

Ryan White Program Service Delivery Guidelines Fiscal Year 2011-2012 (Year 21)

Section III –

- **Ryan White Program System-wide Standards of Care**
- **Ryan White Program Case Management Standards of Service**
- **National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care**
- **HAB HIV Performance Measures (web links to the following measures):**
 - **Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3**
 - **Medical Case Management**
 - **Oral Health Services**
 - **Systems-Level**
 - **Pediatrics**
- **Ryan White Program Minimum Primary Medical Care Standards for Chart Review**
- **Ryan White Program Oral Health Care Standards**
- **Treatment Guidelines & Additional Service Delivery Standards**



***Miami-Dade County
Office of Grants Coordination***

MIAMI-DADE COUNTY RYAN WHITE PROGRAM



SYSTEM-WIDE STANDARDS OF CARE

(Revised March 1, 2011)

Table of Contents

<i>Standard #1: No Barriers to Service.....</i>	<i>Page 1</i>
<i>Standard #2: Staff Qualifications/Training.....</i>	<i>Page 3</i>
<i>Standard #3: Documentation Standards.....</i>	<i>Page 5</i>
<i>Standard #4: Quality Assurance/Performance Improvement.....</i>	<i>Page 7</i>
<i>Standard #5: Confidentiality.....</i>	<i>Page 9</i>
<i>Program Operating Requirements (POR).....</i>	<i>Page 10</i>
<i>POR: Facility/Operation Requirements.....</i>	<i>Page 11</i>
<i>POR: Accreditation Standards.....</i>	<i>Page 13</i>
<i>POR: Client Acknowledgement of Services Received.....</i>	<i>Page 13</i>
<i>POR: Service Delivery Information System (SDIS).....</i>	<i>Page 14</i>

**MIAMI-DADE COUNTY
RYAN WHITE PROGRAM
SYSTEM-WIDE STANDARDS OF CARE**

The following sets of standards are an essential component of the Ryan White Program's quality management program and form the basis for on-going monitoring and evaluation of Ryan White Program-funded service providers by the Miami-Dade County Office of Grants Coordination and/or its authorized representatives. With the exception of staff qualifications (Standard #2), it is not expected that *newly* contracted organizations be in full compliance with the System-Wide Standards of Care at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. However, all providers are expected to maintain full compliance at all times with documentation of client eligibility (*Standard #3*).

SYSTEM-WIDE STANDARDS OF CARE

No Barriers to Service

Standard #1

Client access to services, system wide, shall be facilitated and barriers to service eliminated.

Guidelines	Indicator	Data Source
<p>(1.1 – 1.5) Providers shall eliminate barriers to service caused by: (A) hours of operation, (B) language and culture, and/or (C) lagtime. <i>Exemptions: (A) All services not specified (B) None (C) 1.5 None; (C) 1.6 Prescription Drugs, Medical Case Management, MAI Medical Case Management</i></p>	<p>A: Hours of Service:</p> <p>1.1 Medical care, pharmaceuticals, and medical case management shall provide a minimum of 40 hours access to services per week including 4 hours outside of regular business hours (9:00 am – 5:00 pm, Monday-Friday). Outpatient medical care and oral health care providers will offer, post, and maintain daily walk-in slots to accommodate clients with urgent/emergent health issues.</p>	<ul style="list-style-type: none"> ➤ Scope of Service Description ➤ Posted hours of service
	<p>1.2 24-hour on-call access to pharmaceutical services, emergency medical and oral health care, and crisis counseling</p>	<ul style="list-style-type: none"> ➤ Scope of Service Description ➤ Posted hours of service
	<p>B: Language:</p> <p>1.3 Agencies must offer and provide language assistance services, including bilingual staff and interpreter services (including Spanish and Haitian Creole) at no cost to each client with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.</p>	<ul style="list-style-type: none"> ➤ Record Review ➤ Personnel Files ➤ Observation ➤ Written Policies and Procedures ➤ Invoices (reviewed during on-site visit)
	<p>1.4 Agencies must provide to clients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.</p>	<ul style="list-style-type: none"> ➤ Observation ➤ Personnel Files ➤ Record Review

Guidelines	Indicator	Data Source
	<p>1.5 Agencies must assure the competence of language assistance provided to limited English proficient clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except when requested by the client)</p> <p>1.6 Interpreters for hearing impaired and special assistance for those requiring such (as visually impaired persons) shall be made available</p> <p>1.7 Agencies should ensure that clients receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language</p> <p>C: Lagtime:</p> <p>1.8 80% of clients will see a core service worker no later than 5 workdays from the client's initial date of contact or date of medical case management referral</p> <p>1.9 80% of clients initially presenting at a non-case management agency shall be referred to a medical case management agency no later than 2 workdays from the date of initial contact with the referring agency</p>	<ul style="list-style-type: none"> ➤ Observation ➤ Personnel Files ➤ Record Review <ul style="list-style-type: none"> ➤ Record Review <ul style="list-style-type: none"> • Intake information including date of initial contact or copy of referral • SDIS referral report

Staff Qualifications/Training

Standard #2

Agencies shall ensure that all staff has sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population: agencies must provide initial orientation and training for new staff and ensure all staff participate in ongoing HIV/AIDS trainings, thereby promoting provision of high quality, up-to-date services.

Guidelines	Indicator	Data Source
<p>(2.1 – 2.2) Supervisory staff and core service staff shall meet the qualifications of education and experience required by the Miami-Dade County Office of Grants Coordination and the Miami-Dade HIV/AIDS Partnership. Agencies should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. <i>Exemptions: 2.1 None; 2.2 Home Delivered Meals, Food Bank, Transportation Vouchers, Prescription Drugs, Medical Case Management (Refer to Case Management Standards for education/experience requirements).</i></p>	<p>2.1 Core service supervisors are licensed and/or have a bachelor’s degree in social sciences, counseling or nursing; have management experience; or have equivalent HIV/AIDS or related experience</p> <p>2.2 Core service staff have an associate degree (AA) in social sciences, counseling or nursing, HIV/AIDS or related experience, including living with HIV, may be substituted on a year-for-year basis. Exempt personnel must be supervised by staff that meets minimum supervisory qualifications (2.1)</p>	<p>➤ Personnel Files</p> <ul style="list-style-type: none"> • Copies of degrees/licenses • Documentation of work experience (letters of recommendation, work references, etc) <p>➤ Personnel Files</p> <ul style="list-style-type: none"> • Copies of degrees/licenses • Documentation of work experience, HIV/AIDS experience (letters of recommendation, work references, training certificates, etc.) • Personnel Records
<p>(2.3) Initial orientation and training shall be given to new staff. <i>Exemptions: None</i></p>	<p>2.3 Documentation of initial orientation and training including Ryan White Program services, standards and requirements</p>	<p>➤ Personnel Files</p> <ul style="list-style-type: none"> • Signed, dated orientation schedule or Orientation Attendance Log • Signed, dated Ryan White Program standards or form acknowledging training/receipt of same
<p>(2.4) Staff members will have a clear understanding of their job definition and responsibilities. <i>Exemptions: None</i></p>	<p>2.4 Written job description including responsibilities</p>	<ul style="list-style-type: none"> • Signed, dated job description

Guidelines	Indicator	Data Source
<p>(2.5 – 2.6) Policies and procedures for service provision shall be in written form and made available to all staff. <i>Exemptions: None</i></p> <p>(2.7) Training in OSHA and universal precautions appropriate to job duties is provided and staff adheres to these principles.</p> <p>Agencies should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery <i>Exemptions: None</i></p>	<p>2.5 Written Policies and Procedures (P & P's)</p> <p>2.6 Documentation that staff have read and are familiar with P & P's</p> <p>2.7 Documentation of training</p>	<ul style="list-style-type: none"> ➤ Administrative Policies and Procedures ➤ Personnel Records <ul style="list-style-type: none"> • Signed, dated agency policies and procedures • Signed, dated letter documenting P&P review, understanding ➤ Signed, dated training acknowledgement, attendance logs with dates and subject matter of training, agency training logs ➤ Signed, dated Ryan White Program standards or form acknowledging receipt/training on same
<p>(2.8) Core service staff is knowledgeable about Ryan White Program standards and service requirements. <i>Exemptions: None</i></p>	<p>2.8 Annual update on Ryan White Program standards and service requirements</p>	<ul style="list-style-type: none"> ➤ Personnel Records <ul style="list-style-type: none"> • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training
<p>(2.9) Staff shall remain updated on HIV/AIDS information. <i>Exemptions: None</i></p>	<p>2.9 At least once annually: core service staff shall attend an HIV/AIDS seminar/training appropriate to their level of service delivery</p>	<ul style="list-style-type: none"> ➤ Agency training record
<p>(2.10) Personnel working with children are to be screened in accordance with state or local laws. <i>Exemptions: None</i></p>	<p>2.10 Clearance letters for abuse and criminal screening</p>	<ul style="list-style-type: none"> ➤ Personnel files

Documentation Standards

Standard #3

Standardized forms and consistent up-to-date protocols will be utilized across the system to ensure uniform quality of care.

Guidelines	Indicator	Data Source
<p>(3.1 – 3.12) Documentation for intake and service provision shall include, at a minimum, standard forms and required client data. The treatment or care plan shall be unique for each client, culturally sensitive, non-judgmental, personalized and with an appropriate standard of care and with respect to a person’s right to privacy.</p>	<p>Record contains: 3.1 Financial assessment and proof of HIV OR a Ryan White Program Certified Referral 3.2 Eligibility screening for third party payers 3.3 Consent for enrollment/treatment OR a Ryan White Program Certified Referral 3.4 Consent to Release and Exchange Information (SDIS) OR a Ryan White Program Certified Referral 3.5 Intake history (Client demographics and personal contact information) 3.6 Documentation that client confidentiality is explained 3.7 Documentation that grievance procedure is explained 3.8 Documentation that choice of providers is explained 3.9 Service provision history 3.10 Treatment/Service Plan documenting reason(s) for treatment, process and progress, outcomes of treatment 3.11 Treatment/Service Plan update at least once per year <i>Note: Medical Case Managers are required to update Program Certified Referrals (Recertification) every 6 months dependent on service category</i> 3.12 SDIS Notice of Privacy Practices</p>	<p>➤ Record Review</p> <ul style="list-style-type: none"> • All required forms are complete, initialed, dated, signed as appropriate • Copies of required eligibility documents are present, current (within 6 months), and legible • Documentation of eligibility screening for third party payers is present • Cases are closed as appropriate

Guidelines	Indicator	Data Source
<p>(3.13 – 3.17) Referrals: Providers must maintain adequate documentation on referral activities. <i>Exemptions: None</i></p>	<p>3.13 Inbound referrals for all Ryan White Program Certified Referrals, shall record origin of referral and service requested</p> <p>3.14 Outbound referrals for all Ryan White Program Certified Referrals shall record the referral destination and service requested, must have an end date, and will note the type of service referred to (e.g., medical, nutrition)</p> <p>3.15 All inbound referrals filed in client record</p> <p>3.16 Service referrals not initiated by a medical case manager shall be documented in a progress note or treatment plan</p> <p>3.17 Out of network referrals require a completed general referral form with supporting documents as relevant (e.g., proof of HIV, proof of residency, proof of income); original referral shall be kept in client's chart and a copy will be given to the service provider by the client and/or by the referring out of network case manager</p>	<ul style="list-style-type: none"> ➤ SDIS Referral Report ➤ Record Review
<p>(3.18 – 3.20) Providers must avail themselves of all other available resources to provide needed services to HIV/AIDS clients including the Ryan White service network, key points of service entry, city, state and private organizations. <i>Exemptions: None</i></p>	<p>3.18 Linkage agreements</p> <p>3.19 Service resources</p> <p>3.20 Inbound, Outbound Referrals</p>	<ul style="list-style-type: none"> ➤ Administrative Records ➤ Lists of Service Resources ➤ SDIS Referral Report

Quality Assurance/Performance Improvement

Standard #4

Ongoing quality assurance activities with regular feedback to core service staff promote performance improvement and quality care.

Guidelines	Indicator	Data Source
<p>(4.1 – 4.4) Supervisory record reviews are conducted regularly, with feedback to core service staff resulting in improved performance. <i>Exemptions: None</i></p>	<p>4.1 Record reviews will be conducted and submitted to Behavioral Science Research on a quarterly basis</p> <p>4.2 No less than 20 records or 10% of Ryan White Part A or MAI population (whichever is less)</p> <p>4.3 Evidence of feedback between supervisor and employee</p> <p>4.4 Documentation review ensures Ryan White eligibility standards are met and that case notes are appropriate, timely, and legible</p>	<ul style="list-style-type: none"> ➤ Supervisor’s Records <ul style="list-style-type: none"> • Documentation of reviews with identifying client information • Documentation of employee feedback ➤ Record Review ➤ Review submission ➤ Personnel file
<p>(4.5) Medical Services: Quality assurance or patient care review meetings will identify problems to be resolved through action. <i>Exemptions: None</i></p>	<p>4.5 Documentation of quarterly patient care reviews or quality assurance meetings recording attendance, date, subject matter, steps taken to resolve identified problems with time frames for resolution.</p>	<ul style="list-style-type: none"> ➤ Meeting minutes ➤ Attendance logs
<p>(4.6) Non-Medical Services: Quality improvement issues will be addressed through staff meetings. <i>Exemptions: None</i></p>	<p>4.6 Documentation of quarterly quality improvement meetings recording attendance, date, subject matter, steps taken to resolve identified problems with times frames for resolution.</p>	<ul style="list-style-type: none"> ➤ Meeting minutes ➤ Attendance logs

Guidelines	Indicator	Data Source
<p>(4.7 – 4.8) Annual client satisfaction survey conducted and results utilized as appropriate to improve service delivery. <i>Exemptions: None</i></p> <p>(4.9 - 4.12) Agencies should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction assessments, and outcome-based evaluations.</p>	<p>4.7 Client satisfaction survey to include: Rating of services, perception of treatment by staff, satisfaction with services provided, fair access to services provided.</p> <p>4.8 Written plans and objectives incorporate results as appropriate from client satisfaction surveys.</p> <p>4.9 Updated and clearly displayed mission statement to include a commitment to the delivery of culturally and linguistically competent services</p> <p>4.10 Agency information and educational material available in English, Spanish and Creole translated from the appropriate cultural perspective</p> <p>4.11 Appropriate number of bilingual staff (or a current directory of interpreters) able to provide services in the predominant language(s) of the agency's clients</p> <p>4.12 Percentage of clients served in their preferred language</p>	<ul style="list-style-type: none"> ➤ Review of client satisfaction survey ➤ Client Satisfaction Survey ➤ Administrative records ➤ Record Review ➤ Personnel file ➤ Quality Management Plan ➤ Client satisfaction survey addresses delivery of services in a culturally and linguistically appropriate manner ➤ Written policies and procedures ➤ Observation

Confidentiality

Standard #5

Every agency shall provide staff with initial and ongoing training regarding client confidentiality to ensure client information is protected in accordance with state and federal laws.

Guidelines	Indicator	Data Source
<p>(5.1 – 5.2) Every agency shall have a written Policy and Procedure (P & P) addressing confidentiality. <i>Exemptions: None</i></p> <p>(5.3) Services shall be provided in a confidential setting. <i>Exemptions: None</i></p> <p>(5.4) All hard copy materials and records shall be securely maintained.</p> <p>(5.5) All clients shall be informed regarding their rights to confidentiality. <i>Exemptions: None</i></p> <p>(5.6) No release of client information without a signed, dated client release. <i>Exemptions: None</i></p>	<p>5.1 Written P & P addressing HIV confidentiality and agency procedures, including policies and procedures that limit access to passwords, electronic files, medical records, faxes, release of client information</p> <p>5.2 P & P is signed and dated annually by staff</p> <p>5.3 Areas in which client contact occurs allow exchange of confidential information in a private manner.</p> <p>5.4 Records, hard copy materials maintained under double lock in files and in areas secure from public access.</p> <p>5.5 Documentation signed and dated by client acknowledging client has been fully informed of his/her right to confidentiality.</p> <p>5.6 Signed, dated Release of Information* specific to HIV, TB, STD, substance abuse and mental health OR note reflecting client’s unwillingness to sign a Release.</p> <p><i>* This release shall be renewed annually.</i></p>	<ul style="list-style-type: none"> ➤ Administrative P & P’s ➤ Personnel files <ul style="list-style-type: none"> • Signed, dated copy of P & P for all staff ➤ Observation ➤ Observation ➤ Record review ➤ Record Review

Program Operating Requirements (POR)

POR #1	Indicator	Data Source
(POR 1.1 – 1.3) Agencies must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area. <i>Exemptions: None</i>	The following shall be posted in an area to which clients have free access: POR 1.1 Hours of operation POR 1.2 Grievance procedures POR 1.3 Client’s Bill of Rights and Responsibilities	➤ Observation

POR #2	Indicator	Data Source
(POR 2.1) Computer and backup systems are kept current. <i>Exemptions: None</i>	POR 2.1 Computer and backup systems are updated at least weekly	➤ Record Review ➤ SDIS

POR #3	Indicator	Data Source
(POR 3.1– 3.4) Client participation and education in the treatment process shall be maximized. <i>Exemptions: None</i>	Documentation shall reflect: POR 3.1 Client and family (as defined by client) participation in care decisions POR 3.2 Development of client’s understanding of treatment options POR 3.3 Client empowerment POR 3.4 Monitoring of client adherence to prescribed plans of treatment and care including medication regimens	➤ Record Review • Progress Notes • Treatment/Care Plans
(POR 3.5) Client education and knowledge lead to improved compliance, health status. <i>Exemptions: None</i>	POR 3.5 Documentation of client education and/or resources provided, as appropriate	

POR: Facility/Operation Requirements

POR #4	Indicator	Data Source
(POR 4.1 – 4.7) All provider sites are safe and secure. <i>Exemptions: None</i>	POR 4.1 Site is clean and well-maintained, inside and out	➤ Observation
	POR 4.2 Clients have untroubled access coming and going	
	POR 4.3 Security personnel are available as needed	➤ Personnel Records
	POR 4.4 Written policy to refuse service to clients who are being verbally abusive, threatening physical abuse or possessing illegal substances or weapons on provider property	➤ Administrative Policies and Procedures
	POR 4.5 Facility complies with applicable Occupational Safety and Health Administrative (OSHA) requirements	➤ Observation
	POR 4.6 Facility complies with the American's with Disability Act's programmatic and accessibility requirements	➤ Observation
	POR 4.7 Facility complies with the Domestic Violence Leave requirements	

POR #5	Indicator	Data Source
(POR 5.1) Client access to care will be facilitated during regular hours and after hours. <i>Exemptions: As noted in Standard 1.1</i>	POR 5.1 Written P & P addresses contacts (including appointments) during regular hours and walk-ins, emergency and after hours care.	➤ Administrative Policies and Procedures <i>(Refer to Standard #1.1)</i>

POR #6	Indicator	Data Source
<p>(POR 6.1 – 6.2) Agencies shall provide an explanation of the agency's grievance procedures and confirm clients' understanding of such. Conflict and grievance resolution processes shall be culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients. <i>Exemptions: None</i></p>	<p>POR 6.1 Written P & P's addressing formal and informal grievance procedures for clients</p> <p>POR 6.2 Documentation that client has had grievance procedures, formal and informal explained and/or given to him/her and understands same.</p>	<ul style="list-style-type: none"> ➤ Administrative Policies and Procedures ➤ Record Review

POR #7	Indicator	Data Source
<p>(POR 7.1 – 7.2) Agency policies are known to staff and supervisors. <i>Exemptions: None</i></p>	<p>POR 7.1 Written P & P's addressing agency procedures including a formal grievance procedure for staff.</p> <p>POR 7.2 Documented acknowledgement that staff are familiar with written P & P's, including grievance procedures.</p>	<ul style="list-style-type: none"> ➤ Administrative Policies and Procedures ➤ Personnel Records

POR: Accreditation Standards

POR #8	Indicator	Data Source
(POR 8.1) Agency complies with appropriate professional licensing in accordance with professional training and responsibilities of caregivers, the agency's functions, or both, through national associations and/or the Florida Department of Health. <i>Exemptions: None</i>	POR 8.1 Current licenses, accreditations are posted and on file	<ul style="list-style-type: none"> ➤ Administrative Records ➤ Observation
(POR 8.2) Staff are licensed as specified in the Ryan White Program Service Descriptions. <i>Exemptions: None</i>	POR 8.2 Copies of current licenses are on file	<ul style="list-style-type: none"> ➤ Personnel Records

POR: Client Acknowledgement of Services Received

POR #9	Indicator	Data Source
(POR 9.1) Client acknowledgement of service(s) received and cost shall be maintained.	POR 9.1 Client shall acknowledge by signature and date, specified services and cost of services received at each visit. Required information includes client name, date of service, definition of unit, service provided, and number of units.	<ul style="list-style-type: none"> ➤ Record Review <ul style="list-style-type: none"> • Signed, dated logs with name and services received noted OR ➤ Billing Review <ul style="list-style-type: none"> • Signed, dated encounters or superbills with name and services received noted OR • Receipt given to client with a copy in the chart <i>(Refer to POR #1.4)</i>

POR: Service Delivery Information System (SDIS)

POR # 10	Indicator	Data Source
(POR 10.1 – 10.2) Timely entry into the SDIS of new client information, updated client information and of services provided. <i>Exemptions: None</i>	POR 10.1 New client information shall be entered at intake POR 10.2 Updated client information and service information shall be entered in accordance with time specifications as detailed in the current Ryan White Program contract	<ul style="list-style-type: none"> ➤ Record Review ➤ SDIS

POR #11	Indicator	Data Source
(POR 11.1) A record (client chart) shall be maintained for each individual client	POR 11.1 An individual record (chart) shall be maintained for each client that records the services provided by the Ryan White Program.	<ul style="list-style-type: none"> ➤ Record Review

MIAMI-DADE COUNTY RYAN WHITE PROGRAM



MEDICAL CASE MANAGEMENT STANDARDS OF SERVICE

(Revised March 1, 2011)

Table of Contents

<i>Standard #1: Staff Qualifications.....</i>	<i>Page 1</i>
<i>Standard #2: Training.....</i>	<i>Page 2</i>
<i>Standard #3: No Barriers to Service.....</i>	<i>Page 3</i>
<i>Standard #4: Eligibility and Financial Assessment.....</i>	<i>Page 4</i>
<i>Standard #5: Initial Client Assessment and Plan of Care.....</i>	<i>Page 5</i>
<i>Standard #6: Referrals/Follow-up.....</i>	<i>Page 7</i>
<i>Standard #7: Updates to Client Record.....</i>	<i>Page 8</i>
<i>Standard #8: Documentation Standards.....</i>	<i>Page 9</i>
<i>Standards #9 and #10: Quality Assurance/Performance Improvement.....</i>	<i>Pages 10 & 11</i>
<i>Standard #11: Service Delivery Information System (SDIS).....</i>	<i>Page 11</i>
<i>Standard #12: Advance Directives.....</i>	<i>Page 12</i>
<i>Standard #13: Case Closure/Case Transfer.....</i>	<i>Page 12</i>
<i>Program Specific Operating Requirements.....</i>	<i>Page 13</i>

**MIAMI-DADE COUNTY
RYAN WHITE PROGRAM
MEDICAL CASE MANAGEMENT STANDARDS OF SERVICE**

In addition to the System-wide Standards of Care applicable to all Part A and Minority AIDS Initiative (MAI)-funded providers, the following program specific standards apply to **medical case management providers only**. These standards are an essential component of the Ryan White quality management program and form the basis on-going monitoring and evaluation of Part A and MAI-funded medical case management providers by the Miami-Dade County Office of Grants Coordination.

With the exception of staff qualifications (*Standard #1*), it is not expected that contracted organizations be in full compliance with the Medical Case Management Standards of Service at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. However, all providers are expected to maintain full compliance at all times with the standards for documentation of client eligibility (*Standards #4 & #7*).

Medical case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring, and evaluating available options and services. Medical case management addresses situational needs and promotes continuity of care for the client. Medical case management is predicated upon client empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services. Medical case management addresses the needs of both individual and family entities, including both adults and children.

The purpose and goals of medical case management are: 1) to maintain the client in on-going medical care and treatment; 2) to coordinate services across funding streams; 3) to reduce service duplication across providers; 4) to assist the client with accessing needed services; 5) to use available funds and services in the most efficient and effective manner; 6) to increase the client's adherence to the care plan (i.e., including coordination and follow-up of medical treatment and the medication regimen) through counseling; 7) to empower clients to remain as independent as possible; 8) to improve service and client health outcomes; and 9) to control costs while ensuring that client needs are properly addressed.

Staff Qualifications

Standard #1

All medical case management supervisors, medical case managers and peer counselors shall have sufficient education, knowledge, skills, and experience to competently serve the HIV/AIDS client population.

Guidelines	Indicators	Data Source
<p>(1.1 – 1.9) All medical case management supervisors, medical case managers and peer counselors must meet the qualifications of education and experience required by the Miami-Dade County Office of Grants Coordination.</p>	<p>Medical Case Management Supervisors: 1.1 Master’s degree OR Bachelor’s degree with 5 years work experience in HIV/AIDS 1.2 HIV/AIDS and supervisory experience preferred 1.3 Completion of a proficiency test based on required system-wide training within 12 months of hire</p> <p>Medical Case Managers:*</p> <p>1.4 Bachelor’s degree in a social science area OR, Bachelor’s of Science in Nursing (BSN) degree with 6 months of case management experience OR, Bachelor’s degree not in a social science with 1 year of case management experience 1.5 Knowledge of HIV/AIDS disease and the Miami-Dade HIV/AIDS service delivery system preferred 1.6 Completion of a proficiency test based on required system-wide training within 12 mos. of hire. <i>*An individual in a case management position prior to the effective date of these standards (August 12, 2002) may substitute applicable experience on a year-to-year basis for the required education.</i></p> <p>Peer Counselors 1.7 High school degree 1.8 One year’s experience in HIV/AIDS services 1.9 Training on funding streams for HIV/AIDS services and eligibility criteria for these services</p>	<ul style="list-style-type: none"> ➤ Personnel files <ul style="list-style-type: none"> • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Proof of knowledge on HIV/AIDS services, eligibility for these services and funding streams • Training Certificate • Copy of degree • Documentation of HIV/AIDS service system experience (letters of reference, documented telephone interview) • Proof of training on HIV/AIDS services , eligibility for these services and funding streams

Training

Standard #2

To ensure the highest level of medical case management service, medical case management supervisors, medical case managers and peer counselors, through initial and ongoing monthly trainings, shall be continuously updated on changes in HIV/AIDS health care, the community-wide service system (services and limitations), community resources, local, state, and federal programs in the area.

Guidelines	Indicators	Data Source
<p>(2.1 – 2.4) Medical case management supervisors, medical case managers, and peer counselors shall comply with all training requirements mandated and approved by the Miami-Dade County Office of Grants Coordination.</p> <p>(2.5) Medical case managers and peer counselors shall maintain all updated materials and lists of resources provided at trainings.</p>	<p>Medical case management supervisors, medical case managers and peer counselors shall complete:</p> <p>2.1 HIV/AIDS 104¹ within 1 month of hire</p> <p>2.2 Medical case management supervisors: 32 hours annually of quarterly Ryan White Program Medical Case Manager Supervisor Training, of which up to 8 hours may be substituted by another Ryan White Program-approved supervisory management-related training</p> <p>2.3 Medical case managers and peer counselors: 20 hours annually of monthly system-wide case management related training (i.e., monthly Ryan White Program Medical Case Manager Training)</p> <p>2.4 In addition to the training hours in 2.3, medical case managers and peer counselors in the Ryan White Program System less than 2 yrs: 20 hours of basic case management training¹</p> <p>2.5 Provider/service listings, updated Ryan White Program Case Management Handbook, other training materials as appropriate</p>	<p>➤ Personnel files</p> <ul style="list-style-type: none"> • 104 Certificate dated within 1 month of hire • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training. • Agency training record • Case management system- wide attendance logs • Training Certificate • Training agendas • On-site inspection/observation

¹HIV/AIDS 104 and basic case management training are not part of the 20-hour system-wide training requirement (item 2.3).

No Barriers to Service

Standard #3

Client access to medical case management and peer counseling services shall be facilitated in a timely and orderly manner.

Guidelines	Indicators	Data Source
<p>(3.1 – 3.2) Initial intake and financial eligibility assessment initiated.</p>	<p>No later than 5 workdays from a request for service or receipt of referral:</p> <p>3.1 Appointment made for intake/financial eligibility assessment</p> <p>3.2 Medical case manager assigned</p>	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Intake/financial eligibility forms dated within 5 days of filed referral or date of service request AND • Intake progress note reflects: Date of referral or service request and date of intake/financial eligibility assessment • Record reflects name of assigned medical case manager and date of assignment
<p>(3.3) If client wishes to meet with a peer counselor, an appointment is facilitated.</p>	<p>3.3 Meeting will take place no later than 2 workdays from the date of request for service or receipt of referral.</p>	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Dated progress note reflects date of referral OR date of request for service AND service rendered or refused per progress note from peer counselor documenting appointment completed or appointment declined <i>(See Standards #4 and #5)</i>

Eligibility and Financial Assessment *

Standard #4

A comprehensive eligibility and financial assessment shall be completed taking into account all funding streams and services for which the client may qualify: the client's education and orientation to the service delivery system and to client rights and responsibilities shall be initiated.

Guidelines	Indicators	Data Source
<p>(4.1 – 4.11) Eligibility and financial assessment shall ensure all required documents are present and filed in the eligibility section of the client chart. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws, choice of providers, explanation of grievance procedures, privacy in compliance with HIPAA regulations (4.11), and rights and responsibilities (4.2).</p>	<p>No later than 10 workdays from receipt of referral or date of request for service, the following shall be completed:</p> <ul style="list-style-type: none"> 4.1 Client Chart/Record Face Sheet 4.2 Composite Consent (includes Client Bill of Rights and Responsibilities) 4.3 Consent to Release and Exchange Information (SDIS) 4.4 Proof of HIV 4.5 Proof of Income 4.6 Financial Assessment 4.7 Current and valid proof of Miami-Dade County residency 4.8 Picture ID (for identification purposes only, may be expired) 4.9 Social Security (if client has SS Number) 4.10 Eligibility screening for third party payers 4.11 Miami-Dade County Notice of Privacy Practices 4.12 Outreach Consent 	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • All required forms are complete, initialed, dated, and signed as appropriate. (See Standard #5, 5.9- 5.11) • Copies of required eligibility documents are present and legible. • Documentation of eligibility screening for third party payers is present. (See Standard #11, 11.1 – 11.4)

* Eligibility and financial assessment need not be done by a case manager. This function may be performed by a trained eligibility clerk or a peer counselor with the appropriate training to conduct financial assessment and eligibility screening.

Initial Client Assessment and Plan of Care

Standard #5

The medical case manager shall develop a comprehensive and individualized Needs Assessment and Plan of Care (POC); orientation and education on the service delivery system shall continue; the client shall be assisted to access timely, appropriate services; medication adherence shall be reinforced and medical information necessary to appropriately serve the client shall be obtained; and the POC will include activities related to the coordination and follow-up of the client’s medical treatment.

Guidelines	Indicators	Data Source
<p>(5.1 – 5.3) An initial comprehensive assessment and plan of care shall be completed for all case management clients to include:</p> <p>Adherence assessment with appropriate client referrals to existing adherence programs as part of the POC.</p> <p>Referrals to the University of Miami for pregnant women shall be made within 24 hours of initial contact with the case manager.</p>	<p>No later than 5 workdays from completion of the eligibility/financial assessment the medical case manager shall complete:</p> <p>5.1 Initial Comprehensive Assessment 5.2 Initial Plan of Care (POC) 5.3 Referrals</p>	<p>➤ Record review ➤ SDIS review</p> <ul style="list-style-type: none"> • Completed, dated, signed (medical case manager and client) comprehensive assessment • Completed, dated, signed (medical case manager and client) POC based on needs identified in the comprehensive assessment
<p>(5.4 – 5.7) All referrals shall be documented in the POC. <i>(Applies to the referring agency.)</i></p>	<p>Referrals documented in the POC will include:</p> <p>5.4 Date and purpose of referral 5.5 Frequency of the requested service, if applicable 5.6 Provider of the requested service (agency receiving the referral) 5.7 Documentation reflecting follow-up of referral(s)</p>	<ul style="list-style-type: none"> • SDIS Referral Report • POC • Progress notes <p><i>(See Standards# 6, 6.2 – 6.8; #11, 11.1 – 11.4)</i></p>
<p>(5.8) The client will be scheduled to meet with a peer counselor, unless the client refuses and the refusal is documented.</p>	<p>5.8 Progress note reflecting date of appointment with a peer counselor or documentation that an appointment was refused.</p>	<p>➤ Record review ➤ Progress notes ➤ SDIS review</p>

Guidelines	Indicators	Data Source
<p>(5.9 – 5.10) Medical case managers shall ensure all required medical data is complete, legible, dated, filed in the appropriate section of the client chart and entered into the SDIS.</p> <p>(5.11) Applications for eligibility under entitlement and benefit programs must be completed and filed with the appropriate entities.</p> <p>(5.12) A progress note shall document the needs assessment and POC.</p>	<p>Medical Certification of Diagnosis 5.9. The medical case manager shall obtain Medical Certification of Diagnosis within 90 days of completion of the initial POC. The form shall be filed in the client record and the information entered into SDIS within 48 hours of availability.</p> <p>Quarterly/Annual Lab Results 5.10 The case manager shall obtain initial (using Quarterly/Annual Lab Results Form) quarterly labs within 90 days of completion of the initial POC: the form shall be filed in the client record and the information entered into the SDIS within 48 hours of availability.</p> <p>5.11 Within 45 days of completion of eligibility and financial screening: dated, signed copies of applications, referral and progress note reflecting screening and submission of forms.</p> <p>5.12 Dated, signed progress note corresponding to completion date of POC</p>	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review ➤ Record review ➤ SDIS review ➤ Record review ➤ SDIS review • POC • Progress notes ➤ Record review • POC • Progress notes

Referrals/Follow-Up

Standard #6

Medical case managers and peer educators shall follow-up to verify clients are receiving necessary services as documented in the Plan of Care and coordinate their efforts with other service providers to ensure service delivery is as seamless as possible to the client. The client's satisfaction with services received shall be assessed.

Guidelines	Indicators	Data Source
(6.1) The peer counselor shall follow-up, either face to face or by telephone, within 2 weeks of his/her initial meeting with a newly enrolled client.	6.1 Dated, signed progress note	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review
(6.2 – 6.4) Certified referrals between Ryan White Program providers shall be generated electronically through the SDIS using the Ryan White Program Certified Referral Form and recertified as appropriate for the service.	6.2 POC 6.3 SDIS 6.4 Progress notes	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review ➤ Record Review (See Standard #5, 5.4 – 5.7)
(6.5) Medication referrals shall note the name of the medication, dosage, strength and quantity.	6.5 POC	<ul style="list-style-type: none"> ➤ Record review • POC
(6.6 – 6.7) Referral follow up for medications and other services shall be done in a timely way to ensure coordination and benefit of service. All follow-up shall be documented in the progress notes.	Progress notes shall reflect: 6.6 Medication referrals followed-up no later than 5 workdays from the referral date 6.7 Referrals for other services followed-up no later than 30 days from the appointment date or service delivery date.	<ul style="list-style-type: none"> ➤ Record review • Progress notes ➤ Record review ➤ SDIS review • Progress notes
(6.8) All follow up on referrals shall assess the client's satisfaction with the service.	6.8 Client satisfaction, or lack thereof, documented in progress note.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • Progress notes

Updates to Client Record

Standard #7

Appropriate client contact shall be maintained as needed to monitor the client's personal/medical status. Coordination and follow-up of the client's medical treatment shall be conducted. The efficacy of the Plan of Care (POC) shall be assessed to ensure service needs, goals, objectives, and barriers as noted in the POC are addressed.

Guidelines	Indicators	Data Source
(7.1) An update (client contact) shall be documented no less than once every 3 months, or more often as client need may dictate per documentation.	7.1 Dated, signed progress note documenting client contact and adherence monitoring.	➤ Record review • Progress notes
(7.2 – 7.3) Client medical care and compliance shall be monitored to ensure optimal health results.	7.2 Quarterly/Annual Lab Results updated every quarter with CD4 and VL entered in SDIS within 7 business days of availability. 7.3 Annual medical data entered in SDIS prior to end of the calendar year.	• Quarterly/Annual Lab Results • SDIS
(7.4 – 7.9) Financial eligibility, client chart/record face sheet, needs assessments and plans of care shall be updated no less than once every 6 months, more often as client need may dictate per documentation. ¹ The Medical Certification of Diagnosis for non-AIDS clients shall be updated every 6 months.	Dated and signed as appropriate: 7.4 Client Chart/Record Face Sheet 7.5 Financial assessments 7.6 Needs Assessments and Plans of Care 7.7 Medical Certification of Diagnosis 7.8 Progress notes 7.9 Quarterly/Annual Lab Results	➤ Record review ➤ SDIS review • Updated forms • Progress notes reflecting update and noting Medical Certification of Diagnosis has been addressed
(7.10) The Composite Consent for Enrollment and the Consent to Release and Exchange Information in the SDIS shall be renewed annually. Client must sign and date both forms annually.	7.10 Dated, signed Composite Consent and Consent to Release and Exchange Information in the SDIS Forms	➤ Record review

¹ A six-month reassessment must include, at a minimum, updating the financial assessment, the needs assessment (Sections 1-5 and 12), Plan of Care and Medical Certification of Diagnosis, as needed. Individual client need may require updating additional sections of the needs assessment and Plan of Care. A complete assessment process is required once every 12 months.

Documentation Standards

Standard #8

To ensure consistency and quality of care across the medical case management service system, standardized forms shall be used and uniform standards of documentation shall be followed.

Guidelines	Indicators	Data Source
(8.1) Standardized forms shall be used.	8.1 Required SDIS forms are complete, dated and signed as necessary, and filed in the client record.	➤ Record review ➤ SDIS review • SDIS printouts
(8.2 – 8.4) Agencies shall have available in 3 languages: Composite Consent for Enrollment (includes the Client Bill of Rights and Responsibilities), Consent to Release and Exchange Information in the SDIS, and Miami-Dade County Notice of Privacy Practices	8.2 Signed, dated Composite Consents and Outreach Consent 8.3 Signed, dated Consents to Release and Exchange Information (SDIS) 8.4 Signed, dated Miami-Dade County Notice of Privacy Practices	➤ Record review
(8.5) All client contacts shall be documented in the progress notes no later than 2 business days after occurrence.	8.5 Dated, signed progress notes	➤ Record review ➤ SDIS
(8.6) All peer counseling and medical case management units of service billed to the Ryan White Program shall be documented in the client chart.	8.6 Dated, signed progress notes	➤ Record review • Progress notes • Reimbursement requests
(8.7) Documentation shall accurately record the time services began and ended and number and type of service units provided (15 minute encounters).	8.7 Dated, signed progress notes documenting time and units, (e.g. 11:30 AM to 11:58 AM, 2 units, FFE)	➤ Record review • Progress notes • Reimbursement requests

Guidelines	Indicators	Data Source
(8.8) All documentation shall be complete and legible, dated, signed and include the name and title of the individual making the entry.	8.8 All required forms and progress notes	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Progress notes • Forms

Quality Assurance / Performance Improvement

Standard #9

Ongoing, systematic record reviews shall be performed with feedback provided to case managers resulting in continuously improving quality of service and performance.

Guidelines	Indicators	Data Source
(9.1 – 9.4) Medical case management supervisors shall implement and document ongoing record reviews as part of quality assurance and performance improvement activity. Review tools will be dated and signed by the supervisor.	9.1 Record reviews conducted and submitted to Behavioral Science Research on a quarterly basis 9.2 No less than 20 records or 10% (whichever is less) of Ryan White Part A or MAI population reviewed 9.3 Review documents information is entered in a timely fashion, is complete, legible and appropriate 9.4 Dated, signed review tools including client identification information	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Review of client records • Review of supervisor’s reviews
(9.5 – 9.6) Quarterly client care review and/or quality improvement meetings shall be documented.	9.5 Meeting attendance logs 9.6 Meeting minutes reflect issues discussed, problems identified, actions for correction and a time frame for completion of same	<ul style="list-style-type: none"> ➤ Attendance logs ➤ Minutes

Standard #10

The medical case manager shall carry a reasonable case load that allows the medical case manager to effectively plan, provide, and evaluate tasks related to client and system interventions.

Guidelines	Indicator	Data Source
(10.1 – 10.3) Case loads shall be reviewed between the supervisor and medical case manager to determine and document caseload size.	10.1 Case review at least every 6 months 10.2 Active case load not to exceed 70 clients, not including situational clients 10.3 Active case load for medical case management supervisors not to exceed 35 clients	<ul style="list-style-type: none"> ➤ SDIS <ul style="list-style-type: none"> • Case load (print out of active case load per medical case manager) ➤ Administrative <ul style="list-style-type: none"> • Supervisory logs or records documenting case review • Case load lists (medical case managers and supervisors)

Service Delivery Information System (SDIS)

Standard #11

Service access for clients, data collection and reporting requirements shall be facilitated by requiring all pertinent client data be entered into the SDIS in a timely manner.

Refer to Standards #4, #5, #6, #7, #8, #9, #10, and #13.

Guidelines	Indicators	Data Source
(11.1) All Ryan White Program intake information shall be entered into the SDIS in a timely manner.	11.1 Ryan White Program Intake information entered into the SDIS at time of initial contact.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review
(11.2 – 11.4) Financial eligibility, needs assessment and POC information shall be completed and entered into SDIS.	11.2 Financial eligibility, needs assessments and POCs entered into the SDIS within 48 hours 11.3 Dated, signed eligibility, assessment and POC 11.4 SDIS print outs	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review

Advance Directives

Standard #12

The client shall be assisted in developing a legally binding advance directive that is on file in the event of personal incapacitation.

Guidelines	Indicators	Data Source
(12.1 – 12.2) No later than one year from the date of the initial POC completion, the medical case manager will ensure that the client has completed an advance directive and a copy of it is on file; or will document that the client refused said service.	12.1 Advance directive to address the client’s care and treatment decisions in the event of incapacitation is indicated in the progress notes or POC 12.2 Progress note or POC reflects client declined to develop an advance directive.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> ● Needs Assessment ● Plan of Care ● Progress Notes

Case Closure/Case Transfer

Standard #13

Client records shall be closed with a case closure form; clients who wish to transfer shall be enabled to do so in a timely manner.

Guidelines	Indicators	Data Source
(13.1) Client records shall be closed with a Case Closure or Case Transfer Form.	Client records shall include: 13.1 A Case Closure Form detailing the reasons for closure	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> ● Progress notes ● Case Closure Form ● Case Transfer Form ● Outgoing record log ● Current (at time of request) Consent to Release Information
(13.2 – 13.5) Clients who wish to transfer shall be assisted to do so.	Copies of client records for transfers shall be mailed: 13.2 No later than 10 days from the date of the receipt of a written request from the client or the client’s legal representative	<ul style="list-style-type: none"> ➤ Record Review

Guidelines	Indicators	Data Source
<p>(13.6) Closure information shall contain an address/phone number/emergency contact where the client may be reached or detail the reason why said information cannot be obtained.</p> <p>(13.7) Case closures and transfers shall be entered into the SDIS.</p>	<p>13.3 Prior to releasing information a current Consent to Release Information must be in the record</p> <p>13.4 A completed Transfer Form.</p> <p>13.5 Initial agency shall make necessary changes in SDIS within 2 business days of transfer</p> <p>13.6 Completed Case Closure or Case Transfer Form</p> <p>No later than 24 hours after completing a closure or transfer:</p> <p>13.7 Data in SDIS</p>	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • Closure or Transfer Form

Program Specific Operating Requirements (PS)

Standard #PS 1

Standard	Indicators	Data Source
<p>Medical case management providers must offer both medical case management and peer education and support network services.</p>	<p>PS1.1 Progress notes</p> <p>PS1.2 Reimbursement requests</p>	<ul style="list-style-type: none"> ➤ Personnel files ➤ Record review ➤ SDIS

Standard #PS 2

Standard	Indicators	Data Source
<p>Medical case management providers must have trilingual capabilities.</p>	<p>PS2.1 Progress notes</p> <p>PS2.2 Staff interviews</p>	<ul style="list-style-type: none"> ➤ Record review ➤ Personnel files ➤ Observation

Standard #PS 3

Standard	Indicators	Data Source
Medical case management agencies must document they have sought enrollment in the Medicaid PAC Waiver Program within 30 days of the contract execution date.	PS3.1 Copy of completed, dated application PS3.2 PAC Waiver number(s)	➤ Agency records

Standard #PS 4

Standard	Indicators	Data Source
Medical case management agencies shall ensure clients are aware of their rights and responsibilities.	PS4.1 Copy of the Client Rights and Responsibilities posted in a public area.	➤ Observation

Standard #PS 5

Standard	Indicators	Data Source
Medical case management providers shall ensure the provision of interpreters/assistance to the hearing, vision, and reading impaired.	PS5.1 Providers shall allocate funds in their budgets to ensure provision of interpreters/assistance to the hearing, vision, and reading impaired.	➤ Budget review ➤ Invoices

Standard #PS 6

Standard	Indicators	Data Source
Providers shall ensure continuity and coordination of care across services.	PS6.1 Providers shall maintain linkage agreements with other service providers throughout the community.	➤ Administrative Review ➤ Linkage Agreements

Please note: With respect to the Miami-Dade County Ryan White Program, the term “health care organizations” in the following document is defined as “health care organizations and other HIV-related organizations” that receive funds under the Ryan White Part A and/or Minority AIDS Initiative (MAI) Programs.

NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE

**U.S. Dept. of Health and Human Services
Office of Minority Health
March 2001**

Definitions and Terms:

CULTURE:

“The thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.”

CULTURAL AND LINGUISTIC COMPETENCE:

“Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors and needs presented by consumers and their communities.”

CLAS mandates are current Federal requirements for all recipients of Federal funds. All funded agencies will be monitored for compliance with the following CLAS mandates:

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

- Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

CLAS guidelines are activities recommended by the Office of Minority Health for adoption as mandates by Federal, State and national accrediting agencies:

- Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcome-based evaluations.
- Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
- Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

- Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

CLAS recommendations are suggested by the Office of Minority Health for voluntary adoption by health care organizations:

- Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

HAB HIV Performance Measures

The Health Resources and Services Administration, HIV/AIDS Bureau (HRSA/HAB) has developed several performance measures that can be used by all programs funded by the Ryan White HIV/AIDS Program that provide HIV care or other relevant services. The measures can be used either at the provider or system level. Striving to reach 100% achievement for each performance measure is a laudable goal, but is not required. HRSA/HAB recommends that grantees use national benchmarks and baseline data to set realistic goals for funded agencies. As a result, the Miami-Dade HIV/AIDS Partnership and the County's Ryan White Program have adopted several of these performance measures.

Complete documents of the following HIV Performance Measures from can be found at <http://hab.hrsa.gov/special/habmeasures.htm>:

- **HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3**
- **HAB HIV Performance Measures: Medical Case Management**
- **HAB HIV Performance Measures: Oral Health Services**
- **HAB HIV Performance Measures: Systems-Level**
- **HAB HIV Performance Measures: Pediatrics**

Copies of these documents can also be requested by contacting:

Carla Valle-Schwenk
Program Administrator
Miami-Dade County Office of Grants Coordination
Ryan White Program
111 NW 1st Street, 19th Floor
Miami, FL 33128
PH: 305-375-4742
FAX: 305-375-4454
EMAIL: cvalle@miamidade.gov

Miami-Dade County Ryan White Program

Minimum Primary Medical Care Standards for Chart Review

Medical Care Subcommittee Miami-Dade HIV/AIDS Partnership

Statement of Intent: All Ryan White Program funded practitioners are required by contract to adhere, at a minimum, to the Public Health Service (PHS) Guidelines.

Requirements for Practitioners (Physicians, Nurse Practitioners, and Physician Assistants):

- Practitioner must be a Physician (MD or DO), Nurse Practitioner, or Physician Assistant with current and valid license to practice medicine within the State of Florida
- Practitioners must have a minimum of three years of experience treating HIV clients or have served a high volume (50) of HIV+ clients in the past year
- Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two years. When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
 - a. DHHS Clinical Guidelines
<http://www.aidsinfo.nih.gov/Guidelines/>
 - b. American Cancer Society Guidelines for the Early Detection of Cancer
http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp
 - c. European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV
<http://www.ncbi.nlm.nih.gov/pubmed/18257770>
 - d. Lipid Disorders subset of the AIDS Education and Training Centers
http://www.faetc.org/PDF/15th_Annual/Advanced_Track/Finals_for_Handouts/Managing_Multiple_Diseases/Orrick_Handout_MMD_dyslipidemia.pdf
 - e. CDC Recommended Adult Immunization Schedule
<http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>
 - f. Incorporating HIV Prevention into the Medical Care of Persons Living with HIV
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>
- Follow an action plan to address any areas for improvement that are identified during quality assurance reviews

Minimum Standards of Which Practitioners Will Be Measured

Assessments and Referrals

2. **Initial** – At initial visit
 - a. Comprehensive initial history
 - b. Physical examination, including review of systems
 - c. Vital signs, including weight
 - d. Gynecological exam including pap smear and pelvic for females
 - e. Rectal examination and stool guaiac testing
 - f. Sexual transmitted infection assessment
 - g. Age appropriate cancer screening
 - h. Adherence to medications
 - i. Risk reduction (including safer sex practices)
3. **Interim Monitoring and Problem-Oriented visits** - At every visit:
 - a. Vital signs, including weight
 - b. Physical examination related to specific problem, as appropriate
 - c. Interval changes in vital signs addressed, especially trend in weight over time
 - d. Adherence to medications
 - e. Risk reduction (including safer sex practices)
4. **Annual** – At each annual visit:
 - a. Update comprehensive initial history, as appropriate
 - b. Physical examination, including review of systems
 - c. Vital signs, including weight
 - d. Interval changes in vital signs addressed, especially trend in weight over time
 - e. Gynecological exam including pap smear and pelvic for females
 - f. Rectal examination and stool guaiac testing
 - g. Sexual transmitted infection assessment
 - h. Age appropriate cancer screening
 - i. Adherence to medications
 - j. Risk reduction (including safer sex practices)

Assessments to be included at Incremental Visits

5. **Gynecological Exam**^{i ii} (females), including Pap smear and pelvic - Starting at 3 years post sexual activity onset or at age 21, at initial evaluation, or upon entry to prenatal care, and another Pap smear 6 months later. If both smears are negative, annual screening is recommended thereafter in asymptomatic women. More frequent screenings recommended - every 6 months - for women with symptomatic HIV infection, prior abnormal Pap smears, or signs of HPV infection

6. **Mammogram**ⁱⁱⁱ (females) - Starting at age 40, screening recommended annually
7. **Colon and Rectal Cancer Screening**^v - Colorectal cancer screening recommended for individuals starting at age 50. For those with several first-degree relatives who had prostate cancer at an early age, this discussion should take place at age 40. If unable to perform or if patient refuses, a fecal occult blood test (FOBT)^{iv} should be performed every year. For FOBT used as a screening test, the take-home multiple sample method should be used. A FOBT done during a digital rectal exam in the practitioner's office is not adequate for screening
8. **Purified Protein Derivative (PPD)**^v - QuantiFERON TB Gold or Tuberculin Skin Test (TST), placed by the Mantoux method, should be performed as close to diagnosis of HIV infection and annually thereafter. If tested when CD4 < 200, repeat after CD4 increases to above 200. Annual PPD is recommended if patient is deemed high risk (repeated or ongoing exposure to known active TB, after incarceration, after living in congregate setting, active drug user or other risk factor for TB). If PPD positive or has had active Tuberculosis documented with adequate treatment, annual chest X-ray should be performed. If chest X-ray cannot be afforded, cough screen questionnaire may be used as suggested by David Ashkin, MD
9. **Assess annually and document health education on:**
 - a. Nutritional assessment/care
 - b. Oral health care
 - c. Mental Health assessment/care
 - d. Exercise
 - e. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
 - f. Domestic violence
 - g. Birth control
 - h. Living will (completion or review)
10. **Additional Charting/Documentation:**
 - a. Problem list complete and up-to-date
 - b. Medications list complete with start and stop dates, dosages
 - c. Allergies list complete and up-to-date
 - d. Immunization list complete and up-to-date

Laboratory

11. **CD4 T-cell count**ⁱⁱ - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, treatment failure, or if clinically indicated. For patients documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for > 2-3 years, can extend interval monitoring to every 6 months

12. **HIV RNA**ⁱⁱ - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation, treatment failure, or if clinically indicated. For patients documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for > 2-3 years, can extend interval monitoring to every 6 months
13. **Resistance testing**ⁱⁱ - entry into care, ART initiation or switch, treatment failure, or if clinically indicated. For treatment-naïve patients, if resistance testing was performed at entry into care, repeat testing is optional post-ART initiation; for patients with viral suppression who are switching therapy for toxicity or convenience, resistance testing will not be possible and therefore, is not necessary. Genotype conducted at entry into care, prior to start of antiretroviral (ARV) therapy and when failing therapy (HIV viral load \geq 1,000)
14. **HLA-B*5701**ⁱⁱ - If considering start of abacavir and document in record carrying data forward to most current volume
15. **Tropism testing**ⁱⁱ – If considering use of CCR5 antagonist (HIV viral load must be \geq 1000) or if clinically indicated. If performed, record carried forward to most current volume
16. **Basic chemistry**ⁱⁱ - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated. Serum Na, K, HCO₃, Cl, BUN, creatinine, glucose (preferably fasting). It is suggested to monitor phosphorus while on tenofovir; determination of renal function should include estimation of creatinine clearance using Cockcroft & Gault equation^{vii} or estimation of glomerular filtration rate based on MDRD equation
17. **ALT, AST, T. bili, D. bili**ⁱⁱ - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated
18. **CBC w/ differential**ⁱⁱ - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation if a zidovudine-containing regimen, or if clinically indicated
19. **Fasting Lipid Profile**ⁱⁱ (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, consider 2-8 weeks post-ART initiation, every 6 months if abnormal or borderline at last measurement, every 12 months if normal at last measurement, or if clinically indicated
20. **Fasting Glucose**ⁱⁱ (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, every 3-6 months if abnormal or borderline at last measurement, every 6 months if normal at last measurement, or if clinically indicated

21. **Urinalysis**ⁱⁱ - entry into care, at time of ART initiation or change, every 6 months in patients with HIV-associated nephropathy, and every 12 months in patients on a tenofovir-containing regimen, or if clinically indicated^{viii}
22. **Pregnancy test**ⁱⁱ (females) – if starting an efavirenz-containing regimen or if clinically indicated
23. **Hepatitis A Screening**^{ix} - At initial screening, Hepatitis A total antibody (HAVAb) or IgG (not IgM). Unless Hepatitis C infected, may consider administering immunization when CD4 cell count greater than 200 cells/mm³
24. **Hepatitis B Screening**^{vi} - At initial screening, Hepatitis B core antibody (HBcAb) total or IgG (not IgM), Hepatitis B surface antibody (HBsAb), and Hepatitis B surface antigen (HBsAg). If HBsAg is positive, evaluate Hepatitis B Viral Load by DNA PCR, and obtain Hep Be Ag and Ab
25. **Hepatitis C Screening**^{vi} - At initial screening, Hepatitis C antibody (HCVAb). If HCVAb is positive evaluate Hepatitis C (HCV) Viral Load, genotype, and include treatment plan in record; If negative and active Injection Drug User or other HCV risk factor, repeat HCVAb in 12 months; If there is an unexplained chronic LFT elevation, Hepatitis C viral load should be evaluated (even if HCVAb is negative)
26. **Syphilis, N. gonorrhoeae (GC), C. trachomatis (Chlamydia)**^x - Screening should be performed at least annually for all sexually active patients, more frequently might be appropriate depending on individual risk behaviors, the local epidemiology of STDs, and whether incident STDs are detected by screening or by the presence of symptoms. For men who have sex with men (MSM) via Receptive anal intercourse - screen for rectal gonorrhea and Chlamydia. For men who have sex with men (MSM) via receptive oral intercourse - screen for pharyngeal gonorrhea (Chlamydia not recommended). For men who have sex with men (MSM) with multiple or anonymous partners, or have sex during , illicit drug use, or use methamphetamine, or have sex partners with these risk factors, screening is recommended at 3-6 month intervals.^{xi} Assume that all adult patients are sexually active unless noted in history or progress note that patient denies being sexually active
27. **Prostate-specific antigen (PSA) Screening**^{xii} (males) - Offered annually, beginning at age 50, to men who have at least a 10-year life-expectancy. For African American men and those with a first-degree relative (father, brother, son) who had prostate cancer at an early age (< 65y/o), this discussion should take place at age 45. For those with several first degree relatives with prostate cancer at an early age, screening should begin at age 40. Information should be provided to all men about what is known and what is uncertain about the benefits, limitations, and harms of early detection and treatment of prostate cancer so that they can make an informed decision about testing.

Immunizations/Treatments

28. **Influenza vaccination**^{xi} - Offer TIV annually and document in record
29. **Pneumococcal polysaccharide (PPSV) vaccination**^{xi} - Offer initial vaccination as close to HIV diagnosis as possible, and then 1 booster after 5-6 years. Document in record carrying data forward to most current volume
30. **Hepatitis A vaccination**^{xi} - Offer vaccination if not immune. Assess for response 30 days after vaccination by performing Hep A antibody IgG or Hep A Total antibody. Document in record carrying data forward to most current volume
31. **Hepatitis B vaccination**^{xi} - Offer vaccination if not immune. Double dose is recommended. Assess for response 30 days after vaccination by performing Hepatitis B surface antibody quantitative (Hep B SAb Quant). Document in record carrying data forward to most current volume
32. **Tetanus, diphtheria, pertussis (Td/Tdap)**^{xiii} - Substitute 1-time dose of Tdap, for adults age 19-64 who have not received a dose of Tdap previously, for Td booster; then boost with Td every 10 yrs. Document in record carrying data forward to most current volume
33. **ARV therapy is considered and discussed** - If offered, the risks and benefits are discussed
34. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** - specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis Carinii Pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines^{xiv}

ⁱ Routine pelvic examination and cervical cytology screening. ACOG Committee Opinion No. 431. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:1190–3.

ⁱⁱ <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/womenHiv.htm>
Accessed July 22, 2009.

ⁱⁱⁱ http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp. Accessed July 21, 2009.

^{iv} http://my.clevelandclinic.org/services/fecal_occult_blood_test/hic_fecal_occult_blood_test.aspx. Accessed July 22, 2009.

^v Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.

^{vi} Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. November 3, 2008; 1-139. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed July 21, 2009. Page 6, Table 3.

^{vii} <http://www.clinicalcalculator.com/english/nephrology/cockroft/cca.htm>. Accessed July 22, 2009.

^{viii} For patients with renal disease, consult “Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America” (Clin Infect Dis 2005; 40: 1559-85).

^{ix} <http://www.aidsetc.org/pdf/workgroups/pcare/pcwg-heptools.pdf>. Accessed July 21, 2009.

^x *Counseling for Patients with HIV Infection and Referral to Support Services*, page 18, *Sexually Transmitted Diseases Treatment Guidelines, 2006*, <http://www.cdc.gov/MMWR/PREVIEW/MMWRHTML/rr5511a1.htm>. Accessed July 21, 2009

^{xi} <http://www.faetc.org/PDF/Newsletter/Newsletter-Volume10-2009/HIVCareLink-Vol10-Issue-5-April-15.pdf>. Accessed July 22, 2009.

^{xii} http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp.

Accessed July 21, 2009.

^{xiii} <http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>. Accessed July 22, 2009.

^{xiv} Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.

Miami-Dade County Ryan White Program Oral Health Care Standards

Standard 1: Oral health care providers shall ensure that all staff has sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population: initial orientation and training for new staff shall be provided and all staff shall participate in ongoing HIV/AIDS trainings.

	Standards of Care	Measure
Standard 1.1	All oral health care staff will possess appropriate licenses, credentials and expertise; experience working with HIV/AIDS clients is desirable.	Copy of current license for each staff person, with provider number, as required by Florida law: copies of current required operational licenses as required by Florida law. Documentation of work experience (letters of recommendation, work references, etc.)
Standard 1.2	Policies and procedures.	Written policies and procedures manuals.
Standard 1.3	Newly hired staff will receive orientation within one month of hire, including training on Ryan White Program eligibility and service requirements.	Documentation of completed orientation on file including documentation of training on Ryan White Program eligibility and service requirements.
Standard 1.4	Ongoing annual HIV/AIDS staff training.	Documentation of all completed annual trainings on file.

Standard 2: Clients receiving services meet Ryan White Program eligibility requirements and are informed of their rights per Ryan White Program standards.

	Standard	Measure
Standard 2.1	Ryan White Program client eligibility screening and demographics present.	Proof of HIV status, financial eligibility, permanent residency in Miami-Dade County OR Current (not > 6 mos.) Ryan White Program Certified Referral.

Miami-Dade County Ryan White Program Oral Health Care Standards

		Demographics include at a minimum: address, phone number, emergency information, age, race/ethnicity and gender.
Standard 2.2	Ryan White Program required documents present, signed, and dated.	Signed and dated Consent to Release and Exchange Information in the SDIS OR current (not > 6 mos.) Ryan White Program Certified Referral; <u>documentation that SDIS Notice of Privacy Practices was provided.</u>
Standard 2.3	General Consent for Treatment	Signed general consent for treatment present

Standard 3: All clients shall have a completed initial medical history with updates as appropriate; medical conditions and allergies are noted; an oral health history is taken.

	Standard	Measure
Standard 3.1	Initial Comprehensive Medical History	There is an initial comprehensive medical history including medications and conditions affecting diagnosis and management of oral health care. The initial comprehensive medical history is signed and dated by the client and dentist.
Standard 3.2	Medical History is updated as appropriate.	Medical history is updated every 6 months or at the next appointment after six months.
Standard 3.3.	Medical conditions and allergies are noted.	Medical conditions and/or medications requiring an alert are flagged. Allergies or NKA are noted.
Standard 3.4	An oral health history is taken.	Oral health history is taken that includes problems with or reactions to anesthesia, specific or chief complaints (if any), problems with previous treatment (if any).

Miami-Dade County Ryan White Program

Oral Health Care Standards

Standard 4: Documentation across providers shall reflect, at a minimum, services provided, treatment plans, examinations, charting grids, informed consents, refusal of treatment, and periodontal maintenance.

	Standard	Measure
Standard 4.1	Treatment assessment and planning.	<p>Completed treatment plan is in the progress notes OR a treatment plan form is completed.*</p> <p><i>*If clients access oral health services for episodic care only, documentation in treatment notes will reflect clients were advised to return for examination and a treatment planning appointment. If client does not present for this appointment, documentation in client's chart of advice to return for planning may serve as treatment plan.</i></p>
Standard 4.2	Documentation reflects services provided.	<p>Documentation, at a minimum, includes:</p> <ul style="list-style-type: none"> Date of service Tooth number, if appropriate Service description Anesthetic used including strength and quantity Materials used, if any Prescriptions or medications dispensed, including name of drug, quantity and dosage Education provided Signature and title
Standard 4.3	<p>A comprehensive examination is provided*</p> <p>*Not applicable for episodic care, follow up, or problem-focused examinations.</p>	<p>Comprehensive Examination includes:</p> <ul style="list-style-type: none"> Cavity charting Complete periodontal exam or periodontal screening record

Miami-Dade County Ryan White Program

Oral Health Care Standards

	<p>OR</p> <p>A problem-focused oral examination is performed.</p>	<p>Documentation of restorations & prosthesis Full mouth radiographs Pre-existent conditions Disease presence Structural anomalies Oral hygiene Instruction Prescriptions or medications Dispensed including name of drug, quantity and dosage Education provided</p> <p>Problem-focused examination includes: Chief complaint is documented Problem-focused evaluation is performed Prescriptions or medication Dispensed include name of drug, quantity, and dosage Radiographs as necessary Specific oral treatment plan Education provided Return for further evaluation documented</p>
<p>Standard 4.4</p>	<p>Charting grids are completed as appropriate.</p>	<p>Charting of the examination findings/treatment is completed in the appropriate tooth grids.</p>
<p>Standard 4.5</p>	<p>Informed specific consents are present for each oral surgery procedure.</p>	<p>A signed, informed, specific consent is present for all oral surgery procedures that includes the risks, benefits, alternatives and consequences of not having the procedure.</p>
<p>Standard 4.6</p>	<p>Refusal of treatments/radiographs is documented.</p>	<p>Client refusal for treatment/radiograph is documented (form or in progress note) with DDS signature, client signature or initials and date; <u>signature and date of witness are present.</u></p>

Miami-Dade County Ryan White Program

Oral Health Care Standards

		Reason for DDS refusal to perform a requested treatment is documented; signature and date of witness are present.
Standard 4.7	<p>Periodontal maintenance is regularly performed.*</p> <p>*Not applicable for clients who are “No shows” AND “No show” is documented; not applicable for episodic care.</p>	Periodontal maintenance is performed according to the treatment plan or at the next appointment, if later than six months.

Standard 5: Client care and referrals shall be coordinated with other care providers, as appropriate.

	Standard	Measure
Standard 5.1	<p>Treatment provided for oral opportunistic infection (when indicated) is coordinated with client PCP.*</p> <p>*Not applicable if no oral OI Dx/treatment documented.</p>	Documentation reflects treatment provided for oral OI and coordination with PCP.
Standard 5.2	<p>Referral and coordination of care.*</p> <p>*Not applicable if no condition documented and no referral made.</p> <p>Tobacco use and referral.*</p> <p>*NA for clients not using tobacco products.</p> <p>Nutritional problems and referral.*</p> <p>*Not applicable when no indication of nutritional problems.</p>	<p>Documentation in client record of the condition and referral to a specific specialty or ancillary service provider.</p> <p>Documentation of heavy tobacco use and referral to a tobacco counseling program.</p> <p>Documentation of nutritional problems and referral to a nutritionist for nutritional counseling.</p>

Miami-Dade County Ryan White Program Oral Health Care Standards

Standard 6: Clients shall receive education in preventive oral health practices; tobacco, and nutritional counseling as appropriate.

	Standard	Measure
Standard 6.1	<p>Education will be provided in preventive oral health practices¹ including hygiene, nutritional education² as related to oral health care and education, as appropriate, concerning tobacco use³.</p> <p>¹Not applicable for episodic care.</p> <p>²Not applicable for episodic care.</p> <p>³Not applicable if no indication of tobacco use; not applicable for episodic care.</p>	<p>Documentation of education in preventive oral health practices including hygiene is provided every six months or at next appointment if later than six months.</p> <p>Documentation of nutritional education as related to oral health.</p> <p>Documentation of education, as appropriate, concerning tobacco use.</p>

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

OUTPATIENT MEDICAL CARE (INCLUDING MINORITY AIDS INITIATIVE)

Guidelines: Providers will adhere to the following clinical guidelines for treatment of HIV/AIDS specific illnesses (which can be found at www.aidsinfo.nih.gov/guidelines/, unless otherwise noted):

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. January 10, 2011; pp 1-166. Available at: <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed 1/31/2011.
- Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. August 16, 2010; pp 1-219. Available at: <http://aidsinfo.nih.gov/ContentFiles/PediatricGuidelines.pdf>. Accessed 1/31/2011.
- Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. May 24, 2010; pp 1-117. Available at: <http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>. Accessed 1/31/2011.
- A Guide to Primary Care for People with HIV/AIDS, 2004 Edition, John G. Bartlett, M.D., et al, U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; and Pocket Guide to Adult HIV/AIDS Treatment, February 2006 edition. (Available at: www.hab.hrsa.gov/tools/primarycareguide/)
- A Guide to the Clinical Care of Women with HIV/AIDS, 2005 Edition, Jean Anderson, MD, U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. (Available at: www.hab.hrsa.gov/publications/womencare05/)
- Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the HIV Medicine Association of the Infectious Diseases Society of America, Morbidity and Mortality Weekly Report (MMWR), April 10, 2009, vol. 58, No. RR-4; including pediatric dosing update for Valcyte, dated September 15, 2010. (Available at: http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009.pdf)

**RYAN WHITE PROGRAM
TREATMENT GUIDELINES &
ADDITIONAL SERVICE DELIVERY STANDARDS**

OUTPATIENT MEDICAL CARE (INCLUDING MINORITY AIDS INITIATIVE)
(continued)

- Guidelines for Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children, Recommendations from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the HIV Medicine Association of the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the American Academy of Pediatrics, Morbidity and Mortality Weekly Report (MMWR), September 4, 2009, vol. 58, No. RR-11.
(Available at: http://aidsinfo.nih.gov/contentfiles/Pediatric_OI.pdf)
- Clinical Manual for Management of the HIV-Infected Adult, AIDS Education and Training Centers (AETC) National Resource Center, 2006 Edition, updated July 2007.
(Available at: <http://aidsetc.org/>)
- Care and Treatment for Hepatitis C and HIV Co-infection, HIV/AIDS Bureau, April 2006;
Available at <http://hab.hrsa.gov/tools/coinfection/>.
- Clinical Guide on Supportive and Palliative Care for People with HIV/AIDS, Alexander, Carla, MD; et. al., 2003 Edition. (Available at: www.hab.hrsa.gov/tools/palliative/)
- In addition, providers will adhere to other generally accepted clinical practice guidelines.

Standards:

- Providers will inform clients as to generally accepted clinical guidelines for HIV+ pregnant women, treatment of AIDS specific illnesses, clients infected with tuberculosis, hepatitis, or sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.
- Providers will screen for TB and make necessary referrals for appropriate treatment. In addition, providers will follow Universal Precautions for TB as recommended by the CDC. Providers will also screen for hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

SUBSTANCE ABUSE TREATMENT/COUNSELING – RESIDENTIAL & OUTPATIENT (INCLUDING MINORITY AIDS INITIATIVE)

Guidelines: Providers will adhere to generally accepted clinical guidelines for substance abuse treatment of persons living with HIV/AIDS. The following are examples of such guidelines:

- Published by the American Society of Addiction Medicine (ASAM), these guidelines include principles for working with HIV-positive patients in addiction treatment settings including, but not limited to, HIV antibody testing, post-exposure prophylaxis (PEP) for HIV, integrating HIV-positive patients into addiction treatment programs and groups, neuropsychiatric components of HIV/AIDS, approaching the medical evaluation in the era of HIV/AIDS, and harm-reduction strategies in addiction medicine (*Guidelines for HIV Infection and AIDS in Addiction Treatment*, American Society of Addiction Medicine, Melvin Pohl, M.D., Chair, et al, Chevy Chase, MD, most current as of March 1, 2011; and the *Principles of Addiction Medicine*, Fourth Edition).
- Published by the ASAM, national guidelines were developed for the implementation of a patient placement system. The purpose of this clinical guide is to place the patient in a level of care that has the appropriate resources to treat the patient's condition [*ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R)*, American Society of Addiction Medicine, Washington, DC, Second Edition-Revised (April 2001)].
- Published by the ASAM, public policy statements (see www.asam.org/policycategory.cfm) related to the substance abuse treatment of clients living with HIV/AIDS, that include *Access to Sterile Syringes and Needles (formerly "Needle Exchange")*, *Hepatitis C (with Physician Supplement)*, *HIV/AIDS Education for Drug and Alcohol Treatment*, *HIV Testing of Patients in Addiction Treatment Facilities*, *Primary Medical Care for HIV Infected Patients in Addiction Treatment*, and *The Treatment of Patients With Alcoholism or Other Drug Dependencies*, and *Who Have or are at Risk for Acquired Immunodeficiency Syndrome (AIDS)*, 1994-2003.
- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

SUBSTANCE ABUSE TREATMENT/COUNSELING – OUTPATIENT & RESIDENTIAL (INCLUDING MINORITY AIDS INITIATIVE) (continued)

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida’s Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.
- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30, Substance Abuse Services, of the Florida Administrative Code by the State of Florida Department of Children and Families, as may be amended.

MENTAL HEALTH THERAPY/COUNSELING & PSYCHOSOCIAL SUPPORT SERVICES

Guidelines (Mental Health Therapy/Counseling Levels I and II; and Psychosocial Support Services Levels III and IV): Providers will adhere to generally accepted clinical guidelines for mental health therapy/counseling or psychosocial support counseling of persons living with HIV or AIDS. The following are examples of such guidelines:

- American Psychiatric Association (APA) Policies and Position Statements, and Resource Documents on AIDS and HIV Disease, including: *HIV Infection; HIV and Discrimination; Confidentiality, Disclosure, and Protection of Others; HIV Antibody Testing; Psychiatric Implications of HIV/HCV Coinfection; Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV; HIV Infection and Pregnant Women; HIV and Children; HIV and Adolescents; Needle Exchange Programs; Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments; HIV-Infected Psychiatrists; Occupational HIV Exposure: Protocols and Protections; HIV & Crystal Methamphetamine; HIV Infection and People Over 50;* as well as *Outpatient Psychiatric Services*, American Psychiatric Association, Arlington, VA, 2003 through 2008, as may be amended.
- *Practice Guideline for the Treatment of Patients with HIV/AIDS*, American Psychiatric Association, Arlington, VA, November 2000; including *Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS*, Marshall Forstein, M.D., et al, American Psychiatric Association, April 2006, as may be amended.

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

MENTAL HEALTH THERAPY/COUNSELING & PSYCHOSOCIAL SUPPORT SERVICES *(continued)*

Guidelines (Pastoral Care): Providers will adhere to generally accepted clinical guidelines for pastoral care counseling of persons with HIV/AIDS. References for these guidelines include those issued by:

- *Association for Clinical Pastoral Education*
- *American Institute of Islamic Studies and Culture*
- *Canadian Association for Pastoral Practice and Education*
- *National Association of Catholic Chaplains*
- *National Association of Jewish Chaplains*

HOME DELIVERED MEALS

Guidelines:

- Providers will adhere to generally accepted nutritional standards for provision of meals to persons living with HIV or AIDS. One accepted clinical practice guideline is provided by The American Dietetic Association, *Manual of Clinical Dietetics*, that includes recommended allowances and a sample menu and daily meal plan for a high-protein, high calorie diet, commonly used for HIV infected individuals who are protein and energy malnourished (*Manual of Clinical Dietetics*, 6th Edition, co-published by The American Dietetic Association and the Dietitians of Canada, © October 2000, including the supplement of June 2001 and the errata update of September 2002).