infections, commercial sex work, gay/bisexual and transgender concerns, and other related topics.

B.17.3.3(e). Show evidence of the existence of a consumer advisory board specific to program activities within the provider agency.

B.17.3.3(f). Show evidence of a structured or formal referral process for clients who require assistance with service areas not provided by the agency.

B.17.3.3(g). Show evidence of follow-up efforts to ensure that successful linkages with services have occurred.

B.17.3.4. Agency Responsibilities

Provider agencies must all follow certain administrative procedures in common, as follows:

B.17.3.4(a). Agencies must have written policies and procedures regarding eligibility, client confidentiality, grievances, scope of services, and referral and linkage processes.

B.17.3.4(b). Agencies that have site-based outreach services must maintain documentation that clients have received copies of the policies described at section B.17.3.4(a).

B.17.3.4(c). Agencies must ensure that all outreach workers have regular supervision meetings with licensed or certified social workers or nurse case managers.

B.17.3.4(d). Agencies must provide all outreach workers with agency employee identification cards or badges.

B.17.3.4(e). Agencies must provide outreach workers with agency forms, referral cards or other documents, such as encounter forms, on which to record their contacts and to use for follow up.

B.17.3.4(f). Agencies must provide outreach workers with information about HIV and Ryan White services.

B.17.3.4(g). Agencies with street outreach services must provide office space for outreach workers to complete essential documentation of all services delivered.

B.17.3.4(h). Agencies are responsible for monitoring outreach services.

B.17.4. Summary

This subsection provides miscellaneous further information on this service.

B.17.4.1. Recommendations

None.

B.17.4.2. References and Further Sources

None.

B.1.4.3. Appendix

See following pages.

B.17.4.3(a). Sample Outreach Encounter Form

Outreach/Linkage to Care **Minority AIDS Initiative** ***Encounter/Contact Form***

1. Confidential Information

____

(Consumer/Client Name) (ID #, if follow-up) (Date)

____

(Outreach Staff Name)

____

(Location or Exact Address of Encounter) (Record Public Site) (New Contact or Follow-up)

2. Demographic Information

Date of Birth: __________ Marital Status: __________ Last Grade Completed: __________

Soc. Sec. No.: ____________________ Gender: __________ Race: __________

Descriptive Information: ____

(If unable to obtain demog. data, record some descriptive information about consumer/client.)

3. Risk Assessment (circle answers)

Does consumer/client have regular health care provider?	Yes	No	Not Assessed
Has consumer/client had HIV test within last 6 months?	Yes	No	Not Assessed
Does consumer/client abuse alcohol?	Yes	No	Not Assessed
Is consumer/client HIV positive?	Yes	No	Not Assessed
Does consumer/client abuse drugs?	Yes	No	Not Assessed
Does consumer/client abuse non-IV drugs?	Yes	No	Not Assessed
Does consumer/client practice high risk sex?	Yes	No	Not Assessed

4. Harm Reduction Measures (information/education provided client; check all that apply)

☐ Transmission of HIV
☐ Needle exchange
☐ Cleaning needles/syringes
☐ Condoms
☐ Substance-abuse treatment

5. Referrals (check and name agency)

- ☐ Primary medical care: ____
- ☐ Drug treatment: ____
- ☐ Family planning: ____
- ☐ HIV counseling: ____
- ☐ Dental services: ____
- ☐ Housing/shelter: ____
- ☐ Counseling/support group: ____
- ☐ Food service/soup kitchen: ____
- ☐ Transportation: ____
- ☐ Pediatric services: ____
- ☐ Adolescent services: ____
- ☐ Domestic-violence services: ____
- ☐ Hispanic-specific services: ____
- ☐ STD clinic: ____
- ☐ TB clinic: ____
- ☐ Mental-health services: ____
- ☐ Case management: ____
- ☐ Voucher assistance: ____
- ☐ Pastoral counseling: ____
- ☐ Day/respite Care: ____
- ☐ Pharmacy assistance: ____
- ☐ Legal services: ____
- ☐ Sexual-assault services: ____
- ☐ Hearing-impaired services: ____
- ☐ Other: ____

6. Use This Space for Follow-up Comments

____
____
____
____

B.18. Outreach/Linkage to Care

Origination: November 1996.

B.18.1. Service Definition

The terms "outreach" and "linkage to care" refer to those activities that promote the access to, and continuation of, appropriate services at the earliest possible stage of HIV disease by addressing the multitude of issues and service barriers that impact upon the individual. These activities take place outside the walls of the traditional health-care system and are intended to empower the individual to manage his or her care independently.

This service category should be distinguished from the similar service funded through the Minority AIDS Initiative and described at section B.17 hereof. As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.18.2. Service Standards of Care

Not applicable.

B.18.3. Administrative Standards of Care

The following are minimum Title I standards for the provision of outreach and linkage-to-care services in the Baltimore EMA. All standards should be followed during the funding period. Agencies and individuals may exceed these standards.

B.18.3.1. Licensure, Knowledge, Skills And Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.18.3.1(a). All programs/staff will:

- (i). Possess a background (indigenous/peer) of cultural competence with respect to diverse populations (including people of color, gays, bisexuals, transgendered persons, adolescents, women of childbearing age, injection-drug users and their partners, commercial sex workers and other groups that are at high risk for HIV infection).
- (ii). Show evidence that staff is knowledgeable and trained as specified in sections B.18.3.1(b) and B.18.3.1(c) hereof.

(iii). Show evidence of knowledge in accessing venues of at-risk populations (family-planning services, substance-abuse treatment programs, penal and drug-treatment transition houses, shelters, soup kitchens, bars, social clubs, open air drug markets, etc.).
(iv). Show evidence of staff's knowledge of available resources, access issues and the capacity to direct clients to primary medical care, support and ancillary services.

B.18.3.1(b). All staff of Title I-funded outreach and linkage-to-care services will attend a minimum of one professional-development training course or seminar annually. The course work for staff development must be in one or more of the following service areas: substance-abuse and drug-treatment services, mental health, domestic violence, clinical trials/protocols/vaccines, tuberculosis, sexually transmitted diseases, partner notification, bereavement, cultural competence, nutrition, housing services, suicide, adolescent health issues, communication, opportunistic infections, commercial sex work, gay/bisexual and transgender concerns and other related topics.

B.18.3.1(c). The following is a partial list of organizations or programs that offer training in the required areas:
(i). The Maryland AIDS Administration's "HIV Counseling Skills — Level I" training or a comparable course.
(ii). The American Red Cross African "American HIV Instructor Training" course.
(iii). The Baltimore City Health Department HIV training curriculum.
(iv). Baltimore Trials, Inc.'s and Johns Hopkins University's training programs on clinical trials/vaccines.
(v). A certified program on substance abuse and treatment, e.g., Critical Appraisal Skills Program (CASP), National Institute on Drug Abuse (NIDA), Office of Education and Training for Addictions (OETAS), Baltimore Substance Abuse Systems (BSAS), etc.
(vi). The Maryland AIDS Administration's case-management training course titled, "Working Effectively with Special Populations."
(vii). The AIDS Professional Education Center at the University of Maryland at Baltimore.

B.18.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.18.3.2(a). The agency will develop and institute policies and procedures for the protection of the rights and confidentiality of each client.

B.18.3.2(b). The agency will show evidence of a written policy on client confidentiality.

B.18.3.2(c). The agency will show evidence that client encounter forms/files are secured and protected, especially when completing forms while working on the streets.

B.18.3.2(d). The agency will show evidence that there is a client grievance policy and procedures.

B.18.3.3. Quality Assurance

All recipients of Title I funds providing outreach services will do the following:

B.18.3.3(a). Utilize outreach encounter forms with required demographic, referral and follow-up documentation for each client seen. See section B.18.4.3(a) hereof.

B.18.3.3(b). Conduct a minimum of quarterly client satisfaction surveys on a minimum of 10 percent of the site-based population and request feedback from follow-up documentation gained from street-based outreach.

B.18.3.3(c). Show evidence that outreach activities are monitored for appropriateness, accountability and effectiveness (through on-site observation, monitoring, individual quarterly evaluations, etc.).

B.18.3.3(d). Conduct in-service training for all new staff hired to perform outreach and linkage-to-care functions pertaining to: substance-abuse and drug-treatment services, mental health, domestic violence, clinical trials/protocols/vaccines , tuberculosis, sexually transmitted diseases, partner notification, bereavement, cultural competence, nutrition, housing services, suicide, adolescent health issues, communication, opportunistic infections, commercial sex work, gay/bisexual and transgender concerns and other related topics.

B.18.3.3(e). Show evidence of the existence of a community advisory board specific to program activities.

B.18.3.3(f). Show evidence of a structured referral process for clients who require assistance with other service areas.

B.18.3.3(g). Show evidence of follow-up efforts to ensure that successful linkages with services have occurred.

B.18.4. Summary

This subsection provides miscellaneous further information on this service.

B.18.4.1. Recommendations

None.

B.18.4.2. References and Further Sources

None.

B.18.4.3. Appendix

See following pages.

B.18.4.3(a). Sample Outreach Encounter Form

Outreach/Linkage to Care ***Encounter/Contact Form***

1. Confidential Information

____

(Consumer/Client Name) (ID #, if follow-up) (Date)

____

(Outreach Staff Name)

____

(Location or Exact Address of Encounter) (Record Public Site) (New Contact or Follow-up)

2. Demographic Information

Date of Birth: __________ Marital Status: __________ Last Grade Completed: __________

Soc. Sec. No.: ____________________ Gender: __________ Race: __________

Descriptive Information: ____

(If unable to obtain demog. data, record some descriptive information about consumer/client.)

3. Risk Assessment (circle answers)

Does consumer/client have regular health care provider?	Yes	No	Not Assessed
Has consumer/client had HIV test within last 6 months?	Yes	No	Not Assessed
Does consumer/client abuse alcohol?	Yes	No	Not Assessed
Is consumer/client HIV positive?	Yes	No	Not Assessed
Does consumer/client abuse drugs?	Yes	No	Not Assessed
Does consumer/client abuse non-IV drugs?	Yes	No	Not Assessed
Does consumer/client practice high risk sex?	Yes	No	Not Assessed

4. Harm Reduction Measures (information/education provided client; check all that apply)

☐ Transmission of HIV
☐ Needle exchange
☐ Cleaning needles/syringes
☐ Condoms
☐ Substance-abuse treatment

5. Referrals (check and name agency)

- ☐ Primary medical care: ______
- ☐ Drug treatment: ______
- ☐ Family planning: ______
- ☐ HIV counseling: ______
- ☐ Dental services: ______
- ☐ Housing/shelter: ______
- ☐ Counseling/support group: ______
- ☐ Food service/soup kitchen: ______
- ☐ Transportation: ______
- ☐ Pediatric services: ______
- ☐ Adolescent services: ______
- ☐ Domestic-violence services: ______
- ☐ Hispanic-specific services: ______
- ☐ STD clinic: ______
- ☐ TB clinic: ______
- ☐ Mental-health services: ______
- ☐ Case management: ______
- ☐ Voucher assistance: ______
- ☐ Pastoral counseling: ______
- ☐ Day/respite Care: ______
- ☐ Pharmacy assistance: ______
- ☐ Legal services: ______
- ☐ Sexual-assault services: ______
- ☐ Hearing-impaired services: ______
- ☐ Other: ______

6. Use This Space for Follow-up Comments

______
______
______
______

B.19. Program Support: Community Education

Origination: November 1996.

Revision: July 2000; ratified, August 2000.

B.19.1. Service Definition

Community education, as a capacity-building activity, refers to those activities that are designed to raise the general knowledge base of the entire EMA as relating to HIV/AIDS, across the continuum of the disease and the epidemic. Community education is distinguished from any other direct client or direct provider education activity allowed under any of the other service categories.

B.19.1.1. Key Services

Examples of community-education activities are:

B.19.1.1(a). Town meetings on triple therapy.

B.19.1.1(b). Public service announcements on needle-exchange programs.

B.19.1.1(c). First call for help.

B.19.1.1(d). Billboards that identify Ryan White providers or activities.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.19.2. Service Standards of Care

Not applicable.

B.19.3. Administrative Standards of Care

The following are minimum standards for the provision of program support: community education. Agencies and individuals may exceed these standards.

B.19.3.1. Authorization of Community Education Projects

Certain protocols must be followed before a community-education project can be established, as follows:

B.19.3.1(a). Each community-education project, prior to initiation, will be presented at a planning council meeting with a plan, cost breakout, and where appropriate, a monitoring or follow-up plan.

B.19.3.1(b). Community education projects will have the active involvement of HIV educators, PLWH/As and community health professionals experienced in HIV care at the developmental stage.

B.19.3.2. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience. Capacity-building and community-education activities will meet the following criteria:

B.19.3.2(a). Information will be applicable across the EMA, tailored to the audience and incorporating the most current data available.

B.19.3.2(b). Providers offering community-education activities must incorporate HIV/AIDS consumer, provider and community needs in planning activities

B.19.3.2(c). Providers should have a general knowledge of the service resources within the EMA.

B.19.3.2(d). Providers should have experience in utilizing all facets of the EMA toward enhancing the existing service capacity within communities.

B.19.3.2(e). Providers should have skills and experience in developing linkages among existing providers, consumers and the larger community to conceptualize the expansion of service capacity or to identify needed new services.

B.19.3.3. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.19.3.3(a). Participants attending public forums sponsored by the planning council are asked to maintain the confidentiality of others participating.

B.19.3.3(b). For the purposes of community education, no single provider or program will be presented as the standard to be met by other providers.

B.19.3.3(c). Professional and personal reputations will be respected.

B.19.3.4. Quality Assurance

Providers will document each community-education activity outcome, including final costs and quantitative and/or qualitative data, where appropriate, for review by the planning council.

B.20. Transportation: Direct

Origination: September 1997.

Revision: September 2000; ratified, September 2000.

B.20.1. Service Definition

This service category covers the *direct* provision of transportation services to HIV clients, in order to improve their access health care and psychosocial support services, by means of taxis, leased vans or commercial transportation services. Programs funded under this category must provide consideration for HIV-disabled clients needing assistance in navigating stairs, getting in/out of vehicles, and folding and moving their wheelchairs. The coordination of transportation services also falls under this service category.

B.20.1.1. Key Services

The two principal conveyance modalities contemplated within this service category are taxi and van services, though not exclusively so. The use of taxi or van or similar direct services is permissible when:

B.20.1.1(a). No other public transportation is available.

B.20.1.1(b). Mass transit is available but when the client is physically compromised.

B.20.1.1(c). The client's appointment is particularly urgent or when a time factor does not allow utilization of other means.

B.20.1.1(d). The client lives in one of the six metropolitan counties that, with Baltimore City, make up the EMA. Such direct transportation may be used for transportation within a county, from one county to another, or from a county to the city.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.20.2. Service Standards of Care

The following are minimum standards for the provision of transportation services. Agencies and individuals may exceed these standards.

B.20.2.1. Baseline Evaluation

The baseline-evaluation period has two components, as follows: (a) setting of terms for individuals or companies *directly* providing transportation services and (b) setting of terms for

HIV service agencies *indirectly* providing transportation by subcontracting such services to third parties.

B.20.2.1(a). Terms for individuals or commercial entities *directly* providing direct transportation services, public taxi rides or commercial van conveyance services are as follows:

(i). A formal, written agreement must be signed that details the relationship between the provider of transportation services and the Ryan White agency purchasing services on behalf of Ryan White clients.

(ii). Any agreement must define the terms and conditions for authorizing transportation, special services or assistance needed by HIV-positive clients, conditions for payment, emergency procedures, complaint procedures, termination conditions and any local or state regulations that apply to such services and contractual agreements.

B.20.2.1(b). Terms for HIV service agencies *indirectly* providing direct transportation services (for HIV clients) by subcontracting are as follows:

(i). Typically, this category includes referrals from another agency through case management, client advocates, medical personnel, etc.

(ii). No client self-referrals and no Medicaid-eligible clients can receive Title I-funded transportation services.

(iii). Only in documented emergencies will Ryan White CARE Act Title I funds be used to convey a Medicaid-eligible consumer.

(iv). Documentation of Ryan White eligibility, both HIV status and financial eligibility, must be part of the referral.

(v). Destinations eligible for conveyance transportation include: primary medical care, the Department of Social Services, housing, support groups, counseling, and other supportive services appointments (except substance-abuse treatment appointments).

(vi). A completed referral form must be submitted to the agency for each trip.

(vii). Referrals must be made at least 24 hours in advance for conveyance services.

(viii). The HIV service agency subcontracting transportation may reserve the right to plan a route that picks up one or more clients from a general area of the EMA and to drop clients at a common destination or several destinations in a general area of the EMA.

(ix). The agency will accommodate consumer arrival times for scheduled appointments and return trips for consumers.

(x). The agency will maintain documentation signed by consumers that indicates their willingness to utilize the conveyance service.

(xi). The agency must have a written policy statement about, first, consumer rights when using the services and, second, agency expectations of consumers who use the agency transportation services.

B.20.3. Administrative Standards of Care

The following are minimum standards for the provision of transportation services. These standards may be exceeded.

B.20.3.2. Licensing, Knowledge, Skills, and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.20.3.2(a). If the provider is an individual, he or she must submit:
- (i). A copy of his/her current driver's license.
- (ii). Evidence of current automobile insurance coverage.
- (iii). A recent copy of his/her Maryland Motor Vehicle Administration driving record showing no more than four points over the past three years.
- (iv). Documentation that the driver is permitted to use his/her vehicle for commercial purposes.
- (v). Documentation that the vehicle is serviced, according to applicable standards from the licensing agency, and has passed any required safety inspections for vehicles that convey commercial passengers.

B.20.3.2(b). If the provider is an agency or business, it must submit evidence that:
- (i). The agency is licensed or approved for operation by the Maryland Public Service Commission and has a copy of its charter to operate available upon request of funding agency.
- (ii). Drivers have permits from the Public Service Commission to operate commercial vehicles.
- (iii). Drivers have had no more than four points on their driver's licenses over the past three years.
- (iv). Vehicles to be used are licensed and insured to the level required for a public transportation vehicle.
- (v). All drivers have passed the Maryland driver's test and have passed a drug and alcohol screening. This documentation must be available for review by the funding agency.
- (vi). Vehicles are routinely serviced and inspected in compliance with standards that apply to commercial vehicles used to convey special populations and/or the public, whichever is applicable.

B.20.3.2(c). Program staff will possess the knowledge, skills, and experience necessary to competently deliver expected services.

B.20.3.2(d). The agency must show evidence that supervisory staff members can read regional maps and have a working knowledge of the streets in Baltimore City.

B.20.3.2(e). The agency must show evidence that staff members are trained and knowledgeable regarding HIV/AIDS and the affected community.

B.20.3.2(f). The agency must document that agency drivers have successfully completed a defensive driver's course.

B.20.3.2(g). The agency must document if any drivers have completed CPR and/or first aid courses.

B.20.3.2(h). The agency must show evidence that only licensed carriers are utilized for client transportation.

B.20.3.3. Client Rights and Confidentiality

The provider must have policies/procedures for the protection of the rights and confidentiality of each client:

B.20.3.3(a). The agency must show evidence of a written agency policy on client confidentiality.

B.20.3.3(b). The agency must show evidence in existing records/files of client knowledge of policies and procedures.

B.20.3.3(c). The agency must show evidence that existing records and files containing client information are secured and protected.

B.20.3.3(d). The agency must show evidence of an agency grievance procedure and that the procedure was shared with all clients.

B.20.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.20.3.4(a). The agency must have a quality-assurance plan designed to monitor both appropriateness and effectiveness of all services delivered.

B.20.3.4(b). The agency must show evidence that transportation services are arranged for, coordinated and/or delivered in a timely and safe manner.

B.20.3.4(c). The agency must show evidence that an individual assessment is conducted to determine that this service is the appropriate mode for the client

B.20.3.4(d). The agency must show evidence that access is available, particularly to low-income and/or physically disabled residents of the EMA who have HIV/AIDS.

B.20.3.4(e). The agency must show evidence that HIV-disabled clients have appropriate access to the service agency, appropriate vehicular access, and suitable folding chairs, and that appropriate assistance is provided.

B.20.3.4(f). The agency must show evidence of the application and assessment process which includes but is not limited to: written applications; criteria for acceptance or rejection; ranking criteria utilized for eligible applications when waiting lists exist; a formal grievance process; and a termination process.

B.20.3.4(g). The agency must show evidence that appropriate referrals are made if clients require assistance with other services.

B.20.3.4(h). The agency must show evidence that an active advisory board exists that is made up of representatives from the HIV/AIDS community. This advisory board should meet at least quarterly.

B.20.3.4(i). The agency must show evidence of providing the most cost effective mode of transportation for the geographic area, while maintaining safe and effective care.

B.21. Transportation: Indirect

Origination: November 1996.

Revision: August 1999; ratified, August 1999.

B.21.1. Service Definition

This service category covers the *indirect* provision of transportation to HIV clients, in order to improve their access health care and psychosocial support services, by means of the provision of subsidies for various types of public transportation, such subsidies to take the form of taxi vouchers, light-rail or bus tokens, mass transit daily or monthly passes, or metro (subway) fare cards. The coordination of transportation services also falls under this service category. This entire section presupposes that clients funded as described herein are physically able to travel by mass transit.

B.21.1.1. Key Services

This service category involves the subsidizing of clients' use of public or other transportation, principally by the following means:

B.21.1.1(a). *Monthly mass transit passes*, for use:
- (i). Where mass transit exists.
- (ii). By clients who are new to the care system.
- (iii). By clients who have multiple, often complex problems that need to be addressed by several different providers during a short period of time and for whom the scheduling of multiple taxi rides in short succession would not be practical. Children under age three ride free with an adult pass. Under some circumstances, a monthly disability bus pass may be appropriate for some clients; however, children cannot ride free under this type of pass.

B.21.1.1(b). *Daily mass transit passes*, which are used for clients that have several stops to make during any one day. Children under age three can ride free.

B.21.1.1(c). *Mass transit tokens or single-use fare cards*, for use:
- (i). When the client is going only to a single destinations.
- (ii). When the providing agency determines that the client's eligible trips are not of such frequency as to merit a monthly bus pass.

B.21.1.1(d). *Taxi vouchers*, for use:
- (i). When the client is capable of getting his or her own taxi ride.
- (ii). When the client's destination is not on a mass transit route.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.21.2. Service Standards of Care

The following are minimum standards for the provision of transportation services. Agencies and individuals may exceed these standards.

B.21.3.1. Baseline Evaluation

Providing agencies should make a baseline evaluation of the client's needs and eligibility in the following manner:

B.21.3.1(a). The agency should determine the client's eligibility for Ryan White services.

B.21.3.1(b). The agency should assess with the client whether he or she has other means of transportation to meet his or her needs before providing Ryan White-funded services.

B.21.3.1(c). Agency staff should assess:
(i). The client's health status.
(ii). The urgency of the problem that requires transportation.
(iii). The most economic and efficient means for the client to travel.

B.21.3.1(d). Staff should complete agency documentation forms, showing the method of transportation and include the information and the assessment justification in the client's file.

B.21.3. Administrative Standards of Care

The following are minimum standards for the provision of transportation assistance by means other than a centralized conveyance agency. Agencies and individuals may exceed these standards.

B.21.3.3. Licensing, Knowledge, Skills, and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.21.3.3(a). Mass transit passes and tokens are tangible assets that can easily be converted to cash. It is therefore necessary that the agency have procedures and locations to secure these items.

B.21.3.3(b). Staff authorized to issue passes and tokens or taxi vouchers must be fully trained in the security procedures within the agency.

B.21.3.3(c). The agency must provide on-going supervision appropriate to the professional level of the staff providing transportation assistance.

B.21.3.3(d). Staff must be fully trained regarding the documentation needed to account for disbursed passes, tokens and vouchers as well as client eligibility and assessment processes.

B.21.3.3(e). The agency must show evidence that staff is knowledgeable about HIV/AIDS, at a minimum through in-service training.

B.21.3.3(f). The agency must show evidence that in-service staff development is available and that staff have opportunities to attend other professional development training or seminars related to HIV/AIDS services.

B.21.3.4. Client Rights And Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.21.3.4(a). The agency should have policies and procedures in place for the protection of the rights of each client and the confidentiality of each client file.

B.21.3.4(b). The agency should show evidence of a written policy on client confidentiality.

B.21.3.4(c). The agency should show evidence that clients have been informed of their rights to services and of the agency confidentiality policy.

B.21.3.4(d). The agency should show evidence that existing records and files are secured and protected.

B.21.3.4(e). The agency should show evidence that it has a grievance procedure and that the procedure has been shared with clients.

B.21.3.5. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken.

B.21.3.5(a). The agency must have a quality assurance plan designed to monitor both appropriateness and effectiveness of the services delivered.

B.21.3.5(b). The agency must show evidence that the services given were delivered in a timely and efficient manner.

B.21.3.5(c). The agency must show evidence that an individual assessment is conducted to determine the most appropriate mode of transportation for the client.

B.21.3.5(d). The agency must show evidence that the intake and assessment process includes but is not limited to:
(i). Written intake/application for service.
(ii). Criteria/justification for the service or method of transportation selected.
(iii). Documentation that shows disbursement or service authorization.

(iv). Documentation that shows client awareness of grievance procedures, client rights, and eligibility criteria.

B.22. Treatment Adherence

Origination: October 1998.

Revision: September 2000; ratified, September 2000.

B.22.1. Service Definition

Throughout the Baltimore EMA, service providers experience the failure of clients to keep appointments and/or to follow through with planned medical regimens. The rate of no-shows for appointments varies across the EMA, but some treatment services may have nearly 50 percent of their scheduled appointments not kept. Since failure to keep scheduled appointments, especially HIV medical care appointments, has a serious impact on the state of wellness of the individual, as well as causing a serious waste of limited staff and financial resources, the planning council has designated funds to address adherence issues. Standards for case management shall be used as service guidance for the provider agency and the staff members delivering treatment-adherence services.

The goal of the project is to provide intensive services directed toward identification and remediation of barriers that interfere with the client's adhering to the needed medical services or following the planned medical treatments.

B.22.1.1. Key Services

Two services are covered under this category, first, the encouragement of individuals to keep medical appointments and, second, the encouragement of individuals to keep to their medication regimens.

B.22.1.1(a). In terms of *appointments*, the project contemplates working with those HIV-positive individuals who are known to the Ryan White Title I services continuum but who have identified problems with keeping appointments with primary medical care providers.

B.22.1.1(b). In terms of *medication regimens*, individuals who keep health-care appointments but who are not following the agreed upon treatment regimen are also a target group for this project.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.22.2. Service Standards of Care

The following are minimum standards for the provision of adherence services. Agencies and individuals may exceed these standards.

B.22.2.1. Baseline Evaluation

The first component of the evaluation is the determination of the client's eligibility; the second is the determination of the applicable service model to remedy the identified problem.

B.22.2.1(a). Eligibility criteria are these:
- (i). Those individuals who have missed medical or other related appointments over the previous 12 months are eligible. Individuals who are not following the planned medical regimen may also be offered this service.
- (ii). Referrals may be made from within the health-care provider facility, from outside the health-care provider facility, or through client self-referral.
- (iii). Possible referring entities include: primary medical care facilities, community-based agencies, and substance-abuse or mental-health services agencies.

B.22.2.1(b). The service model can include either of the following:
- (i). A nurse, social worker, and case manager.
- (ii). A nurse, social worker, and case manager partnered with a trained peer counselor.

B.22.2.1(c). The service model may include the following staff:
- (i). A client-care facilitator with, at minimum, a bachelor's degree in social work (B.S.W.) and five years HIV experience or a master's degree in social work (M.S.W.) with two years HIV experience. Caseload size should be between 30 and 35 active cases. Services should include: intake, assessment, service planning, care coordination, follow up, referral, and other interventions that lead to the goal of becoming fully adherent. Reporting on the project is a major responsibility of the staff.
- (ii). A client-care facilitator with the same qualifications as for the previous option. A peer counselor will work with the client-care facilitator in providing the services to the client. The peer counselor must be HIV positive, have experience working with HIV-positive consumers and be able to appropriately model adherent behavior. The peer counselor must have completed high school and completed training through at least one DHMH-sponsored HIV training program. Services to be offered are the same in both models.

B.22.2.1(d). Funds are provided within both models for support services for enrolled consumers.

B.22.2.2. Further or Continued Services

Follow-up measures or visits should adhere to the following protocols.

B.22.2.2(a). Assessment of barriers to adherence is performed by the nurse, social worker or case manager working in the adherence program.

B.22.2.2(b). The adherence intervention plan must be developed with the client.

B.22.2.2(c). Clients must sign the intervention plan, which may include contact with or from the peer counselor.

B.22.2.2(d). Evaluation of the implementation plan should be performed periodically, at minimum quarterly.

B.22.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.22.3.1. Reporting

At minimum, the adherence project reporting form should include the following:

B.22.3.1(a). Medical status.

B.22.3.1(b). Barriers and co-morbidities.

B.22.3.1(c). Planned interventions.

B.22.3.1(d). These elements are additional to the elements of the agency's standard intake form.

B.22.3.1(e). The adherence project reporting form must be completed as appropriate and submitted periodically as the client progresses through his/her planned program.

B.22.3.2. Quality Assurance

Each funded agency must have a quality-assurance plan.

B.23. Primary Medical Care: Co-morbidity

Origination: June 1999 (ratified, September 1999).

Revision: April 2003; ratified, May 2003.

B.23.1. Service Definition

The PMC "co-morbidity" service refers to the provision of integrated care for clients identified and diagnosed with HIV *and* one or more of the co-morbid conditions of: substance abuse, a mental health diagnosis, or homelessness. These conditions have been identified as barriers to clients' accessing primary medical care and as complicating conditions in the treatment of HIV disease.

The population of the Baltimore EMA exhibits many co-morbid issues. Of the respondents to the planning council's 2001 client survey, over 26 percent reported themselves as homeless. Fifteen percent reported a mental-health diagnosis within the previous year. Over one third of HIV cases reported active substance abuse in the previous year. These co-morbid factors impact on the health-care delivery system through missed appointments and failure to adhere to medical treatments. These factors, left untreated or unaddressed, may reduce the life expectancy of the HIV-positive individual, spread the HIV epidemic, and create major social problems. Service delivery systems that treat each co-morbid condition independently have been the norm in the HIV-care system. This service category is intended to address the barriers that co-morbidity creates for clients in seeking and remaining in medical treatment and securing the other health and support services that are essential to the well being of the client.

B.23.1.1. Key Services

The two principals of the co-morbidity service are, first, care co-location and, second, care integration.

B.23.1.1(a). In terms of care *co-location*, programs should have integrated HIV primary medical care, case management, substance-abuse treatment and/or psychiatric and mental-health services available on site for patients.

B.23.1.1(b). In terms of care *integration*, the system of care for co-morbid clients shall be integrated and coordinated with a clearly delineated system to accomplish the goals of removal of the barriers to care-coordination and improvement in the overall quality of life for persons living with HIV/AIDS.

As used herein, the term "client" encompasses the terms "patient" and "service consumer." These standards apply to both Ryan White Title I and MAI co-morbidity funded agencies.

B.23.2. Service Standards of Care

This section describes those service standards necessary for the provision of care under this category.

B.23.2.1. Baseline Evaluation

Standards for primary medical care, case management, substance abuse and mental health shall be used as service guidance for the provider agency/organizations and the staff delivering services. The starting point for co-morbidity services shall be the development of the care team, followed by the intake of the client, an eligibility determination, and then the assessment of his or her needs.

B.23.2.1(a). The development of the care team shall approximate the following:
- (i). The agency shall establish a client care team and have an infrastructure that supports team conferencing.
- (ii). Each treatment team should be configured around the needs of the individual client.
- (ii). The basic team will consist of:
  - The primary medical physician, who must always be present for case conferencing.
  - The provider agency staff member for the client's primary co-morbid condition (i.e., substance abuse, mental health, or both).
  - A care coordinator.
  - A peer advocate (recommended).
  - Other persons as determined by the client's needs.

B.23.2.1(b). Intake includes:
- (i). Completion of agency-required intake forms.
- (ii). Collection of demographic information, where relevant.
- (iii). Documentation of services provided to the client that is maintained by the agency.

B.23.2.1(c). Documentation of eligibility should ensure that the client is:
- (i). Within Ryan White income guidelines.
- (ii). Enrolled in primary medical care.
- (iii). HIV positive and demonstrates difficulty with adhering to one or more of the components of his or her care program such as:
  - Medications
  - Medical appointments
  - Substance-abuse treatment appointments.
  - Mental-health treatment appointments or care treatment.

B.23.2.1(d). Assessment includes:
- (i). Review of services offered and discussion with the client of his or her needs.
- (ii). A statement which clearly diagnoses the co-morbid conditions that have been determined as barriers to adherence to primary medical care medications.

(iii). Client participation in setting goals and developing a service plan. The client must sign the care plan to show that he/she acknowledges the need to participate in co-morbidity.
(iv). The client care plan will be developed and signed by all members of the care team.

B.23.2.3. Further or Continued Services

As the client's treatment plan develops, follow-up visits and further activities should adhere to the following protocols.

B.23.2.3 (a). A care-plan review meeting by the entire care team shall occur, at a minimum, every three months.

B.23.2.3 (b). The care-plan review will ensure that relevant referrals and follow ups are provided as identified by client need.

B.23.2.1 (d). The role of the care team is to identify and address areas of concern, at minimum quarterly, through team meetings and discussion of the client's progress.

B.23.2.1(e). The care team shall be responsible for updating the client's chart after every appointment.

B.23.2.1(f). The care team shall provide written updates to the client chart when there is a case review.

B.23.2.1(e). The care coordinator should be the staff person who carries the co-morbid caseload, i.e., the social worker or case manager.

B.23.2.1(f). The role of the care coordinator is to identify eligible clients from referrals within the agency.

B.23.2.1(g). The care coordinator shall perform the client intake at the second screening level. (Initial screening occurs when the provider identifies the client to be eligible for general agency services.)

B.23.2.1(h). The care coordinator shall coordinate the team's involvement with the client and see that a treatment care program is developed for each client.

B.23.2.1(i). The care coordinator shall monitor the client's progress through coordination of client conferencing meetings.

B23.2.1(j). The care coordinator shall facilitate communication within the team that ensures all members are aware of the client issues so that primary services in addressing each of the issues receives ancillary support from each of the other team services.

B.23.3. Administrative Standards of Care

This subsection describes agency's minimum administrative requirements.

B.23.3.1. Licensing, Knowledge, Skills, and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.23.3.1(a). Service staff will possess the requisite knowledge, including culturally linguistically appropriate service standards.

B.23.3.1(b). Service staff will have experience and knowledge of HIV-related issues.

B.23.3.1(c). The agency must have documentation that shows staff and volunteers are licensed or certified when required by their profession.

B.23.3.1(d). The care coordinator will have over two years' HIV-related experience with a care coordination background and meet at least one of the following criteria:
(i). Have a master's level training with experience in the field of human services and clinical experience.
(ii). Be a licensed graduate social worker with certification.
(iii). Be a registered nurse.
(iv). Be a pastoral counselor.
(v). Have a master's degree in psychology.

B.23.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.23.3.2(a). The agency shall provide:
(i). Written policies and procedures on the protection of the rights and confidentiality of each client.
(ii). Evidence in existing records/files that agency procedures have been discussed with clients and copies of grievance and clients' rights and confidentiality have been given.
(iii). Evidence that existing records/files containing client information are secured and protected.
(iv). Other patient record/chart materials or required documentation.

B.23.3.2(b). The agency must maintain records of clients served through the provision of co-morbid services. All documentation of services provided will be recorded in the primary medical care chart.

B.23.3.2(c). Each of the team members should provide written updates in the primary medical care chart to ensure an on-going record of the services provided to the client.

B.23.3.3. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.23.3.3(a). The agency must identify a screening mechanism to identify which clients qualify for coordinated level of care provided by the co-morbidity service category.

B.23.3.3(b). The client provider ratio must not exceed 1 care coordinator for every 35 clients.

B.23.3.4. Quality Assurance

The agency must show:

B.23.3.4(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.23.3.4(b). Documentation of care plan reviews, both peer and supervisory.

B.23.3.4(c). Documentation of utilization review.

B.23.3.4(d). Documentation of the most recent site visit by the administrative agency.

B.23.3.4(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.23.3.4(f). Documentation of periodic data and narrative reports to the administrative agency.

B.23.3.4(g). Documentation of a process to solicit client satisfaction with services at least annually.

B.23.3.4(h). Documentation that it meets the service category standards and/or any applicable professional or federal practice standards.

B.24. Program Support: Capacity Building

Origination: May 1997 (ratified, September 1997).

Revision: September 2000; ratified, 2000.

B.24.1. Service Definition

Capacity building refers to those activities that are designed to raise the general knowledge base of, to increase the level of services from, or to form collaborative relationships among, HIV-related service providers or administrative entities throughout the entire EMA. The general goals of capacity-building activities are: to enhance the continuum of care by helping service providers build their programs, to assist with the staff-development training opportunities necessary to improve the quality of services, and to develop strategies and identify resources to address gaps in services or remediate deficiencies in the health care system. These capacity-building improvement activities should be considered distinct from the direct client or direct provider activities allowed under any of the other service categories described herein.

B.24.1.1. Key Services

Examples of capacity building activities are:

B.24.1.1(a). Collaboration meetings with managed-care organizations and Ryan White providers.

B.24.1.1(b). Staff-training workshops for providers' staff .

B.24.1.1(c). Development of a Ryan White provider services directory.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.24.2. Service Standards of Care

Not applicable.

B.24.3. Administrative Standards of Care

The following are minimum standards for the provision of program support: capacity building. Agencies and individuals may exceed these standards.

B.24.3.1. Authorization of Capacity Building Projects

Certain protocols must be followed before a capacity-building project can be established, as follows:

B.24.3.1(a). Each capacity-building project, prior to initiation, will be presented at a planning council meeting with a plan, a cost breakout and, where appropriate, a monitoring or follow-up plan.

B.24.3.1(b). Capacity-building projects will have the active involvement of HIV providers, PLWH/As, other appropriate health professionals experienced in HIV care, and other human-service professionals at the developmental stage.

B.24.3.2. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.24.3.2(a). Capacity-building information will be applicable across the EMA, tailored to the audience and reflecting the most current data available.

B.24.3.2(b). Providers offering capacity-building activities must incorporate HIV/AIDS client, provider and capacity needs in planning activities.

B.24.3.2(c). Providers should have a general knowledge of the service resources within the EMA.

B.24.3.2(d). Providers should have experience in utilizing all aspects of the service spectrum within the EMA toward enhancing the existing service capacity within community.

B.24.3.3. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.24.3.3(a). Participants attending public forums sponsored by the planning council are asked to maintain the confidentiality of other participants.

B.24.3.3(b). For the purposes of capacity building, no single provider or program will be presented as the standard to be met by other providers.

B.24.3.3(c). Professional and personal reputations will be respected.

B.25. Buddy/Companion Services

Origination: November 1996.

Revision: February 2001; ratified, October 2001.

Revision: September 2003; ratified, October 2003.

B.25.1. Service Definition

Buddy/companion service is an activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

B.25.1.1. Key Services

Key services may include:

B.25.1.1(a). Social support/companionship.

B.25.1.1(b). Transportation (non-medical).

B.25.1.1(c). Home chores (if appropriate).

B.25.1.1(d). Social activities.

B.25.1.1(e). Personal tasks.

B.25.1.1(f). Assisting in setting up networks of support for consumers/clients in the community.

As used herein, the term "client" encompasses the terms "patient" and "service consumer." The terms "buddy/companion services," "buddy services" and "companion services" are used interchangeably. Finally, the term "volunteer" encompasses the terms "buddy," "companion" and buddy/companion."

B.25.2. Service Standards of Care

The following are minimum standards for the provision of buddy/companion services. Agencies and individuals may exceed these standards.

B.25.2.1. Baseline Evaluation: Client

For the client, the baseline-evaluation period has three principal phases, as follows: eligibility determination, intake and needs assessment.

B.25.2.1(a). *Eligibility determination* must ensure that the client is:
(i). HIV infected.
(ii). Within the Ryan White income guidelines.
(iii). Not an active substance abuser.

B.25.2.1(b). *Intake* includes:
(i). Completion of all agency-required forms, where appropriate.
(ii). Collection of demographic information for services.
(iii). Documentation of eligibility for on-going services such as support groups.
(iv). Documentation of buddy services provided to the client.

B.25.2.1(c). *Needs assessment* includes:
(i). A review of services offered and discussion with the client of his or her needs.
(ii). A determination of those buddy services that are appropriate to meet the client's needs.

B.25.2.2. Baseline Evaluation: Volunteer

For the volunteer, the baseline-evaluation period has three principal phases, as follows: eligibility determination, capability assessment and intake.

B.25.2.2(a). *Eligibility determination* must ensure that the volunteer:
(i). Has no recent criminal convictions.
(ii). Is not an active substance abuser.
(iii). Is over 18.

B.25.2.2(b). *Capability assessment* comprises a determination of the volunteer's:
(i). Understanding of commitment.
(ii). Physical ability.
(iii). Psychological stability.
(iv). Motivation.

B.25.2.2(c). Volunteer *intake* includes, at minimum, the volunteer's:
(i). Completion and signing of a written application.
(ii). Signing of a confidentiality agreement.
(iii). Agreement to complete training.
(iv). Agreement to comply with reporting procedures.

B.25.2.3. Agency Responsibilities

The provider agency must also adhere to certain service standards, as follows:

B.25.2.3(a). The agency must have written policies regarding eligibility, confidentiality, grievance procedures, referral and linkage, agency expectations of clients and termination policies.

B.25.2.3(b). The agency must maintain documentation that such policies have been given to each client seeking services

B.25.2.3(c). When appropriate, the agency staff will refer and link clients to other needed services.

B.25.2.3(d). Program monitoring will be conducted in the following manner:
(i). On-going buddy services should be monitored on a periodic basis, at least once per quarter for the first six months, then once during the second six months, assuming that both the client and the volunteer are reporting positively on services. Monitoring must be more frequent if either party identifies issues that need to be addressed.
(ii). Informational and educational buddy groups or services should be reviewed periodically, at least annually, to ensure that information is current.
(iii). The agency must maintain written documentation to ensure that the volunteer is adhering to program guidelines.

B.25.2.3(e). For *group buddy services*, the agency will provide:
(i). A description of each group.
(ii). A statement of the purpose of the group.
(iii). Requirements of members (e.g., attendance, number of meetings, open/closed nature of meetings, etc.).
(iv). Confidentiality policies,.
(v). Membership eligibility criteria, if any.

B.25.2.3(f). For *individual buddy services*, the agency will provide:
(i). A description of the type of service.
(ii). A statement of the purpose of the service.
(iii). General agency goals for the service.
(iv). Individual client goals.

B.25.3(g). The agency must maintain written documentation that volunteers are reviewed a minimum of once every six months.

B.25.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.25.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.25.3.1(a). Volunteers and staff will possess the knowledge (including cultural sensitivity to the populations served), skills and experience necessary to competently perform expected services.

B.25.3.1(b). The agency must have documentation that shows the staff to be licensed or certified when required by the profession.

B.25.3.1(c). The agency will have a training program for all staff and volunteers who will be responsible for services to clients.

B.25.3.1(d). All volunteers must successfully complete the training program before providing services to clients.

B.25.3.1(e). The training will cover, at a minimum, the following topics:
(i). Cultural competency.
(ii). HIV/AIDS.
(iii). Co-morbidity (e.g., substance abuse, mental illness).
(iv). Confidentiality.
(v). Emotional and social needs of clients.
(vi). Boundaries and roles.
(vii). Resources and referrals.
(viii). Legal rights and obligations.

B.25.3.1(f). Staff will include professionals well versed in their field of expertise who will hold panel discussions with volunteers and clients with expertise in providing buddy services.

B.25.3.1(g). The agency will conduct continuing education programs for volunteers at least once a year.

B.25.3.2. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.25.3.2(a). The agency should develop and implement policies and procedures for the protection of the rights and confidentiality of each client.

B.25.3.2(b). The agency should show evidence of the client's knowledge of existing policies and procedures.

B.25.3.2(c). The agency should show evidence of compliance with policies and procedures on the part of staff and volunteers.

B.25.3.2(d). The agency will show evidence of being licensed by an appropriate body.

B.25.3.2(e). Clients have the right to accept or refuse a selected volunteer buddy at any stage of the relationship.

B.25.3.2(f). Clients must respect any wish for anonymity on the part of the volunteer, a policy that provider agencies must explain and enforce.

B.25.3.3. Volunteer Rights and Responsibilities

Providers should be able to document the following in terms of volunteers' rights and responsibilities.

B.25.3.3(a). Volunteers must sign an agreement to protect the confidentiality of client at all times. A breach of confidentiality will constitute a breach of contract and will result in permanent termination.

B.25.3.3(b). Volunteers have the right to accept or refuse a selected client at any stage of the relationship.

B.25.3.3(c). Volunteers have a right to anonymity, which is to say that neither the client nor the agency may publicize the names of volunteers without the latter's written consent.

B.25.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken. Specifically, the agency must show evidence:

B.25.3.4(a). Of a quality-assurance plan designed to monitor both the appropriateness and effectiveness of all services delivered.

B.25.3.4(b). That the delivery of direct services is monitored for professional accountability through the following: regular and on-going team meetings, individual professional evaluations at least annually, and formal supervision (which may be peer supervised).

B.25.3.4(c). Of a formal grievance or appeal process for clients.

B.25.3.4(d). That each client receives an intake screening, an eligibility determination and, for eligible clients, an initial assessment.

B.25.3.4(e). That agency policies are given to all clients.

B.25.3.4(f). Of a process for identifying clients who qualify for buddy/companion services.

B.25.3.4(g). Of client progress toward meeting established goals by documentation of activity.

B.25.3.4(h). Of the existence and meeting at least quarterly of a formal advisory board made up of agency clients.

B.25.3.4(i). Of case conferences or volunteer meetings at least monthly.

B.25.3.4(j). That information and referral is provided to clients when buddy/companion services are not available. If a waiting list exists, the agency must show evidence of a plan to attempt to communicate regularly regarding waiting list status.

B.25.3.4(k). Of referrals and other resources and information.

B.25.3.4(l).Of written criteria for services, fee structure, intake process, discharge, transfer and closing procedures.

B.25.3.4(m). Of a process to solicit client satisfaction with services at least annually.

B.26. Nutritional Counseling

Origination: March 2003 (ratified, May 2003).

B.26.1. Service Definition

Nutritional counseling refers to the provision of appropriate nutritional counseling from a licensed, registered dietitian. Counseling sessions take place in addition to and outside primary-care appointments. The provision of nutritional counseling services is critical to the maintenance of a healthy diet that can make a difference in overall quality of life.

B.26.1.1. Key Services

Key services include:

B.26.1.1(a). Counseling on basic dietary restrictions and menu planning.

B.26.1.1(b). Culturally appropriate education about nutritional health.

B.26.1.1(c). Referral to food-assistance programs (including WIC, emergency food providers and food stamps).

B.26.1.1(d). Performing a BIA with interpretation at least annually to monitor body cell mass (muscle mass).

B.26.1.1(e). Provision of nutritional screening and assessment of such factors as weight changes, current medications, side effects/symptoms, functional capacity, accompanied by nutritional counseling.

B.26.1.1(f). Education specific to the individual's unique needs.

B.26.1.1(g). Meal-plan development.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.26.2. Service Standards of Care

The following are minimum standards for the provision of nutritional counseling. Agencies and individuals may exceed these standards.

B.26.2.1. Baseline Evaluation

The baseline-evaluation period has three principal phases, as follows: eligibility determination, intake and needs assessment.

B.26.2.1(a). A statement of *eligibility* can be completed by the referring agency. Eligibility must be documented to ensure that the client:

(i). Is within the Ryan White income guidelines for the uninsured and underinsured (for those with insurance but without nutritional counseling coverage).

(ii). Is HIV positive or directly affected by HIV (such as non-HIV-positive household/family members or caretakers of someone that is HIV positive). For non-HIV-positive family members or caretakers, there must be documentation showing the relationship to the HIV-positive individual.

B.26.2.1(b). *Intake* includes:

(i). Completion of agency-required intake forms, where appropriate.

(ii). Collection of demographic information, if relevant.

(iii). Documentation of services provided to the client; this documentation must be maintained by the nutritional counseling agency.

B.26.2.1(d). *Assessment* includes:

(i). Review of services offered and discussion with the consumer of his or her needs.

(ii). Determination of those nutritional counseling services that are appropriate.

B.26.2.2. Further or Continued Services

Follow-up services should adhere to the following protocols.

B.26.2.2(a). Counseling should occur on a routine basis, at least annually, to determine whether the client and/or agency service goals are being met.

B.26.2.2(b). Additional counseling can be made available as deemed necessary by the dietitian or referring medical provider.

B.26.2.2(c). The registered dietitian is responsible for reviewing services at least annually to ensure that information given to clients is current.

B.26.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.26.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.26.3.1(a). Nutritional counseling providers will maintain current licenses required by the State of Maryland and be registered through the American Dietetic Association.

B.26.3.1(b). Nutritional counselors will possess the knowledge (including cultural sensitivity to the population served), skills and experience necessary to competently perform expected services.

B.26.3.1(c). Counselors will have experience and knowledge of HIV-related issues.

B.26.3.1(d). At least three continuing professional education (CPE) hours annually will be focused on HIV/AIDS.

B.26.3.1(e). It is preferred that nutritional counseling providers should be members of the HIV/AIDS Dietetic Practice Group of the American Dietetic Association.

B.26.3.1(f). The agency is responsible for ensuring that staff members providing nutritional counseling meet all the qualifications to maintain licensure and have access for consultation with another licensed or certified dietitian as well as access to consultation with practitioners who have extensive HIV experience.

B.26.3.1(g). The agency must have documentation that shows staff and volunteers are licensed or certified when required by their profession.

B.26.3.1(h). The agency will have a training program for all staff and volunteers who will be responsible for services to clients.

B.26.3.1(i). The agency will show evidence that all staff and volunteers attend in-service and specialized training on HIV and related topics.

B.26.3.2. Agency Responsibilities

Provider agencies must all follow certain administrative procedures in common, as follows:

B.26.3.2(a). The agency must have written policies regarding eligibility, confidentiality, grievance procedures, referral and linkage, agency expectations of clients and termination policies.

B.26.3.2(b). The agency must maintain documentation that copies of policies have been given to the clients seeking services.

B.26.3.2(c). The agency must ensure that each client receives an intake screening, an eligibility determination and, if determined eligible, an initial assessment.

B.26.3.2(d). When appropriate, the agency staff shall refer and link clients with other needed services.

B.26.3.2(e). The agency shall maintain documentation of client progress toward meeting established goals.

B.26.3.2(f). The agency shall ensure that the delivery of direct services is monitored for professional accountability through the following: regular and on-going team meetings or case conferences at least monthly; individual professional evaluations at least annually; and formal supervision (which may be peer supervised).

B.26.3.2(g).The agency shall have a consumer advisory board and maintain documentation of its meetings.

B.26.3.2(h). That board shall meet at least quarterly and shall be made up of agency clients.

B.26.3.2(i). The agency must develop reasonable caseload standards or ratios and establish a priority system for acceptance of new cases.

B.26.3.2(j). If a waiting list exists, the agency must show evidence of a plan to attempt to communicate regularly with those clients on the list regarding their waiting-list status.

B.26.3.2(k). The agency must have written criteria for services; a fee structure; an intake process; and discharge, transfer and closing procedures. It must document that clients are informed of these.

B.26.3.3. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality. Service providers of nutritional counseling must show:

B.26.3.3(a). Written policies and procedures on the protection of the rights and confidentiality of each client.

B.26.3.3(b). Evidence in existing records/files of client knowledge of policies and procedures.

B.26.3.3(c). Evidence that existing records/files containing client information are secured and protected.

B.26.3.3(d). Evidence in existing records of clients' consent for release of information to other service providers and of a signed release that shows client consent to secure information from other providers.

B.26.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken. The agency must show:

B.26.3.4(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.26.3.4(b). Documentation of record reviews, both peer and supervisory.

B.26.3.4(c). Documentation of utilization review.

B.26.3.4(d). Documentation of the most recent site visit by the administrative agency.

B.26.3.4(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.26.3.4(f). Documentation of periodic data and narrative reports to the administrative agency;

B.26.3.4(g). Evidence of a process to evaluate client satisfaction with services at least annually.

B.26.3.4(h). Evidence that it meets the service category standards and/or any applicable professional or federal practice standards.

B.27. Minority AIDS Initiative: Life Skills Enrichment

Origination: March 2003 (ratified, April 2003).

B.27.1. Service Definition

"Life skills enrichment" is an intensive support service that provides information, training and skill-building experiences directed to helping individuals who may lack the knowledge and skills of daily living to maintain themselves in long-term or permanent housing. Services are targeted to individuals who are homeless, at risk of being made homeless by virtue of living in unstable housing situations (e.g., with friends or relatives), or in transitional housing. The goal of this service is to assist clients to gain the knowledge and skills necessary to remain in stable housing and to secure and maintain themselves in primary medical care.

B.27.1.1. Key Services

Key services include:

B.27.1.1(a). The identification of individuals just established in permanent housing or in the process of securing permanent housing.

B.27.1.1(b). Life-skills training, including: time management, money management or budgeting, tenant/landlord and employer/employee negotiation and communication skills, housekeeping and home management, using public transportation, HIV treatment, medication adherence, substance-abuse and mental-health service adherence, and family communications.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.27.2. Service Standards of Care

This section describes those service standards necessary for the provision of care under this category.

B.27.2.1 Baseline Evaluation

The baseline-evaluation period has three principal phases, as follows: referral/intake, eligibility determination, and needs assessment.

B.27.2.1(a). In regard to *referral and intake*:

(i). Clients may self-refer or may be referred for consideration for this service.

(ii). Referrals must have documentation of client eligibility for Ryan White Title I services.

(iii). For self-referrals, the provider agency will initiate and complete an intake process.
(iv). All documents from referrals or intake must be maintained in the permanent client folder.

B.27.2.1(b). *Eligibility* determination must ensure that the client:
(i). Is within the Ryan White income guidelines.
(ii). Is HIV positive and provides recent documentation (within the last six months) of this fact.

B.27.2.1(c). In regard to *assessment*:
(i). The agency providing enriched life skills services shall have a written process regarding assessing each referral for appropriateness.
(ii). The assessment should, at a minimum, include:

- A history of the individual's housing experiences and current housing situation.
- A history of any substance abuse and/or mental-health services and current needs.
- Information on the individual's family or other support network.
- Information on the individual's financial resources.
- Information on the individual's medical needs, current medications and other health or psychosocial issues.
- A review of services offered and a discussion with the client of his or her needs.

(iii). The staff performing the assessment shall develop a plan with the client regarding the training areas to be addressed through the enriched life skills services.
(iv). The client shall sign off on the proposed plan that also includes a timeline for delivery of services, progress or benchmarks of achievements, and follow-up services upon completion of enriched life skills services.

B.27.2.2. Further or Continued Services

Once the client has been established in the provider agency's enriched life skills program, a curriculum should be presented to him or her.

B.27.2.2(a). Agencies shall have a written curriculum for enriched life skills or a formal outline of program services to be offered to each eligible client served and to be completed within 12 months.

B.27.2.2(b). The curriculum must contain:
(i). Clear goals
(ii). The method of evaluation to be used to monitor the client's progress.

B.27.2.2(c). Monitoring of each client's progress shall occur no less than monthly.

B.27.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.27.3.1. Licensing, Knowledge, Skills and Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.27.3.1(a). The agency shall maintain appropriate licensing and provide proof of having a current license to operate.

B.27.3.1(b). Staff and/or volunteers offering the enriched life skills training will possess the knowledge, including cultural sensitivity to the populations served, skills and experience necessary to competently perform expected services.

B.27.3.1(c). Direct service staff shall have, at minimum, a high school diploma or a general equivalency diploma (GED) and at least three years experience in working with clients in the HIV/AIDS service area. HIV/AIDS life experience may be substituted for two years working experience.

B.27.3.1(d). For programs that deliver services through a group process, staff members overseeing the program and supervising the direct service staff should have at least a college degree (B.A. or B.S.) and at least three years of progressively responsible positions within an AIDS service organization or working in HIV/AIDS services.

B.27.3.1(e). Staff holding supervisory responsibilities shall have good oral and written skills and be able to collect essential demographic and/or client-level data for required reports. Use of peer counselors is strongly encouraged in delivering either group or individual enriched life skills training.

B.27.3.1(f). Staff providing services must have good oral skills, must have accurate information and knowledge of HIV/AIDS, should be able to accept supervision, should be able to follow directions, should be capable of setting appropriate limits for themselves and others, should have the ability to turn their life experiences into teaching concepts, and should know resources to draw upon to present technical information, such as budgeting or negotiating with landlords.

B.27.3.1(g). The agency will have a training program for all staff and volunteers who are responsible for services to clients.

B.21.3.1(h). The agency must show evidence that all staff and volunteers attend in-service and specialized training on HIV and related topics.

B.27.3.2. Agency Responsibilities

Provider agencies must all follow certain administrative procedures in common, as follows:

B.27.3.2(a). The agency must have written policies regarding eligibility, confidentiality, grievance procedures, referral and linkage, agency expectations of clients, and termination policies.

B.27.3.2(b). The agency must maintain documentation that copies of policies have been given to each client seeking services.

B.27.3.2(c). The agency must ensure that each client receives an intake screening and an eligibility determination, and, if determined eligible, an initial assessment.

B.27.3.2(d). When appropriate, the agency staff shall refer clients to and link clients with other needed services.

B.27.3.2(e). The agency shall maintain documentation of client progress toward meeting established goals.

B.27.3.2(f). The agency shall ensure that the delivery of direct services is monitored for professional accountability through the following: regular and on-going team meetings or case conferences at least monthly; individual professional evaluations at least annually; and formal supervision (which may be peer supervised).

B.27.3.2(g). The agency shall have a consumer advisory board and maintain documentation of its meetings. That board shall meet at least quarterly and be made up of agency clients.

B.27.3.2(h). The agency must develop reasonable caseload standards or ratios and establish a priority system for acceptance of new cases.

B.27.3.2(i). If a waiting list exists, the agency must show evidence of a plan to attempt to communicate regularly with those clients on the list regarding their waiting-list status.

B.27.3.2(j). The agency must have written criteria for services; a fee structure; an intake process; and discharge, transfer and closing procedures. It must document that clients are informed of such.

B.27.3.3. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.27.3.3(a). Agencies must assure that there are policies and procedures for the protection of the rights and confidentiality of each client.

B.27.3.3(b). Agencies must show evidence of the client's knowledge of existing policies and procedures.

B.27.3.3(c). Agencies must show evidence of compliance with policies and procedures on the part of staff and volunteers.

B.27.3.3(d). Agencies must show evidence that duties are assigned only to persons who meet the minimum licensing, knowledge and/or educational requirements and who have the skills and experience to complete those duties.

B.27.3.4. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken. The agency must show:

B.27.3.4(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.27.3.4(b). Documentation of record reviews, both peer and supervisor.

B.27.3.4(c). Documentation of utilization review.

B.27.3.4(d). Documentation of the most recent site visit by the administrative agency.

B.27.3.4(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.27.3.4(f). Documentation of periodic data and narrative reports to the administrative agency.

B.27.3.4(g). Evidence of a process to solicit client satisfaction with services at least annually.

B.27.3.4(h). Evidence that it meets the service category standards and/or any applicable professional or federal practice standards.

B.28. Local/Consortium Drug Reimbursement Program

Origination: June 2003.

B.28.1. Service Definition

The local/consortium drug-reimbursement program is an on-going service or program to pay for approved pharmaceuticals and/or medications for persons with no other payment source. It is established, operated and funded locally to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond the state-operated Ryan White Title II program (or other state-funded drug-reimbursement program). The drug-reimbursement standards described herein incorporate the appropriate language from the Section 340B program. The Section 340B Drug Pricing Program was established in response to the passage of Section 340B of P.L. 102-585, the Veterans' Health Care Act of 1992. Section 340B of this law limits the cost of drugs to federal purchasers and to certain grantees of federal agencies. Significant savings on pharmaceuticals may be realized by those entities that participate in this program.

B.28.1.1. Key Services

Key services include:

B.28.1.1(a). Temporary service payment for medications for eligible consumers while their applications for state-administered AIDS Drug Assistance Program (ADAP) or other state-administered medication coverage programs are pending.

B.28.1.1(b). Temporary payment for medications during the period that consumers have lost eligibility for a state-administered program or other program that pays for medications.

B.28.1.2. Key Points

Key points of the program include:

B.28.1.2(a). Payment for medication may be an on-going service.

B.28.1.2(b). Medications covered are as stated in the Maryland AIDS Drug Assistance Program (MADAP) formulary (DHMH 2003). A current listing of medications can be obtained by accessing the MADAP web site at this Maryland Department of Health and Mental Hygiene URL: http://dhmh.state.md.us/AIDS/cvrdmeds.htm.

B.28.1.2(c). Medications not covered under this formulary will be paid for using the direct emergency financial assistance (vouchers) service category. (See section B.13 hereof.)

B.28.1.2(d). Agencies receiving funds through this service category are required to meet any and all conditions of the Section 340B Drug Pricing Program.

B.28.1.3. Excluded Services

The drug-reimbursement program does not include:

B.28.1.3(a). Medications dispensed during the course of a regular medical visit; medications administered during a regular medical visit, such as inoculations; medications that are considered part of the services provided during the regular medical visit; or medications provided or administered during an emergency medical visit.

B.28.1.3(b). Co-payments, which will be funded through the direct emergency financial assistance service category.

As used herein, the term "client" encompasses the terms "patient" and "service consumer."

B.28.2. Service Standards of Care

This section describes those service standards necessary for the provision of care under this category.

B.28.2.1. Baseline Evaluation

The baseline-evaluation period has two principal phases, as follows: intake and needs assessment.

B.28.2.1(a). *Intake* includes eligibility determination that is documented to ensure:
- (i). That the client is within the Ryan White income guidelines for the uninsured and underinsured for those with insurance but without prescription or medication coverage.
- (ii). That the client is HIV positive, with documentation of a viral load or a CD4 test within the previous six months.
- (iii). Completion of agency-required intake forms, where appropriate.
- (iv). Collection of demographic information, if relevant.

B.28.2.1(b). A statement of eligibility can be completed by the referring agency.

B.28.2.1(c). *Assessment* includes:
- (i). The review of services offered and discussion with the client of his or her needs.
- (ii). Determination of those drug-reimbursement services that are appropriate.
- (iii). Client participation in setting goals and developing a service plan.
- (iv). Signature by the client and the agency staff developing the service plan that indicates the scope of services and the agreement of both on the plan.

B.28.2.2. Further or Continued Services

Follow-up visits should adhere to the following protocols.

B.28.2.2(a). Follow-up visits should include:

(i). Review of the service plan.
(ii). Review of resources that might meet the consumer's need.
(iii). Follow-up on referrals to resources that provide prescription assistance, such as Maryland ADAP or Pharmacy Assistance, or to resources for co-payments or medications that are not covered by the formulary.

B.28.2.2(b). The staff should document services provided to the client:
(i). Following each visit where in-house pharmacies are filling prescriptions.
(ii). Upon the provision of services as shown by invoices from community pharmacies filling prescriptions.
(iii). Upon the provision of services as shown by invoices from other sources.

B.28.2.2(c). Drug-reimbursement services may be accessed by any individual client up to three times per year. Each access period must not exceed 60 days.

B.28.2.3(d). Agency staff and the client must review eligibility and make any appropriate changes to the care plan. Both shall re-sign the plan.

B.28.3. Administrative Standards of Care

This section describes the agency's minimum administrative requirements.

B.28.3.1. Licensing, Knowledge, Skills And Experience

Providers should be able to document the following in terms of licensing, knowledge and experience.

B.28.3.1(a). Drug-reimbursement providers will maintain current licenses required by the State of Maryland and, if there is an in-house pharmacy, must be registered through the state Board of Pharmacists.

B.28.3.1(b). Staff working with consumers/clients will possess the requisite knowledge, including cultural and linguistic sensitivity to the population served.

B.28.3.1(c). Staff will have the skills and experience necessary to competently perform expected services.

B.28.3.1(d). Staff will have experience and knowledge of HIV-related issues.

B.28.3.1(e). Staff should have access to consultation with practitioners who have extensive HIV experience.

B.28.3.1(f). Staff providing services will have regular and on-going team meetings or case conferences at least monthly.

B.28.3.1(g) Staff will have individual professional evaluations at least annually.

B.28.3.1(h) Formal supervision should be given by a staff member with a bachelor's degree, a licensed social worker or nurse case manager.

B.28.3.2. Agency Responsibilities

Provider agencies must all follow certain administrative procedures in common, as follows:

B.28.3.2(a). If the agency has an in-house pharmacy, the agency must have written policies that demonstrate its compliance with the Section 340B cost-savings requirement.

B.28.3.2(b) If the agency uses community pharmacies, it must have written policies that demonstrate its compliance with the Section 340B requirements, such as formal agreements with pharmacies that are Section 340B certified or referral and payment documentation that shows use of the appropriate pharmacies to serve the client's prescription needs.

B.28.3.2(c) The agency must have written policies regarding eligibility, confidentiality, grievance procedures, referrals and linkages, agency expectations of clients, and termination policies.

B.28.3.2(d). The agency must maintain documentation that copies of policies have been given to the clients seeking services.

B.28.3.2(e). The agency must ensure that each client receives an intake screening, an eligibility determination and, for eligible clients, an initial assessment.

B.28.3.2(f). When appropriate, the agency staff shall refer and link clients with other needed services.

B.28.3.2(g). The agency shall maintain documentation of client participation in setting goals or developing a service plan.

B.28.3.2(h). The agency shall maintain documentation of the client's progress toward meeting established goals.

B.28.3.2(i). The agency shall ensure that the delivery of direct services is monitored for professional accountability.

B.28.3.2(j). The agency is responsible for ensuring that staff providing drug reimbursement meets all the qualifications to maintain their licenses, if they have professional licenses.

B.28.3.3. Client Rights and Confidentiality

Providers should be able to document the following in terms of clients' rights and confidentiality.

B.28.3.3(a). Service providers of drug reimbursement must show written policies and procedures on the protection of the rights and confidentiality of each client, which must be consistent with HIPAA guidelines.

B.28.3.3(b). Service providers of drug reimbursement must show evidence in existing records or files that clients have knowledge of policies and procedures.

B.28.3.3(c). Service providers of drug reimbursement must show evidence that existing records or files containing client information are secured and protected.

B.28.3.3(d). Service providers of drug reimbursement must show evidence in existing records of clients' consent for release of information to other service providers and evidence that shows client consent to secure information from other providers.

B.28.3.4. Access, Care and Provider Continuity

Providers should be able to document the following in terms of access, care and provider continuity.

B.28.3.4(a). Drug-reimbursement services should be provided on an as-needed basis.

B.28.3.4(b). The supervisory or administrative staff is responsible for reviewing services at least annually to ensure that the service program meets standards.

B.28.3.4(c). The agency will have a training program for all staff and volunteers who are responsible for services to clients.

B.28.3.4(d). The agency must show evidence that all staff and volunteers attend in-service and specialized training on HIV and related topics as least annually.

B.28.3.4(e). The agency shall have a consumer advisory board and maintain documentation of meetings.

B.28.3.4(f). The consumer advisory board shall meet at least quarterly and be made up of agency clients.

B.28.3.4(g). The agency must develop reasonable caseload standards or ratios and establish a priority system for acceptance of new cases.

B.28.3.4(h). If a waiting list exists, the agency must show evidence of a plan to attempt to communicate regularly with those clients on the list regarding their waiting-list status.

B.28.3.4(i). The agency must have written criteria for services; a fee structure; an intake process; and discharge, transfer and closing procedures as well as documentation that clients are informed of such elements.

B.28.3.4(j). The agency is responsible for ensuring that services are provided within these guidelines; services may be accessed by any individual client up to three times per year, and each access period must not exceed 60 days.

B.28.3.5. Quality Assurance

Providers should have a written quality-improvement (-assurance) activity that identifies areas for improvement and the subsequent actions taken. The agency must show:

B.28.3.5(a). An overall mechanism or quality-assurance plan designed to monitor both appropriateness and effectiveness of all services provided.

B.28.3.5(b). Documentation of care plan reviews, both peer and supervisory.

B.28.3.5(c). Documentation of utilization review.

B.28.3.5(d). Documentation of the most recent site visit by the administrative agency.

B.28.3.5(e). Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

B.28.3.5(f). Documentation of periodic data and narrative reports to the administrative agency.

B.28.3.5(g). Documentation of a process to solicit client satisfaction with services at least annually.

B.28.3.5(h). Documentation that it meets the service category standards and/or any applicable professional or federal practice standards.

B.28.4. Summary

This subsection provides miscellaneous further information on this service.

B.28.4.1. Recommendations

None.

B.28.4.2. References and Further Sources

State of Maryland, Department of Health and Mental Hygiene, AIDS Administration. 2003. "Covered Medications." Available at Internet site (http://dhmh.state.md.us/AIDS/cvrdmeds.htm), downloaded October 19, 2003.

PART C:

CONCLUSION

C.1. Glossary of Terms and Acronyms

AA: Administrative agency. In the Baltimore EMA, the administrative agency for Title I CARE Act programs is a private non-profit corporation, Associated Black Charities, Inc. ABC is contracted by the Baltimore City Health Department, in its capacity as Title I grantee, to disburse funds to, and monitor the contract performance of, service providers within the EMA that received Title I funds.

ABC: Associated Black Charities, Inc. See "AA: administrative agency."

ADAP: AIDS Drug Assistance Program.

AETC: AIDS Education and Training Center, a program created as part of the Ryan White CARE Act and consisting of a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers.

AHA: American Heart Association.

AIDS: Acquired immune deficiency syndrome.

ARV: Antiretroviral, used to combat retroviruses, such as HIV.

AZT: Azido-Thymidine, an AIDS medication.

B.A.: Bachelor of arts degree.

BCHD: Baltimore City Health Department, the "grantee" for Ryan White Title I funds coming into the EMA, that is, the initial recipient of the funds.

BIA: Bioelectric impedance analysis.

Bid: Bis in die, a Latin phrase meaning "twice a day."

B.S.: Bachelor of science degree.

BSAS: Baltimore Substance Abuse Systems, Inc.

B.S.W.: Bachelor of social work degree.

CARE Act: Comprehensive AIDS Resources Emergency Act, also known as the Ryan White CARE Act. This federal statute is designed to improve the quality and availability of care for individuals and families affected by HIV/AIDS; it is now the largest source of funding for HIV programs in the nation.

CASP: Critical Appraisal Skills Program, a certified program on substance abuse and treatment.

CBC (1): Complete blood count, the determination of the quantity of each type of blood cell in a given sample of blood, often including the amount of hemoglobin, the hematocrit, and the proportions of various white cells. Also called blood profile.

CBC (2): Congressional Black Caucus, a grouping of African-American members of Congress.

CDC: Centers for Disease Control and Prevention, a federal agency whose mission is to promote health and quality of life by preventing and controlling disease, injury and disability. The CDC is the agency responsible for tracking diseases that endanger public health, such as HIV.

CD4: Cluster of differentiation 4, a large glycoprotein that is found on the surface of T4 cells and is the receptor for HIV.

Chem 7: A battery of 7 chemical tests performed on serum (the portion of blood without cells).

CME: Continuing medical education.

CMV: Cytomegalovirus, any of a group of herpes viruses that attack and enlarge epithelial cells, which form the membranous tissue that forms the covering of most of the internal and external surfaces of the body and its organs.

COMAR: Code of Maryland Regulations, available at the Office of the Secretary of State, State of Maryland, Internet site (https://constmail.gov.state.md.us/comar/dsd_web/comar_web/comar.htm).

CPR: Cardio-pulmonary resuscitation.

DHHS: U.S. Department of Health and Human Services.

DHMH: Maryland Department of Health and Mental Hygiene.

DNA: Deoxyribonucleic acid.

DNR: Do not resuscitate.

EFA: Emergency financial assistance.

EMA: Eligible metropolitan area, a designation used by the Ryan White CARE Act to identify an area eligible for funds under Title I of the CARE Act, which provides moneys for aid to metropolitan areas hardest hit by HIV. The Baltimore EMA consists of the following jurisdictions: Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties.

GED: General equivalency diploma, a high-school equivalency degree typically earned by those who have dropped out of school or otherwise discontinued their education.

Grantee: The recipient of federal funds. In the context of the CARE Act, the term generally refers to the initial recipients of funds under Titles I and II of the act. In Maryland, the Title I grantee is the Baltimore City Health Department, acting for the mayor; the Title II grantee is the Maryland AIDS Administration. The grantee need not be the same entity as the administrative agency. Within the Baltimore EMA, the grantee has contracted Associated Black Charities to serve as the administrative agency, the latter thus being the entity that actually disburses funds to service providers.

HAART: Highly active antiretroviral therapy, treatment with a potent drug "cocktail" to suppress the growth of HIV.

HACCPS: Hazard analysis critical control point standards, standards for food preparation.

HIPAA: Health Insurance Portability and Accountability Act of 1996, a federal statute that, among other things, protects the confidentiality of individual patient records.

HIV: Human immunodeficiency virus.

HOPWA: Housing Opportunities for People with AIDS, a federal program of the Department of Housing and Urban Development that provides housing assistance and supportive services for low-income people with HIV/AIDS and their families.

HRSA: Health Resources and Services Administration, a division of the U.S. Department of Health and Human Services.

IgG: Immunoglobulin G, the most abundant class of antibodies found in blood serum and lymph and active against bacteria, fungi, viruses and foreign particles. Immunoglobulin G antibodies trigger action of the complement system.

IPV: Inactivated poliovirus vaccine.

IGS: InterGroup Services, Inc. See "PCSO: planning council support office."

JCAHO: Joint Commission on Accreditation of Healthcare Organizations.

J.D.: Juris doctor degree.

LFT: Liver function test.

LMP: Last menstrual period.

MADAP: Maryland AIDS Drug Assistance Program.

MMWR: Morbidity and Mortality Weekly Report, a regular publication of the CDC that reports on disease surveillance and trends.

M.S.W.: Master of social work degree.

MTCT: Mother to child transmission.

NEJM: New England Journal of Medicine, a leading medical journal.

NIDA: National Institute on Drug Abuse.

OETAS: Office of Education and Training for Addictions.

OI: Opportunistic infection.

OPV: Oral poliovirus vaccine.

Pap smear: A test for cancer, especially of the female genital tract, in which a smear of exfoliated cells is specially stained and examined under a microscope for pathological changes. The name is derived from that of George Papanicolaou (1883-1962), the American physician who devised the test.

PCP (1): Pneumocystis carinii pneumonia.

PCP (2): Primary-care physician.

PCR: Polymerase chain reaction, a technique for amplifying DNA sequences in vitro by separating the DNA into two strands and incubating it with oligonucleotide primers and DNA polymerase. It can amplify a specific sequence of DNA by as many as one billion times and is important in biotechnology, forensics, medicine and genetic research.

PCSO: Planning council support office, an entity providing administrative and managerial services to a planning council, the latter not being an incorporated entity in its own right. The planning council support office may be public or private sector. In the Baltimore EMA, the Baltimore City Health Department, the grantee, has contracted an independent management consulting organization, InterGroup Services, Inc., to provide this service.

P.L.: Public law. The "P.L." prefix is added to the numerical designation of a particular congressional legislative act once it has been passed and signed into law by the president.

PLWH/A: People (or person) living with HIV/AIDS.

PMC: Primary medical care.

Po: Per os, a Latin phrase meaning "by mouth" or orally.

PPD Test: Purified protein derivative test, a tuberculin skin test.

PPT: Partial prothrombin time, a blood clotting test.

PT: Prothrombin time, a blood clotting test.

Qid: Quater in die, a Latin phrase meaning "four times a day."

RNA: Ribonucleic acid, any of various nucleic acids that are associated with the control of cellular chemical activities.

Rx: Radix, literally "root" in Latin, but now used as an abbreviation for "prescription," reflecting the fact that in pre-modern times, prescriptions were often made of crushed roots.

SIL: Squamous intraepithelial lesion, a general term for the abnormal growth of squamous cells on the surface of the cervix. Squamous cells are flat, fish-like cells that make up most of the outer layer of the skin (the epidermis), the passages of the respiratory and digestive tracts, and the linings of the hollow organs of the body.

SSES: Social Security entitlement services.

SSDI: Social Security Disability Insurance, a federal social insurance program for disabled people.

SSI: Supplemental Security Income, a federal income support program for low-income disabled people.

Sx: Symptoms.

T4: Any of the T cells (as a helper T cell) that bear the CD4 molecular marker and become severely depleted in AIDS.

TB: Tuberculosis.

Tid: Ter in die, a Latin phrase meaning "three times a day."

TMP: Trimethyl phosphate.

TMP-SMX: Trimethprim-sulfamethoxazole.

URL: Uniform resource location, the technical name for an Internet address.

USRDA: U.S. Recommended Daily Allowance, a nutritional standard set by the federal government.

VL: Viral load.

WIC: Supplementary Food Program for Women, Infants and Children, a federal nutrition-support program for low-income women, infants and children (and, recently, youth, too).

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