STANDARDS OF CARE –REQUIRED QM CLINICAL MEASURES					
STANDARD	***INDICATOR***	***NUMERATOR***	***DENOMINATOR***	***DATA SOURCE***	***GOAL/BENCHMARK***
A. Ambulatory Outpatient / Medical Care provided will adhere to the current DHHS/PHS Guidelines regarding on-going health care, health assessments, medical visits, PCP prophylaxis and CD4 and viral load (VL) counts in order for the grantee (State) and providers to meet the HRSA QM Clinical Measure Requirement.	**1.1** Pregnant Women with HIV-infection are prescribed antiretroviral therapy	Number of HIV-infected pregnant women who were currently on or newly prescribed antiretroviral therapy during the 2nd and 3rd trimester	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD,PA, NP at least once in the measurement year	CAREWare, RSR or chart audits	90%
	1.2 Patients/Clients have CD4 counts monitored yearly	Number of Patients/Clients with one or more CD4 counts annually	Number of Patients/Clients		90% of clients have 1 or more CD4 counts annually
	1.3 Patients/Clients who meet current guidelines for ART are offered and/or prescribed ART	Number of Patients/Clients offered and/or prescribed ART	Number of Patients/Clients		90%
	1.4 Patients/Clients who have medical visits with an HIV medical provider at least every 6 months	Number of Patients/Clients with medical visits at least every 6 months	Number of Patients/Clients		90% of Patients/Clients have 2 or more medical visits in an HIV care setting at least 3 months apart every year. Core group 1

STANDARDS OF CARE –REQUIRED QM CLINICAL MEASURES					
STANDARD	***INDICATOR***	***NUMERATOR***	***DENOMINATOR***	***DATA SOURCE***	***GOAL/BENCHMARK***
	1.5 Patients/Clients at risk for PCP are on appropriate prophylaxis	Number of Patients/Clients who are on PCP prophylaxis	Number of Patients/Clients with CD4 count <200 or <14%	CAREWare, RSR or chart audits	90% of Patients/Clients with CD4 <200 or <14% are prescribed PCP prophylaxis, excluding Patients/Clients newly enrolled in care during the last 3 months of the year.
	1.6 Viral Load Monitoring	Number of Patients/Clients with a viral load test performed at least every 6 months	Number of Patients/Clients		90% of Patients/Clients had a viral load test performed at least every 6 months during the measurement year.
	1.7 Viral Load Suppression	Number of Patients/Clients with viral load below limits of quantification (200 copies per ml) at last test during the measurement year	Number of Patients/Clients		90% of Patients/Clients with viral load suppressed to < 200 copies/ml at last test during the measurement year
	1.8 Patients/Clients will receive a health assessment and comprehensive physical exam including an oral exam on initial visit and then annually, and will include mental health and substance use/abuse histories	Number of Patients/Clients with assessment and PE	Number of Patients/Clients		100% Core Group 1
B. Non-Medical HIV/AIDS Case Management services that provide advice and assistance to Patients/Clients in obtaining medical, social, community, legal, financial, and other needed services so the grantee (State) and providers can meet the HRSA QM Clinical Measure Requirement.	Documents include assessments, releases, rights and responsibilities, HIPPA, Primary Care tracking form, care plan, referral documentation, current progress notes and all applicable correspondence, Including clinical quality measure documentation of CD4 Count, Viral Load, PCP, HAART and Medical Visits	Number of client records that accurately reflect the care delivered across Clinical QM measures	Number of Patients/Clients records reviewed	***On-site chart audits review only – do not send as part of quarterly report**	90% of clients records will reflect the care delivered across Clinical QM measures

STANDARDS OF CARE –REQUIRED QM NON-MEDICAL CASE MANAGEMENT MEASURES

I. Definition/Overview

Support for HIV/AIDS Case Management services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services

May include:

• Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible
• All types of case management encounters and communications (face-to-face, telephone contact, other)
• Transitional case management for incarcerated persons as they prepare to exit the correctional system

Note: Non-Medical Case Management does not involve coordination and follow up of medical treatments.
(US Department of Health & Human Services, HRSA/HAB Division of Service Systems Program Monitoring Standards - Part B April, 2011)

II. Services

HIV/AIDS Case Management is a formal and professional service that links persons living with HIV/AIDS (PLWHA) with multiple service needs to a formal continuum of health and social service systems. HIV/AIDS Case Management services strive to ensure that clients with complex needs receive timely coordinated services that enhance a client's ability to function independently as long as it is practical. HIV/AIDS Case Management assesses the needs of the client, the client's family, and the client's support system, and then arranges, coordinates, monitors, evaluates, and advocates for a package of services to meet the client's specific needs.

In Rhode Island, HIV/AIDS Case Management services includes assisting eligible clients to obtain access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs (PAPS), and other state and local health care and supportive services) and identifying clients who have dropped out of medical or ADAP care and assisting them to reconnect with care.

Outcome:
Clients shall receive: 1. Appropriate case management intervention.
2. Continuous and informative case management services over time as the patient/client's disease progresses.

III. Eligibility
Per requirements of Eligibility in the Universal Standards of Care for all Ryan White Services section (Documented HIV status, Rhode Island resident and gross family income at or below 400% of the federal poverty level).

IV. Sections
In this document you will find:

- Personnel
- General Standards
- Quality Assurance

V. Standards of Care and Measures

#	Standard / Indicator	Measure/Evidence
1.0	**PERSONNEL**	
1.1	**Staff Qualifications**	
1.11	HIV/AIDS Case Management staff should demonstrate continuous professional development by earning a minimum of 10 hours of HIV-related training per year.	Personnel records/resumes/applications for employment reflect requisite experience/education. Data Collection Tool: Manual
1.12	Orientation should be provided per individual providing agency Standards.	Agency's orientation program must require all staffers to be familiar and in compliance with all standards required by the grantee and/or state regulatory agencies. Data Collection Tool: Manual

2.0	**Enrollment In Ryan White Services**	
2.1	**The objectives of the eligibility process are to:** 1. Inform the patient/client of: • all Ryan White funded services available; • all Ryan White funded medical case management agencies available in Rhode Island; and • what the patient/client can expect if s/he enrolls in medical case management services. 2. Establish and/or verify patient/client eligibility for Services, including reassessment of clients every 6 months to determine continued eligibility. 3. Collect required state/federal patient/client data for reporting purposes.	Documentation of the objectives of the eligibility process is in Patient/Client record. Data Collection Tool: Manual
2.2	**All funded HIV Case Management agencies must be able to:** 1. Provide enrollment on a walk-in basis 2. Schedule an appointment at the patient/client convenience; and 3. Refer the patient/client to another agency in the event of a waiting list or any capacity constraints prohibiting an agency from serving a patient/client immediately.	Agency policy and procedures reflect the availability of walk-in services. Documentation referral kept on file at the agency. Data Collection Tool: Manual
2.3	The presentation to the patient/client of information regarding the Ryan White service delivery system will include: 1. Confidentiality, release of information, and HIPAA privacy notification as appropriate.	Documentation in patient/client record of the presentation to the patient/client of information regarding the Ryan White service delivery system. Data Collection Tool: Manual

	2. Statement of patient rights and responsibilities; and 3. Agency grievance/complaint procedures.	
3.0	**Patients/clients will be assessed for the need of the following care/services, and referrals, if needed, will be made by a case manager:** **A. Basic Information** Presenting problem Contact and identifying information (name, address, phone, birth date, etc.) Language Spoken/Literacy Level Demographics Emergency Contact Confidentiality Concerns Household Members Documentation of Insurance Status Documentation of HIV Status Documentation of Gross Family Income Documentation of Residence Other current Health Care and Social Service Providers, including case management providers **B. Overview of Status and Needs Regarding:** Medication Access Food/clothing services Financial assistance Housing Transportation Legal services Substance use Mental health Domestic violence Support system	Data Collection Tool: Manual – **Checklist** ***On-site chart audits review only – do not send as part of quarterly report**

	Education Employment Medical case management HIV disease, other medical concerns, access to and engagement in health services Prevention of HIV/AIDS transmission Prevention of HIV disease progression Medical nutrition therapy Oral health services **Checklist**	
3.1	Patient/client will be screened for the need of case management in coordination with a medical care provider.	Documentation of screening is in patient/client record. Data Collection Tool: Manual
3.2	Intake is completed within 3 business days from requested services.	Intake documentation is in patient/client record. Data Collection Tool: Manual
3.3	Patient/client assignment to case manager and case manager contact to patient/client occurs within 5 business days from intake.	Documentation of patient/client assignment to case manager and case manager contact to patient/client is in patient/client record. Data Collection Tool: Manual
3.4	Case manager will set up an appointment with the client to start on all necessary paperwork such as, but not limited to: releases, rights & responsibilities, HIPPA, assessment, care plan, etc. Completion of all paperwork and referral to other services may not exceed 10 business days from date of intake.	Documentation of the case manager and client's appointment and completion of all paperwork is in patient/client record. Data Collection Tool: Manual
3.5	All patient/client receive mental health screening at	Documentation of the mental health screening is in the patient/client's

	time of assessment with case management assessment tool and it is reviewed ongoing as well as every 6 months during care plan review.	record. Data Collection Tool: Manual
3.6	All patient/client receive substance abuse (alcohol & drugs) screening at time of assessment with case management assessment tool and it is reviewed on-going as well as every 6 months during care plan review.	Documentation of the substance abuse (alcohol & drugs) screening at time of assessment with case management assessment tool is in patient/client record. Data Collection Tool: Manual
3.7	Eligible patient/client in need of medications are referred to the AIDS Drug Assistance Program (ADAP) for access to medications to treat HIV-disease and associated opportunistic infections. Patient/client is aided in process by case manager to insure all documentation is in place.	Documentation of patient/client referral to the AIDS Drug Assistance Program (ADAP) is in patient/client record. Data Collection Tool: Manual and ADAP Access Database
3.8	The RI ADAP enrollment process takes place within 2 weeks of the point of identified need.	The RI ADAP enrollment process documentation is in patient/client record. Data Collection Tool: Manual and ADAP Access Database
3.9	The RI ADAP recertification process takes place by the last day of the patient/client's birth month and every 6 months following, and does not cause an interruption in patient/client access to medications. The agency will coordinate with the State to ensure clients are recertified every 6 months.	Documentation of the RI ADAP recertification process is in the agency's program reports. Data Collection Tool: Manual and ADAP Access Database

3.10	Eligible patient/clients with dental needs are referred to dental care to receive an oral exam by a dentist at least once during the measurement year.	Documentation of referral to dental care is in patient/client record. Data Collection Tool: Careware
3.11	Patient/clients are assessed for transportation assistance needs to facilitate patient engagement in care and prevent treatment interruptions. Patient/client must demonstrate a need for transportation assistance during initial assessment and then on-going.	Documentation of the patient/client transportation assistance assessment is in patient/client record. Data Collection Tool: Manual
3.12	Documentation showing need from a landlord or utility company must be provided by patient/client.	Documentation in patient/client record. Data Collection Tool: Manual
3.13	Patient/client are assessed for nutrition and food assistance needs by case manager at the initial assessment as well as twice annually.	Documentation of the patient/client's nutrition and food assistance assessment is in patient/client record. Data Collection Tool: Manual
3.14	Patient/client are assessed for individualized food assistance by the case manager based on need and assessed on-going.	Documentation in patient/client record. Data Collection Tool: Manual
3.15	Case managers will receive a list of patient/client who have not utilized ADAP Benefits in 60 days (31 day report) and will send report update back to ADAP office within 15 days.	Documentation of the RI ADAP benefit utilization process is in the agency's program reports. Data Collection Tool: Manual and ADAP Access Database
3.16	Program staff identifies and communicate as appropriate (with documented consent of patient/client) with other service providers to support coordination and delivery of high quality care and to prevent	Documentation of on standard consent form in patient/client record. Data Collection Tool: Manual

	duplication of services.	
4.0	**Patient/client's have a comprehensive individualized care plan that complies with best practices.**	
4.1	Case Managers will maintain contact, at least once every three months, with all patient/clients receiving case management services.	Documentation of case manager and patient/client contact is in patient/client record. Data Collection Tool: Manual
4.2	Reassessment of the patient/client's needs and care plan revisions is conducted with the patient/client once every 6 months.	Documentation of the reassessment of the patient/client's needs is in patient/client record. Data Collection Tool: Manual
4.3	Patient/clients are discharged or inactivated from HIV Case Management services through a systematic process, including notification to medical provider case management. Documentation of outreach of at least three attempts using any combination of letter sent, phone call made, home visit, or collateral contact.	Documentation of case closure in patient/client record. Documentation of reason for discharge/case closure (e.g., case closure note). Data Collection Tool: Manual
5.0	**Quality Assurance**	
5.1	Service providers shall have an established HIVCase Management quality Assurance/Performance Improvement Plan. This plan shall be monitored for compliance at least twice annually.	Provider maintains a quality assurance/performance improvement plan. ***On-site chart audits review only – do not send as part of quarterly report** Data Collection Tool: Manual

STANDARDS OF CARE – MEDICAL CASE MANAGEMENT PERFORMANCE MEASURES

STANDARD	*INDICATOR*	*NUMERATOR*	*DENOMINATOR*	*DATA SOURCE*	*GOAL/BENCHMARK*
A. Medical Case Management provided will adhere to the current DHHS/PHS Guidelines regarding on-going health care, health assessments, medical visits, viral load (VL) counts in order for the grantee (State) and sub-grantee (providers) to meet the HAB/HRSA QM Performance Measure Requirement.	**1.1** Viral Load Suppression: Percentage of patients with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last viral load test during the measurement year.	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last viral load test during the measurement year.	Number of patients with a diagnosis of HIV with at least one medical visit in the measurement year.	CAREWare, RSR or chart audits	85%
	1.2 HIV Medical Visit Frequency: Percentage of patients with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.	Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period.	Number of patients with a diagnosis of HIV with at least one medical visit in the first 6-months of the 24-month measurement period.	CAREWare, RSR or chart audits	90%
	1.3 Gap in HIV Medical Visits: Percentage of patients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year.	Number of patients with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year.	CAREWare, RSR or chart audits	>15%

STANDARDS OF CARE –REQUIRED QM MEDICAL CASE MANAGEMENT PERFORMANCE MEASURES

STANDARD	*INDICATOR*	*NUMERATOR*	*DENOMINATOR*	*DATA SOURCE*	*GOAL/BENCHMARK*
	1.4 Medical Case Management (MCM) Care Plan: Percentage of MCM patients with a diagnosis of HIV who had a MCM Care Plan developed and/or updated two or more times in the measurement year	Number of MCM patients who had a MCM Care Plan developed and/or updated two or more times which are at least 3 months apart in the measurement year	Number of MCM patients with a diagnosis of HIV who had at least one MCM encounter in the measurement year.	CAREWare, RSR or chart audits	75%