

**Standards of HIV/AIDS Care & Services
and HIV/AIDS Prevention & Education
Pennsylvania Department of Health
Division of HIV/AIDS**

Care & Services Standards

INTRODUCTION

The following are Standards of HIV/AIDS Care & Services. These standards, to be implemented beginning January 1, 1998, are specifically applicable to the areas of Case Management, Clinical Care, and Supportive Services. General Standards, found in Appendix I, are applicable to most agencies and/or providers of HIV care and services. Therefore, providers should use the standards in this Appendix J in conjunction with the General Standards.

Case Management Standards

1. General case management service standards.

See Attachment A for a Description of Case Management Services, Goals, and Activities.

A1. Case management practice standards

Standard A1-1: Following a referral or request for case management services, each consumer with HIV is screened (see Glossary) within five working days to determine:

- **The consumer's HIV-positive diagnosis. (NOTE: In cases in which a clinical diagnosis is not available and may take longer than five days to acquire, the case manager should operate on the basis of a consumer's statement about HIV status until the clinical diagnosis becomes available. If a clinical diagnosis is not obtained in a reasonable amount of time as determined by the provider agency, it is the case manager's responsibility to follow up on status and document the results of this follow-up.**
- **Whether a life-threatening crisis is being experienced. (If so, screening should be suspended while immediate action is taken to address the crisis see General Standard B6 regarding crises situations.)**
- **Consumer needs and, given these needs, whether case management services are appropriate for consumer.**
- **The types of services (e.g., TCM, Ryan White) for which the consumer is eligible.**
- **Financial/income status and medical benefits/insurance status.**

Indicator A1-1.1: Screening conducted within five working days of request/referral.

Example of evidence:

- *Consumer contact file contains dated documentation of referral/request for service and consumer screening.*

Indicator A1-1.2: In cases of crisis situations, screening is suspended and the crisis is addressed immediately.

Example of evidence:

- *Consumer contact file addresses ways that crisis situations were handled.*

Indicator A1-1.3: An official, dated diagnosis statement is received by case manager.

Example of evidence:

- *Official, dated statement is in consumer file.*

Standard A1-2: Prior to assessment, each consumer with HIV is given an overview of case management services and the roles and responsibilities of the case manager and the consumer, including the agency's grievance procedures.

Indicator A1-2.1: Case management services, grievance procedures, and rights/responsibilities are described to consumer.

Example of evidence:

- *Consumer contact file contains a signed form indicating that the consumer has received an overview of services, grievance procedures, and roles/responsibilities of case manager and consumer.*

Standard A1-3: Each consumer with HIV who consents to receive case management services receives a biopsychosocial assessment (see Glossary) within 30 days of the consumer's initial screening to identify the consumer's strengths, resources, needs, and problems. This assessment is done under circumstances (e.g., time and location) agreeable to the consumer and includes the following areas:

- Identification of source if referred to services.
- Date assigned to case manager.
- Basic demographic information.
- Assessment of previous or current case management services.
- Summary of physical health history and respective treatment (including complementary therapies).
- Summary of mental health history and respective treatment (including complementary therapies).
- Summary of substance abuse history and respective treatment (including complementary therapies).
- Assessment of risk behavior and risk reduction behavior (e.g., risk of transmitting HIV, sexual risk behavior, domestic violence).
- Summary of medical benefits/insurance.
- Legal history, including probation officer, if applicable.
- Housing/living situation (type of housing/household composition).
- Debt and money management issues.
- Employment issues (current employment; ability to be employed, job training and re-training).

- **Family history/social support.**
- **Names and addresses of primary physician, dentist, and pharmacist.**
- **Current medications/dosage, including nutritional supplements and other substances used in complementary therapies (e.g., homeopathic remedies).**
- **Other formal and informal resources.**
- **Physical and social barriers to services.**
- **Consumer's statement of need.**

Indicator A1-3.1: Case manager has identified past sources of services/care and has obtained summaries of pertinent, existing consumer primary and behavioral health records and legal history, as well as phone numbers and addresses of key providers.

Example of evidence:

- *Existing consumer records received.*
- *Sources of referral, past service/care providers, and providers' phone numbers and addresses listed in biopsychosocial assessment documentation.*

Indicator A1-3.2: The consumer is assessed in key areas listed above.

Example of evidence:

- *Documentation exists in consumer's file that assessment in each area was conducted.*

Indicator A1-3.3: Service Coordination Plan (SCP) is completed at the end of the biopsychosocial assessment; both the consumer and case manager sign the SCP; and a copy of the SCP is given to the consumer.

Example of evidence:

- *Signed and dated SCP in consumer file, with an indication that consumer received a copy.*

Standard A1-4: Each case manager coordinates services among community-based organizations, primary care providers, housing services, and other providers in managing the case of a consumer with HIV by advocating for the consumer and collaborating with these entities. (Also, see General Standard B1.)

Indicator A1-4.1: Case manager plays an active part in linkages among providers.

Example of evidence:

- *Letters of cooperation/collaboration among providers are on file.*
- *Case management notes show evidence of collaboration with providers and advocacy for consumers.*

- *Meeting notes and other written materials give evidence that providers have met to exchange information, coordinate planning, etc.*

NOTE: Case managers providing linkages with benefits/financial counselors, or providing debt/money management or benefits counseling assistance, see Supportive Services Standards F regarding benefits/financial counseling.

Standard A1-5: Written documentation is kept for each consumer with HIV which includes:

- The consumer's name and/or unique identifier number.
- The case manager's name.
- The amount of time, date, place, and a description of each case management service.
- Indication of changes in consumer's biopsychosocial situation.
- Information relating to the services provided which further reflects progress toward reaching goals identified in the SCP. Such documentation should be provided in a format, such as Data/Assessment/Plan (or DAP notes).
- Referrals made to other services.

NOTE: See also, General Standard C1, Indicator C1.4 regarding confidentiality of consumer records.

Indicator A1-5.1: Documentation, both dated and signed by the case manager, is kept.

Example of evidence:

- *Documentation is in consumer file.*

Standard A1-6: The consumer with HIV has face-to-face contact with the case manager at least every 90 days, consistent with consumer needs. As a result of this contact, the following is noted and recorded in the SCP and/or progress note:

- Assessment of progress toward goal achievement.
- Effectiveness of the services and SCP.
- Changes, additions, or deletions to current services, including the need for continued contact and for case management services.

Indicator A1-6.1: Progress notes are kept and review of the SCP is completed at least every 90 days.

Example of evidence:

- *Progress notes and revised SCP is in consumer file.*

Indicator A1-6.2: Problems or critical issues which may hinder access to services are identified and action is taken to resolve them.

Example of evidence:

- *Consumer records and SCP give evidence that problems/issues are identified and action is taken.*

Standard A1-7: Case management services are terminated when:

- **The consumer with HIV, in consultation with the case manager, indicates services are no longer needed or may be met better by another agency (see General Standards C5 and B1, Indicator B1.3).**
- **When six months have lapsed since the consumer last needed contact or service from the case manager, or, in cases in which services have not been needed prior to the end of a six-month period, when the consumer indicates case management services are no longer needed.**
- **When the consumer moves to a new service area.**

NOTE: For appropriate indicators and examples of evidence, see General Standard C3 regarding consumers' rights and responsibilities when refusing services; General Standard C5 regarding appropriate termination and transfer of services; and General Standard B1, Indicator B1.3, regarding provider transfers to other services.

Standard A1-8: Case management services are suspended, but not terminated, when the consumer with HIV is hospitalized, placed in a state correctional facility, or located in some institutional setting where case management is provided or addressed by the institution.

Indicator A1-8.1: The case manager obtains consent from the consumer for transfer of appropriate records and information, and ensures that the transfer of records/information is made to the respective institution for the sake of continuity of case management services.

Example of evidence:

- *Provider has policy on file regarding appropriate transfer of records.*
- *Consumer records indicate that policy regarding transfer of records was maintained and consent was given by consumer.*

Indicator A1-8.2: The consumer is provided seamless case management services when returning from the institution.

Example of evidence:

- *Case manger acquires necessary information about case management received while consumer was in the institution.*
- *Policy is on file for suspending but not terminating cases so that seamless services can be offered on consumer's return to the case management provider.*

A2. Case manager supervision, education, and training standards

Standard A2-1: Case managers meet minimum qualification requirements (see Attachment B for a list of requirements). (Note: Those hired as case managers before July 1, 1996, are given exception through a grandfather clause regarding minimum qualifications.)

Indicator A2-1.1: A personnel file (see General Standard E1-3 and General Standard Attachment B) for each case manager indicates that all qualifications are met by each case manager.

Example of evidence:

- *Resume indicates appropriate degrees/professional (paid) experience.*
- *Certification of HIV training in personnel record.*
- *Other diplomas and certification are noted in personnel record.*

Standard A2-2: Each case manager abides by professional norms (see Attachment B for a list of professional norms).

Indicator A2-2.1: The personnel file (see General Standard E1-3 and General Standard (Attachment B) indicates that all professional norms are evident in each case manager's job performance.

Example of evidence:

- *Annual performance reviews give evidence that case manager understands and abides by professional norms.*
- *Consumer satisfaction surveys indicate case manager has used professional norms as guidance in consumer interaction.*
- *Other documentation indicates that professional norms are understood and incorporated.*

Standard A2-3. Each case manager meets necessary ongoing requirements (see Attachment B for a list of these requirements).

Indicator A2-3.1: A file of written materials *kept by the agency regarding each case manager* indicates that each and every of the above ongoing requirements is met or being met by the case manager.

Example of evidence:

- *Annual performance reviews give evidence that case manager meets or is meeting each ongoing requirement.*
- *Documentation kept by individual case managers, such as letters from other case managers, samples of work developed with other case managers, and a resource file.*

Standard A2-4: Each agency providing case management services determines the maximum number of active cases that can be maintained by each case manager.

Indicator A2-4.1: Internal system exists to determine maximum case load and what actions are taken when a case load exceeds this maximum number.

Example of evidence:

- *Written documentation is on file at agency explaining the internal system.*

Standard A2-5: Each case manager receives appropriate clinical supervision and oversight.

Indicator A2-5.1: Each agency providing case management services establishes qualifications for supervisors of case managers.

Example of evidence:

- *Qualifications are in writing and on file.*

Indicator A2-5.2: A process exists by which each case manager is assigned to, and receives clinical supervision from, a qualified supervisor.

Example of evidence:

- *Agency files indicate that qualified supervisors exist (in-agency supervisors or those who travel from other agencies to provide supervisory tasks).*
- *Personnel files indicate that qualified supervisors provide guidance and conduct case manager performance review.*

Indicator A2-5.3: A process exists by which a supervisor or administrator knowledgeable about appropriate consumer file contents signs off on these files.

Example of evidence:

- *Consumer files contain appropriate sign-off signatures.*

Clinical Care Standards

A. Medical care standards General

NOTE: General medical care standards pertain to primary care, outpatient treatment, home health care, skilled nursing, hospice, and complementary therapy standards.

Standard A1: Each consumer/patient with HIV receives medical care that is linked to a continuum of services to ensure that the biopsychosocial needs of the consumer/patient are met. (Also, see General Standards B1 and B2.)

Indicator A1.1: Each medical care provider communicates and cooperates with consumer/patient and family, case manager, housing services, other care and service providers, and community-based organizations around issues of biopsychosocial needs, including identification of formal and informal support networks.

Example of evidence:

- *Consumers/patients clinical care and case management records give evidence of linkage.*
- *Consumer/patient satisfaction surveys give evidence of linkage.*

Indicator A1.2: When appropriate and/or when requested, consumer/patients receive referrals from medical care providers about traditional forms of medical care as well as complementary therapies.

Example of evidence:

- *Consumer's/patient's clinical care records give evidence that referrals were made to available forms of care.*
- *Consumer/patient satisfaction surveys give evidence that referrals were made when requested.*
- *Clinical care provider performance reviews indicate knowledge of and referrals to traditional and/or complementary care providers.*

Indicator A1.3: Treatments, nutritional supplements, homeopathic remedies, and other forms of traditional medical or complementary therapy interventions are provided to each consumer/patient on the written referral or prescription of the consumer/patient's primary care provider.

Example of evidence:

- *Documentation of written referral or prescription from primary care provider is on file.*

Standard A2: Consumers/patients with HIV are provided medical care that meets the established and most current clinical practices of HIV disease management.

Indicator A2.1: Medical care providers maintain state-of-the-art knowledge of appropriate clinical care of HIV disease and provide care based on this knowledge.

Example of evidence:

- *Provider performance review indicates provider's participation in activities (e.g., clinical update meetings, reading the most current journals and bulletins) that provide state-of-the-art information.*
- *Latest clinical care practices documented in journals, reference books, and other documents are readily available in the provider's place of clinical practice.*
- *Consumer's/patients clinical care records give evidence that most current clinical practices are used.*
- *Existing evaluations, such as consumer/patient outcome studies, indicate most current clinical practices are used.*
- *Providers treating women with HIV disease adopt women-specific, state-of-the-art standards of care, such as standards addressing pregnancy and breast-feeding.*
- *Providers treating infants and children with HIV disease, or whose mothers are infected, adopt pediatric-specific, state-of-the-art standards of care.*
- *Consumers'/patients' clinical care records give evidence that tuberculosis and sexually transmitted disease screenings are performed.*

B. Medical care standards--Specific

B1. Hospice standards

Standard B1-1: Each consumer/patient with HIV receives care from a hospice that is in compliance with standards of the appropriate accrediting entity and all applicable Occupational and Safety Health Act (OSHA) guidelines.

Indicator B1-1.1: Each hospice complies with appropriate accrediting standards and legal laws/guidelines.

Example of evidence:

- *All necessary accrediting documents, such as required documents from the Joint Accreditation Commission of Health Care Organizations and OSHA, are on file and, when appropriate and directed, displayed by the hospice.*

Standard B1-2: Each consumer/patient with HIV understands and elects treatment goals directed toward relief of symptoms rather than cure of the underlying disease.

Indicator B1-2.1: Each consumer/patient receives information about, and is counseled regarding, treatment goals that stress relief of symptoms.

Example of evidence:

- *Documentation of treatment goals signed by the consumer/patient indicates understanding and election of treatment goals that stress relief of symptoms rather than cure.*

Standard B1-3: Each hospice has criteria for considering a person with HIV for admission to hospice care.

Indicator B1-3.1: Criteria exist for admitting consumers/patients to hospice care.

Example of evidence:

- *Written documentation of criteria is available at agency providing hospice care.*

Indicator B1-3.2: Each provider completes an assessment for each new hospice consumer/patient, including a psychosocial evaluation, a symptom assessment, a nutritional assessment, a spiritual assessment, a bereavement assessment, an assessment of the patient's activities of daily living, and an assessment of the home environment if hospice care is offered in the context of the consumer's home.

Example of evidence:

- *Appropriate instruments are on hand and used to assess each new hospice consumer/patient.*
- *Completed assessments are in consumers/patient's file.*

Standard B1-4: Before being admitted to hospice care, each consumer/patient with HIV and family is informed of a range of care and specific types of treatment which exist for symptom relief, physical maintenance, and/or grief management, and are informed of which specific types of treatment are available through that hospice service.

Indicator B1-4.1: Consumer/patient and family receive information about the range of care, treatment, and services and about which of these are made available through the hospice service.

Example of evidence:

- *Written documentation exists listing the types of care, specific treatments, and other services the hospice service offers.*
- *Written documentation exists showing that consumers/patients and families received information about the range of care/treatment/services before the consumer/patient was admitted to hospice care.*

Standard B1-5: Each consumer/patient with HIV and family is informed of hospice policies regarding the use of medications in treating consumer/patients with substance addictions, as well as the use of alcohol and other substances while a consumer/patient receives hospice services.

Indicator B1-5.1: Written policies are explained to consumer/patient and family before admission to hospice care, and the consumer/patient signs a statement signifying an understanding of these policies.

Example of evidence:

- *Written policies are on file.*
- *Written policies are part of a checklist of topics to be covered before hospice admission.*
- *Consumer/patient signature is on file indicating understanding of policies.*

B2. Complementary therapies standards

Standard B2-1: In fields where licenses/certificates/accreditation exist; each provider of complementary therapy holds the appropriate license/certificate/accreditation. (See General Standard A1 for further details.)

C. Behavioral health care standards--General

Standard C1: Each behavioral health care consumer/patient receives behavioral health care from a provider who is trained, or is under the supervision of a practitioner who is trained, in the biopsychosocial aspects of HIV disease. (See Attachment C for a list of important areas for which training in biopsychosocial aspects of HIV disease is critical.)

Indicator C1.1: Providers are trained in, or under the supervision of someone trained in, the biopsychosocial aspects of HIV disease.

Example of evidence:

- *Written proof of training specific to the biopsychosocial aspects of HIV (e.g., proof of participation in training) is on file, and, in the case that the provider does not have, but is under the supervision of such training, explanation of supervisory arrangement is on file.*

Standard C2: Each consumer/patient receiving behavioral health care receives care which is linked to a continuum of services to ensure that the biopsychosocial needs of the consumer/patient are met. (Also, see General Standard B1.)

Indicator C2.1: Each behavioral health care provider maintains linkages with consumer/patient's case manager, primary care provider, housing services, other care and service providers, and community-based organizations around issues of biopsychosocial needs.

Example of evidence:

- *Consumer/patient clinical care and case management records give evidence of linkage.*
- *Consumer/patient satisfaction surveys give evidence of linkage.*
- *Records of consumers/patients who are under 18, as well as records of parents with children under 18, indicate appropriate linkages around parenting/guardian issues, needs of dependent children, and other issues affecting dependent children.*

D. Behavioral health care standards-- Specific

D1. Mental health care standards

Standard D1-1: Each consumer/patient obtaining mental health services receives screening for active or historical substance abuse, given the prevalence of substance use among many populations affected by HIV disease (also see Attachment C).

Indicator D1-1.1: Screening is part of the intake process.

Example of evidence:

- *Documentation of substance abuse, referral and treatment related to substance use, self-medication, and substance-use side effects are in consumer/patient file.*
- *Documentation exists that children under 18 receiving mental health services are closely screened for substance use and family issues related to substance use.*

Indicator D1-1.2: Each consumer/patient identified as actively abusing substances is offered choices for treatment, including referrals to drug and alcohol services.

Example of evidence:

- *Consumer/patient file indicates identification of active substance abuse and documentation that consumer/patient was offered treatment choices.*

Indicator D1-1.3: Each consumer/patient identified with a history of substance abuse is monitored for successes, harm reduction and relapse.

Example of evidence:

- *Consumer/patient file and progress notes indicate monitoring for successes harm reduction, and substance abuse relapse.*

D2. Drug/alcohol care standards

Standard D2-1: Consumers/patients obtaining drug/alcohol care receive care from providers who have sufficient knowledge and skills for addressing interaction between living with HIV disease and drug/alcohol use and recovery. See Attachment C for a full list of biopsychosocial aspects of HIV disease which need to be addressed. Areas in which knowledge and skills are critical to drug/alcohol care include:

- The impact of living with HIV disease on the recovery process.
- The interaction of drug/alcohol use and HIV transmission.
- The interaction of prescribed medications with other drug/alcohol use and the impact of the use of prescribed medications on the recovery process.
- Integrating consumers/patients into drug/alcohol services which also serve consumers/patients who do not have HIV disease (e.g., recovery groups, residential services).
- Integrating consumers/patients into HIV-related services which also serve consumer/patients who do not have drug/alcohol-related problems (e.g., residential settings, hospices).

Indicator D2-1.1: Drug/alcohol care providers demonstrate knowledge and skill in working with consumers/patients regarding these above areas.

Example of evidence:

- *Documentation of training gives evidence that above issues have been addressed.*
- *Provider performance reviews give evidence of knowledge and skill.*
- *Consumer/patient satisfaction surveys give evidence of knowledge and skill.*
- *Consumer/patient records indicate that problems and issues related to above areas were effectively addressed by provider.*

Standard D2-2: Each consumer/patient receiving drug/alcohol care is screened for mental health issues, given the prevalence of mental health problems among the substance-abusing population and the potential neurological consequences of HIV disease (also see Attachment C).

Indicator D2-2.1: Screening is part of the intake process.

Example of evidence:

- *Documentation of mental health screening is in consumer/patient file.*
- *Documentation exists that children under 18 receiving drug/alcohol care are closely screened for mental health issues.*

Indicator D2-2.2: Each drug/alcohol consumer/patient identified with actual or potential mental health issues is offered choices for treatment, including referrals to

appropriate mental health services.

Example of evidence:

- *Consumer/patient file indicates identification of mental health issues and documentation that consumer/patient was offered treatment choices/referrals.*

Indicator D2-2.3: Each consumer/patient identified receiving drug/alcohol care and who has a history of mental health problems is monitored for successes, harm reduction, and relapse.

Example of evidence:

- *Consumer/patient file and progress notes indicate monitoring for mental health issues, successes, harm reduction, and relapse.*

E. Dental health care standards

Standard E1: Each consumer/patient with HIV, who receives dental care, receives care that meets the established and most current clinical practices of HIV disease management.

Indicator E1.1: Dental care providers maintain state-of-the-art knowledge of appropriate dental care for consumers/patients with HIV disease and provide care based on this knowledge.

Example of evidence:

- *Provider performance review indicates provider's participation in activities (e.g., clinical update meetings, reading the most current journals and bulletins) that provide state-of-the-art information.*
- *Latest dental care practices are in writing and readily available in the provider's place of clinical practice.*
- *Consumer/patient dental care records give evidence that most current clinical practices are used.*
- *Existing evaluations, such as consumer/patient outcome studies, indicate most current dental practices are used.*

Standard E2: Each consumer/patient with HIV, who receives dental care, receives this care based on the consumer's/patients current medical status, not on HIV status alone. That is, specific dental approaches should be chosen based on whether, and the level at which, the consumer/patient is medically compromised.

Indicator E2.1: Each dental care provider offers the consumer/patient treatment appropriate to the consumer/patient's medical status.

Example of evidence:

- *Consumer/patient records indicate treatment appropriate to medical status.*

Standard E3: Each consumer/patient with HIV, who receives dental care, receives dental care that is linked to a continuum of services to ensure that the biopsychosocial needs of the consumer/patient are met. (Also, see General Standard B1.)

Indicator E3.1: Each dental care provider communicates and cooperates with consumer/patient and family, primary care provider, case manager, and when appropriate, other providers and agencies to insure issues of biopsychosocial needs are addressed.

Example of evidence:

- *Consumer/patient clinical care and case management records give evidence of linkage.*
- *Consumer/patient satisfaction surveys give evidence of linkage.*

Supportive Services Standards

A. Volunteer buddy/companion/care team service standards

Standard A1: Each consumer with HIV, who requests buddy/companion/care team services, receives respective services which have established and clear policies about delivery and limitations of services. Policies address the following areas:

- **Established boundaries concerning professional and personal relationships between providers (including volunteers) and consumers, as well as ways in which breaches of these boundaries are handled by provider agency.**
- **Extent of services that buddies/companions/care teams are permitted to provide (including assurance that medical tasks are not provided by buddies/companions/care teams), and ways in which breaches are handled by the provider agency.**

Indicator A1.1: A written policy exists addressing the above areas.

Example of evidence:

- *Written policy is in agency file.*

Indicator A1.2: Training of buddies/companions/care teams includes instruction in the above policies.

Example of evidence:

- *Training materials give evidence that policies are addressed.*

Indicator A1.3: Buddies/companions/care teams deliver services which abide by these policies.

Example of evidence:

- *Performance reviews give evidence that policies are implemented.*
- *Consumer satisfaction surveys give evidence that policies are implemented.*

Indicator A1.4: A further policy exists explaining ways that consumers/families are informed about provider policies addressing the above areas.

Example of evidence:

- *Signed statements are on file giving evidence that consumers were informed of policies.*

B. Facility-based day care service standards

NOTE: See Glossary for definitions of day care and respite care.

Standard B1: Each facility-based day care consumer receives assessment of needs and an activity plan based on this assessment.

Indicator B1.1: Means for assessment of consumer needs is incorporated in the program design and structure.

Example of evidence:

- *Written policy for assessment of consumer's needs exists.*

Indicator B1.2: Written activity plans incorporate individual needs of consumer and/or consumer base.

Example of evidence:

- *Written indication that individual needs are being met is in place.*

Indicator B1.3: Written plans for activities are completed on a regular basis.

Example of evidence:

- *Supervisory oversight of plans is noted on a regular basis.*

Indicator B1.4: A schedule of activities is visible and available.

Example of evidence:

- *Written and posted documentation are available on request.*

C. Emergency fund service standards

Standard C1: Each agency offering emergency fund services has policies and procedures in place to guide the use of emergency funds. Guidelines address:

- **Needs for which funds are used.**
- **Appropriate funding streams for supporting specific needs.**
- **Any dollar limitations per consumer over a specific time period.**
- **Guidelines for assessing consumer need and selecting recipients.**
- **Appropriate response time between request for emergency funds and distribution of funds.**
- **Procedures for distributing funds.**

Indicator C1.1: Written policies and procedures include guidelines in the above areas.

Example of evidence:

- *Written policy and procedures are in agency file.*

Indicator C1.2: Training of emergency fund providers includes instruction in the above policies and procedures.

Example of evidence:

- *Training materials give evidence that policies and procedures are addressed.*

Indicator C1.3: Providers who make decisions on the distribution of emergency funds abide by these policies and procedures.

Example of evidence:

- *Performance reviews give evidence that policies and procedures are implemented.*
- *Consumer satisfaction surveys give evidence that policies and procedures are implemented.*

Indicator C1.4: When requesting emergency fund services, each consumer/family is informed of written policies and procedures.

Example of evidence:

- *Documentation exists giving evidence that each consumer/family was informed.*

D. Legal service standards

No HIV-specific standards identified. General Standards apply.

E. Advocacy service standards

Standard E1: Consumers should received advocacy services (whether provided by a member of the bar or other service provider) that are compliant with Act 148 (Confidentiality of HIV-Related Information Act of 1990, 35 P.S. § 7601 et seq.). (See General Standard C1 for further details.)

F. Benefits/financial counseling service

Standard F1: Providers of benefits/financial counseling maintain and provide updated information regarding benefits available to consumers with HIV disease and the laws governing those benefits.

Indicator F1.1: Updated information is maintained.

Example of evidence:

- *Agency files contain information about updated benefits available to people with HIV disease.*

Standard F2: Benefits/financial counselors maintain linkages with the case manager of each consumer with HIV disease if such a case manager is identified by the consumer.

Indicator F2.1: Benefits/financial counselors inform case managers about benefits/financial issues pertaining to consumers.

Example of evidence:

- *Letters exist on file indicating communication with case managers.*
- *Meeting notes and other written documentation give evidence that information has been exchanged with case managers.*

G. Education/risk reduction services

General Standards apply. See also Prevention and Education Services Standards.

H. Nutrition/food service standards

NOTE: Standards for nutrition and food services for nutritional assessment and management of consumers with HIV are provided by The American Dietetic Association.

H1. Drinking water

Standard H1-1: If a consumer with HIV receives drinking water as a service, drinking water is safe.

Indicator H1-1.1: Drinking water meets updated safety requirements (e.g., National Sanitation Foundation requirements for filtered water or processed bottled water).

Example of evidence:

- *Current safe drinking water requirements are on file.*
- *Water meeting requirements is served with meals.*

H2. Food bank, home-delivered meals, and congregate meals

Standard H2-1: Consumers with HIV receive food that is nutritionally sound and safe for people with HIV disease.

Indicator H2-1.1: Food banks review expiration dates on packages/containers of food items containing such dates, as well as damaged packaging, and remove items that may not be nutritionally sound and safe.

Example of evidence:

- *Expired food items and other items that may be unsound or unsafe cannot be found on shelves.*

Indicator H2-1.2: Home-delivered and congregate meal menus are reviewed on a quarterly basis by individuals with formal nutritional backgrounds.

Example of evidence:

- *Results of review of contents/menus are in agency files.*

Indicator H2-1.3: Meals and food packages meet food safety standards as set forth by existing federal, state, and local regulations.

Example of evidence:

- *Written evidence of compliance is on file.*

Standard H2-2: Policies and procedures exist concerning who is eligible for services

and the quantity of food/meals and frequency of services that can be expected.

Indicator H2-2.1: Written policies and procedures address above areas.

Example of evidence:

- *Written policy is in agency file.*

Indicator H2-2.2: Training of food bank and home-delivered and congregate meal providers includes instruction in the above policies.

Example of evidence:

- *Training materials give evidence that policies and procedures are addressed.*

Indicator H2-2.3: Providers of food bank packages and home-delivered and congregate meals abide by these policies.

Example of evidence:

- *Performance reviews give evidence that policies are implemented.*
- *Consumer satisfaction surveys give evidence that policies are implemented.*

H3. Nutritional supplement services

NOTE: See Clinical Care Standard A1, Indicator A1.3, regarding prescriptions/referrals for nutritional supplements.

H4. Nutritional counseling services

Standard H4-1: Following a referral or request for nutrition counseling, each consumer with HIV is screened to determine:

- **HIV-positive status.**
- **Consumer's and family's need for nutrition counseling.**

Indicator H4-1.1: Screening is conducted.

Example of evidence:

- *Consumer contact file contains dated documentation of referral/request for service and results of consumer screening.*

Standard H4-2: Each consumer with HIV and/or their family which is identified to be in need of nutritional counseling receives a nutrition counseling plan, and this plan is integrated into the primary health care plan. The nutritional counseling plan

includes:

- **Assessment of nutrition/dietary intake.**
- **Individual/cultural food preferences.**
- **Consumer's weight, height, medications, allergy history, and history of other chronic disease (such as hypertension and diabetes).**
- **Use of appetite enhancers, supplements, complementary therapies, and vitamin and mineral supplements.**
- **Assessment of consumer's nutrition-related symptoms, for example, patterns of chewing, swallowing, nausea, vomiting, diarrhea, and constipation.**
- **Assessment of need for nutritional supplements.**
- **Socio-economic factors associated with nutrition, for example, availability of food and appliances.**
- **Nutritional goals based on above assessments.**
- **Reassessment of nutritional plan as necessary, but not less than annually.**

Indicator H4-2.1: Each consumer is assessed in above areas and nutritional counseling plan, including nutritional goals, is constructed and signed by consumer.

Example of evidence:

- *Written and signed nutritional counseling plan is in consumer file.*
- *Consumer signature in file indicates a copy of plan was received.*

Indicator H4-2.2: Consumer/family is given a copy of the nutrition counseling plan.

Example of evidence:

- *Consumer file documents that plan was supplied.*

Indicator H4-2.3: Nutrition counseling plan is integrated with consumer's primary health care plan.

Example of evidence:

- *Written documentation gives evidence of communication with primary care provider and case manager regarding the nutrition counseling plan.*

Standard H4-3: Consumer with HIV/family receives counseling and education to meet consumer's nutritional goals.

Indicator H4-3.1: Counseling and education are offered by provider according to consumer/family need.

Example of evidence:

- *Consumer record gives evidence that nutrition counseling and education was received.*
- *Agency records of educational programs indicate consumer/family attendance.*

Standard H4-4: Consumer with HIV receives reassessment of nutritional health status as agreed on and indicated in the nutritional counseling plan.

Indicator H4-4.1: Reassessment is performed as agreed on in nutritional counseling plan.

Example of evidence:

- *Consumer record indicates reassessment was conducted and nutrition counseling plan revised accordingly.*

I. Support group, self-help group, and drop-in center standards--General

Standard I1: Policies about provisions concerning whether child care is or is not provided are maintained by providers.

Indicator I1.1: Policies exist about whether child care is provided and, if so, when and how provided.

Example of evidence:

- *Written policy is on file.*

Indicator I1.2: Policies about whether child care is provided and, if so, when and how provided, are understood and followed by all staff.

Example of evidence:

- *Agency documentation gives evidence that all staff is informed about policies regarding child care provisions.*
- *Child care is provided in the manner by which it is explained in policies.*

Indicator I1.3: Consumers are informed of policy of whether child care is provided at the onset of service and policies are reinforced at times when child care needs arise for consumer.

Example of evidence:

- *Documentation is on file, such as written information regarding child care policies supplied to consumers at the onset of services.*

Standard I2: Target populations are identified by providers, and venues for publicizing services are appropriate and easily accessible to these target populations. (See, also, General Standard B3, Indicator B3.2; and General Standard B4 for further details about outreach.)

Indicator I2.1: Agencies identify target populations and appropriate venues for publicizing services.

Example of evidence:

- *Documentation of needs assessment for identifying target populations is on file.*
- *Documentation exists identifying the venues for publicity as well as rationale for using these venues as the most appropriate and accessible to identified target populations.*

J. Support group, self-help group, and drop-in center standards--Specific

J1. Support and self-help group standards

Standard J1-1: At least one provider staff (paid or volunteer) is present in the facility during the rendering of agency-sponsored, HIV-related support groups (both those facilitated by professionals and by non-professionals) and self-help groups to answer questions that might arise concerning HIV/AIDS and related services.

NOTE: Where appropriate, provider staff should be present in agency-sponsored group processes themselves to monitor the atmosphere of groups and information about HIV/AIDS and related services. However, it is recognized that some self-help group processes require that only group members participate, in which case it would be appropriate for provider staff to be available in the facility but not necessarily involved in the group process. This standard does not necessarily apply to support and self-help groups which rent or borrow agency facilities but are not formally part of agency services.

Indicator J1-1.1: At least one provider staff is present in the facility during agency-sponsored, HIV-related groups.

Example of evidence:

- *Agency written attendance sheets, time sheets, or other documentation gives evidence that at least one staff is present at all times.*

Standard J1-2: Consumers' access to meeting facilities is facilitated by consumer agency policies.

Indicator J1-2.1: Policies exist concerning how and when consumers may gain access to the facility for support and self-help groups, as well as what occurs in the event that no consumer is present when scheduled meetings are to begin.

Example of evidence:

- *Written policy is on file.*

Indicator J1-2.2: Policies concerning facility access and what occurs in the event that no consumer is present at the beginning of scheduled meetings, are understood and followed by staff.

Example of evidence:

- *Agency documentation gives evidence that all staff is informed of policies.*
- *Opening and closing of meeting facilities occur according to policy*
- *Consumer satisfaction surveys note that policies are followed.*

Indicator J1-2.3: Consumers are informed of polices regarding facility access and what occurs in the event that no consumer is present at the beginning of scheduled meetings.

Example of evidence:

- *Documentation is on file, such as written information about policies supplied to consumers at the onset of services.*

J2. Drop-in center standards

Standard J2-1: Consumers find the facility open and at least one provider agency staff (paid or volunteer) present during all scheduled and publicized drop-in service hours.

Indicator J2-1.1: Facilities are open and staff is available during all times when services and events are scheduled.

Example of evidence:

- *Agency documentation, such as sign-in or time sheets, gives evidence that staff was present and facilities were open.*
- *Consumer satisfaction surveys and other feedback documentation give evidence that facilities were available during all scheduled/publicized service hours.*

K. Transportation services standards

NOTE: The following standards apply to transportation services which receive direct contracts through Coalitions/Fiscal Agents to provide transportation for people affected by HIV disease, as well as agencies which are sub-contracted through HIV/AIDS-related providers who maintain contracts with Coalitions/Fiscal Agents. Example of evidence provides further illustrative details.

Standard K1: Each consumer of transportation services receives prompt, dependable, and courteous service.

Indicator K1.1: Transportation service staff (including phone receptionists, dispatchers, and drivers) makes every effort to assure every service request is honored in a prompt, dependable, and courteous manner.

Example of evidence:

- *Consumer satisfaction surveys indicate prompt, dependable, and courteous service.*
- *Other documentation, such as case management notes about transportation services, give evidence of quality of service.*
- *HIV/AIDS-related service providers who sub-contract with transportation services poll clients who use these latter services to make certain that transportation service staff is prompt, dependable, and courteous.*
- *Documentation is present in provider files which periodically verifies and documents that each driver holds a valid driver's license.*
- *Documentation is present in provider files which reflect any driving incidents involving the driver or the provider's vehicle while transporting clients.*

Standard K2: Consumers receive services that provide the most cost-efficient means of transportation for meeting specific consumer needs.

Indicator K2.1: Most efficient means of transportation are used to meet consumer needs.

Example of evidence:

- *Consumer satisfaction surveys indicate efficient means of transportation.*
- *Other documentation, such as case management notes about transportation services, give evidence of most efficient means of transportation.*
- *HIV/AIDS-related service providers who sub-contract with transportation service agencies choose these agencies based on their documented ability to most closely meet the above standard.*

Standard K3: Consumers with special physical needs are accommodated with

commercial vehicles that are accessible to these persons, e.g., lifts for persons in wheelchairs, as stipulated by the Americans with Disabilities Act.

Indicator K3.1: Commercial vehicles used for transportation services are appropriately equipped to be accessible to consumers with special physical needs.

Example of evidence:

- *Specially equipped vehicles are available.*
- *Consumer satisfaction surveys indicate specially equipped vehicles were available when requested.*
- *Other documentation, such as case management notes about transportation services, indicates accessibility of transportation for consumers with special needs.*
- *HIV/AIDS-related service providers who sub-contract with transportation service agencies choose these agencies based on their documented ability to most closely meet the above standard.*

Standard K4: Each consumer is assisted, as appropriate to consumer's needs, by a driver specially trained in assisting persons from the consumer's door at home to vehicle, and from vehicle to another location.

Indicator K4.1: Drivers are trained to assist persons between homes and locations of services.

Example of evidence:

- *Agency files indicate nature of special training for drivers*
- *Personnel files give evidence that each driver is trained.*
- *Consumer satisfaction surveys give evidence that drivers properly assist consumers.*
- *HIV/AIDS-related service providers who sub-contract with transportation service agencies choose these agencies based on their documented ability to most closely meet the above standard.*

Standard K5: In addition to other consumer confidentiality mechanisms, each consumer is assured confidentiality by the absence of signs and other visible indications that vehicles are transporting people with HIV/AIDS.

Indicator K5.1: Signs and other visible indications are never involved in transporting consumers.

Example of evidence:

- *Inspection of vehicles used for transporting consumers gives evidence of the absence of indicators.*
- *Consumer satisfaction surveys and other consumer reports give evidence that*

- *visible indicators are not present during use of transportation services.*
HIV/AIDS-related service providers who sub-contract with transportation service agencies choose only agencies which guarantee (in writing) consumer confidentiality, including the absence of signs and other visible indications that vehicles are transporting people with HIV/AIDS.

L. Home health care standards

No HIV-specific standards identified. General Standards apply.

ATTACHMENT A

DESCRIPTION OF CASE MANAGEMENT SERVICES, GOALS, AND ACTIVITIES

Case management is a consumer-centered service approach. Goals of case management are to (1) assess consumer care and service needs; (2) facilitate coordination of care and services received by each consumer with HIV; and (3) assist each consumer in obtaining required care and services. These goals are achieved by providing education; creating connections between care seekers and care givers; and encouraging the use of the existing support system identified by the consumer. Specific case management activities include:

- Comprehensive biopsychosocial assessment of the consumer's needs and personal support systems.
- Development of a comprehensive, individualized service plan (including information about, and referral to, appropriate health and supportive services).
- Coordination of the services required to implement the service plan.
- Following consumers over time to assess the efficacy of the service plan.
- Advocacy on behalf of the consumer, family, and significant others, including creating, obtaining, or brokering needed consumer resources.
- Periodic re-assessment of the consumer's status.
- Periodic re-evaluation and adaptation of the plan as necessary (including the termination of the case when services are no longer warranted or requested).

The Division of HIV/AIDS acknowledges that, in the current HIV service delivery system, case managers often function in a dual role of provider of health and supportive services. Although these latter services may be provided by a case manager or case management agency, provision of health and supportive services are not considered to be case management. Case management services are defined by the effective culmination and integration of key activities and services, which are outlined in a written service plan.

The service plan, also known as the "care plan" or "service care plan" must include: realistic, measurable and mutually acceptable goals; the action steps and actual or potential providers necessary to reach those goals; a target date for accomplishment of each goal and action step; notation as to which party to the agreement is responsible for each action step; and, the intended result or anticipated outcome of each action step. Progress notes in the client chart are made based upon this plan. Other notations not specifically related to the plan are noted in case file notes and other appropriate locations in the client chart. Plans are updated as new goals and action steps are identified and as goals and action steps are completed.

ATTACHMENT B

CASE MANAGER MINIMUM QUALIFICATION REQUIREMENTS, PROFESSIONAL NORMS AND ONGOING REQUIREMENTS

Minimum qualification requirements for case managers (see Case Management Standards - Standard A2-1):

Each case manager must:

- Have a bachelor's degree in social work, psychology, or sociology, or other related field; or, for nurses, be classified as a Registered Nurse or have a bachelor's of science in nursing.
- Have a working knowledge of HIV/AIDS. This knowledge base is referred to in General Standard B3, Indicator B3.3, as well as in General Standards E1, regarding qualifications for positions and training.
- Have knowledge of, and contact with, health care entities, social service agencies, and public entitlement programs in immediate and surrounding communities; have knowledge of service costs and budgetary parameters; and be fiscally responsible in carrying out all case management functions and activities.
- Be resourceful and creative in accessing required services.
- Possess interpersonal skills which allow effective interaction with consumers and multiple providers in private households, residential care facilities, institutions, and medical settings, while maintaining a spirit of hope and empathy.

Case manager professional norms (see Case Management Standards Standard A2-2):

Each case manager must:

- Have a working knowledge of respective consumer's HIV disease process, based on medical assessments.
- Ensure that consumers are involved in all phases of case management practice to the greatest extent possible by:
- Ensuring that each consumer receives appropriate assistance through accurate and complete information about the extent and nature of available services.
- Helping the consumer decide which services best meet his/her needs.

- Employ every measure to assure that consumer information is treated in strict confidence, in compliance with Act 148, including prescribed uses and limitations of releases of information.
- Intervene at the consumer level to provide and/or coordinate the delivery of direct services to consumers and their families, including:
 - Outreach, referral, consumer identification, and engagement.
 - A biopsychosocial assessment of the consumer (assessment of the consumer's needs and personal support systems).
 - The development of a comprehensive, individualized service plan.
 - Coordination of the services required to implement the plan.
 - Following consumers over time to assess the efficacy of the plan.
 - Advocacy on behalf of the consumer, including creating, obtaining, or brokering needed consumer resources.
 - Reassessment of the consumer's status.
 - Periodic re-evaluation and adaptation of the plan as necessary over the life of the consumer (or termination of the case when services are no longer warranted).
- Be easily accessible to the consumer
- Keep clear, concise, and complete records
- Carry out his/her duties in a culturally sensitive manner.
- Abide by professional ethics.
- Be pro-active/preventive/wellness-oriented.
- Maintain active licenses, if applicable.

Ongoing requirements for case managers (see Case Management Standards - Standard A2-3):

The case manager must:

- Participate in annual training which enhances job-related skills and/or knowledge.
- Develop a resource file and be willing to share resources with fellow case managers.
- Coordinate with other agencies providing similar case management services to prevent duplication.
- Identify resources and/or weaknesses in the local service system and inform fellow case managers.
- Intervene at the service-systems level to support existing case management services and to expand the supply of, and improve access to, needed services.
- Participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates, as well as the case manager's own case management services, and to otherwise ensure full professional accountability.
- Treat colleagues with courtesy and respect and strive to enhance inter-professional, intra-professional, and inter-agency cooperation on behalf of the consumer.
- Ask the advice of colleagues and supervisors whenever such consultation is in the best interests of the consumer.

- Recommend and provide choices to help consumers select services.
- Carry a caseload consisting of consumers who require early intervention, intensive case management, and/or minimal follow-up that adequately allows the case manager to effectively plan, provide, and evaluate case management tasks related to consumer and system interventions.

ATTACHMENT C

BIOPSYCHOSOCIAL ASPECTS OF HIV DISEASE

To address biopsychosocial aspects of HIV disease, providers must have:

- An understanding of the neurological consequences of HIV disease and how such consequences affect proper diagnosis.
- An understanding of how chronic and/or terminal illness may affect or exacerbate pre-existing mental health/drug and alcohol problems.
- An understanding of the normal stages of dying and death and how these impact the therapeutic process.
- An understanding of how HIV disease can negatively and positively impact the family system, *including permanency issues for dependent children and* an understanding of how to help the family system (both families of origin and/or families of choice) resolve negative impacts and encourage positive impacts.
- An understanding of how HIV disease impacts the appropriateness of various treatment modalities (i.e., individual therapy, family therapy, group therapy, detoxification and rehabilitation, psycho-chemotherapy, etc.) at different points in time.
- Where appropriate, an understanding of the interactions between psychopharmacological medications and HIV treatment medications.
- Awareness of risks, risk behaviors, and treatment approaches that would be premature until risks are addressed.
- An understanding of major legal concerns and appropriate actions or referrals (wills, testaments, custody, guardianship, and adoption).