Sacramento County
Department of Health Services
HIV Health Services Planning Council
Quality Advisory Committee
www.sacramento-tga.com

Meeting Agenda:
March 4, 2025, 2:00 PM – 3:00 PM

Meeting Location:
4600 Broadway, Sacramento, CA 95820
2nd Floor Conference/Community Room 2020

Facilitator: Kelly Gluckman - Chair
Scribe: Angelina Olweny – Council Staff
Meeting Invitees:

- Committee Members: Richard Benavidez, Jake Bradley-Rowe, Kelly Gluckman, Keshia Lynch, Lenore Gotelli, Melissa Willett
- Open to the Public

Public Comment: This provides opportunities for the public to address the Council as a whole in order to listen to opinions regarding matters within the jurisdiction of the Council during Regular meetings and regarding items on the Agenda at all other meetings. Public Comment time limit is three (3) minutes.

*Action items

Topic	Presenter	Start Time	Length
Welcome and Introductions	Gluckman	2:00 PM	As Needed
Announcements	All	As Need	
Public Comments - Agenda Items 3-minute time limit	Gluckman		

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March Agenda Review*	Gluckman		
Minutes Review of December 2024*	Gluckman		
FY25 QAC Work Plan Draft*	Gluckman		
QAC Self-Assessment	Gluckman		
Service Standards	Gluckman		
Public Comments	Gluckman		
Technical Assistance	Gluckman		
Adjournment	Gluckman	3:00 PM	

*Action Items

Attachments:
Minutes of December 2024*
FY25 QAC Work Plan Draft*
QAC Self-Assessment Monitoring Form
Medical Case Management Service Standard
Outpatient Ambulatory Health Services Service Standard

Next Meeting: **June 3, 2025**

Sacramento County
Department of Health Services
HIV Health Services Planning Council
QAC Communities Committee
December 3, 2024

HIV HEALTH SERVICES PLANNING COUNCIL – Quality Advisory Committee (QAC)

Meeting Minutes

December 3, 2024, 2:00 p.m. to 3:00 p.m.

Meeting Location:
4600 Broadway, Sacramento, CA 95820
Community/Conference Room 2020

Facilitator: Kelly Gluckman, Chair

Scribe: Angelina Olweny, Council Staff

Committee Member Attendees:

- Kelly Gluckman, Keshia Lynch, Melissa Willett

Members Absent/Excused: Zach Basler, Lenore Gotelli, Richard Benavidez

County Staff: Paula Gammell, Chelle Gossett

Guests: Veronica Franco

Sacramento County
Department of Health Services
HIV Health Services Planning Council
QAC Communities Committee
December 3, 2024

Topic	Minutes
Welcome, Introductions and, Announcements	Welcome, and introductions began at 2:04 PM Tuesday is the Big the Day of Giving. The Capitol was lit red in recognition of World AIDS Day. The capital will be lit red in commemoration of World AIDS Day each year.
Public Comments- Agenda Items	N/A
Agenda Review* September Minutes Review*	The December agenda was presented for review and approval. Keshia Lynch will be added to the attendee list. Kelly Gluckman motioned to accept the agenda as presented and Melissa Willett seconded the motion. The motion passed with a majority. Accept: Kelly Gluckman, Keshia Lynch, Melissa Willett Oppose: N/A Abstain: N/A The September minutes were presented for review and approval. Kelly Gluckman motioned to accept the minutes as presented and Melissa Willett seconded the motion. Keshia Lynch will be added to the attendee list. Melissa Willett motioned to accept the agenda as presented and Kelly Gluckman seconded the motion. The motion passed with a majority. Accept: Kelly Gluckman, Keshia Lynch, Melissa Willett Oppose: N/A Abstain: N/A

Sacramento County
Department of Health Services
HIV Health Services Planning Council
QAC Communities Committee
December 3, 2024

Topic	Minutes
Mental Health Service Standard*	The QAC committee reviewed Mental Health Service Standard. Kelly Gluckman motioned to accept the Mental Health Service Standard as presented and Melissa Willett seconded the motion. The language on page 4 was revised to state that contract staff funded by HIV Care Services Program require Recipient approval. Kelly Gluckman motioned to accept the Mental Health Service Standard with the changes and Keshia Lynch seconded the motion. The motion passed with a majority. Accept: Kelly Gluckman, Keshia Lynch, Melissa Willett Oppose: N/A Abstain: N/A
Food Bank and Home Delivered Meals	The Food Bank and Home Delivered was reviewed. Kelly Gluckman motioned to accept the Food Bank and Home Delivered Meals as presented and Melissa Willett seconded the motion. The following changes were made: The second bullet on page 1 will state that Food Bank and Home-Delivered Meals services should be nutritionally sound. The reference to Choose MyPlate Program from the United States Department of Agriculture will be removed. The second to last paragraph on page 1 will state that Ryan White funding is to be expended in a cost effective, and equitable manner which is based upon verification of client's budget and need that serves the contractually obligated number of unduplicated clients.

Sacramento County
Department of Health Services
HIV Health Services Planning Council
QAC Communities Committee
December 3, 2024

Topic	Minutes
	Kelly Gluckman motioned to accept the Food Bank and Home Delivered Meals Service Standard with the changes and Melissa Willett seconded the motion. The motion passed with a majority. Accept: Kelly Gluckman, Keshia Lynch, Melissa Willett Oppose: N/A Abstain: N/A
Transportation Service Standard	The committee agreed to have the executive committee review the Transportation Service Standard and then present it to the Planning Council for their review and approval. Kelly Gluckman motioned to move the Transportation Service Standard to the executive committee for review, and Melissa Willett seconded the motion. The motion passed with a majority. Accept: Kelly Gluckman, Keshia Lynch, Melissa Willett Oppose: N/A Abstain: N/A
Public Comments	N/A
Technical Assistance	For technical assistance, reach out to Kelly Gluckman
Adjournment	3:06 PM

HIV Health Services Planning Council
QUALITY ADVISORY COMMITTEE
FY 20254-20265 WORK PLAN

MEETING DATE	ACTIVITY	MATERIALS
March 20254	• Data Entry Update for Post Card Survey • Conduct Committee Self-Assessment • Approve 20254-20265 Work Plan	• Committee Self-Assessment
May 20254	• Continue updating Service Standards	
June 20254	• Review 20243 Performance Outcomes from the Recipient • Continue updating Service Standards • FY243 Client Satisfaction Survey Results Report • FY243 Service Post Card Survey Results Report	• 20243 Performance Outcomes • Draft Service Standards • FY243 Client Satisfaction Survey Results Report • FY243 Service Post Card Survey Results Report
September 20254	• Quality Management Program Update from the Recipient • Continue Updating Service Standards • Distribute FY254 Post Card Survey	• Draft Service Standards • Service Survey letter and Post Card Services Worksheet
December 20254	• Prepare FY 20254 Work Plan • Review & Identify All Service Standards needing updates • Plan for Service Survey	• Draft 20254 Work Plan • Service Standards Service Survey

STRATEGIES (from the California Integrated HIV Surveillance, Prevention, and Care Plan)

The following Strategies from the California Integrated HIV Prevention and Care Plan CY 2022-2026, apply to the ongoing work conducted by the Quality Advisory Committee in the Sacramento Transitional Grant Area:

2022-2026 Goals and Objectives
Impact Area 1: Racial Equity

- *Strategy 1b. Racial/Ethnic Data Collection and Stratification:* Identify, collect, analyze, and publicly share data that reflect the specific trends, needs, and outcomes of HIV, HCV, and STIs for BIPOC communities, to inform resource allocation and identify community-based strategies

and solutions.

- *Strategy 1c. Equitable Distribution of Funding and Resources:* Review all CDPH OA and STD Control Branch contracts, budgets, guiding service formulas, policies, and program decisions with a racial justice lens, to advance equitable delivery of resources and opportunities to BIPOC.
- *Strategy 1d. Community Engagement:* Forge strategic partnerships to ensure more diverse public outreach, involvement, and engagement processes to reframe the structure, funding, and policies of HIV, HCV, and/or STI services and messaging to all Californians.
- *Strategy 1e. Racial and Social Justice Training:* Implement capacity building and training opportunities and requirements for all CDPH-funded HIV, HCV, and STI service providers, to strengthen our movement towards achieving cultural humility, equity, and racial justice in our prevention, testing, treatment, and care services.

Impact Area 2: Housing first

- *Strategy 2b. Infrastructure Changes:* Ensure multi-disciplinary teams address HIV/STI/HCV screening and treatment programs statewide, including housing, substance use, mental health, and medical care providers.
- *Strategy 2d. Street Medicine Strategies:* Provide basic medical care and other supportive services to people who remain unhoused (including those who choose to remain unhoused) through walking teams, medical vans, outdoor clinics, and other similar services.

Impact Area 3: Health Access for All

- *Strategy 3a.* Redesigned Care Delivery: Work with health care providers, local health departments, public and private insurers, and private industry to increase access to care statewide through telemedicine, mobile healthcare, and at-home testing programs.
- *Strategy 3d. Culturally and Linguistically Relevant Services:* Improve capacity of public health and health care providers to offer HIV, HCV, and STI services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Impact Area 4: Mental Health and substance Use

- *Strategy 4b. Mental Health and Substance Use Disorder Treatment Access through Telehealth:* Leverage telehealth to increase access to mental health and SUD services, especially for people newly linked to stable housing and people who are monolingual in a language other than English.
- *Strategy 4e. Cross-Sector Collaboration*: Encourage collaboration between local and statewide mental health programs, substance use programs, harm reduction and HIV/HCV/STI programs.

Impact Area 6: Stigma Free

- *Strategy 6b.* Reframe Policies and Messaging: Work with communities to reframe the structure and policies of HIV, HCV, and STI services and associated messaging, so they do not stigmatize people or behaviors.

HIV Health Services Planning Council
Quality Advisory Committee

#	*Rating Category*	*Standards*	**Progress**				**Accomplishments/Barriers** • What has been accomplished (by whom) • **What still needs to occur (by whom) in order to complete the task**
			NA	ND	IP	COM	
1	**Service Quality**	1. Council reviews utilization data, survey data, and other community input to gauge service quality.					
		2. Service Quality Outcomes are reported to PAC in advance of priority and allocations setting process.					
		3. Council assesses cost effectiveness in service standard development.					
		4. Council identifies and assesses barriers to service delivery and access in formulating standards of care.					
		5. Appropriate individuals were used to review and revise service standards.					
		6. PLWH are involved in designing, developing, and conducting standards and measures.					
		7. Service standards are reviewed and discussed by wide range of stakeholders, including clients, providers, Recipient and Council members prior to adoption.					

HIV Health Services Planning Council
Sacramento TGA
Parts A and B
Policy and Procedure Manual

Subject: Medical Case Management Service Standards for Persons Living with HIV/AIDS

No.: SSC 01
Date Approved: 07/25/01
Last Revised: ~~06/22/22~~
Date Reviewed: ~~06/22/22~~

Reference: Ryan White CARE Act Part A Manual SEC. 1. Action taken by the Affected Communities Committee on May 29, 2001; the Executive Committee on June 19, 2001 and July 13, 2001; and the HIV Health Services Planning Council on July 25, 2001.

Policy: This document details the standards of medical case management required to be carried out by service providers funded by the Sacramento TGA's ~~Ryan White CARE Program~~ HIV Care Services Program. These standards are to be applied in conjunction with other service standards for medical, psychosocial and support care for ~~Ryan White~~ HIV Care Services Program eligible clients as developed and approved by the HIV Health Services Planning Council.

PURPOSE OF MEDICAL CASE MANAGEMENT

The Health Resources Services Administration (HRSA) defines medical case management as:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be delivered by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Required Care Objectives include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a medical case manager
- Initial assessment of the client's service needs within 30 days of the first visit
- Development of a comprehensive, individualized care plan at the initial assessment, including client-centered goals and milestones
- Timely and coordinated access to medically appropriate levels of healthcare and support services based on clinical and acuity status of the client
- Routine client monitoring to determine the efficacy of the care plan
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support system
- Treatment adherence counseling to ensure that the client is ready for and adheres to HIV treatments
- Client-specific advocacy and/or review of service utilization as appropriate; and,
- Benefits counseling whereby staff assist eligible clients in obtaining access to other public and private programs for which they may be eligible including but not limited to; Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (HIPP), Disability Insurance, Social Security, pharmaceutical manufacturers' patient assistance programs, Covered California, Housing Opportunities for Persons with AIDS (HOPWA), and/or other state or local health care and supportive services.

PRINCIPLES OF MEDICAL CASE MANAGEMENT

Medical case management is carried out in a manner that is:

- Participatory in that the medical case manager will engage the client in informed decision making to establish a client-optimized individual plan of care.

- Empowering to clients in developing constructive lifestyles and life choices that will facilitate routine medical care by eliminating barriers to care or other factors that impede optimal function of the client.

- Goal-oriented in the development of the client care plan in order to

assess progress and effectiveness of medical case management.

- Flexible in response to the client's immediate, emerging, or otherwise changing needs.

- Culturally proficient in terms and contexts that are understandable and account for the client's personal situation/environment.

- Efficient in design for the purpose of optimizing client specific services based upon need.

- Cost-effective by facilitating the use of resources that will effectively prevent the client from having to access more expensive alternatives.

- Accessible through planned multiple access regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.

- Proactive in will anticipatory referrals to provider services and other supportive resources that most closely match client needs.

FUNCTIONS OF MEDICAL CASE MANAGEMENT

Primary objective is to improve health care outcomes for clients afflicted with HIV or associated conditions.

Required objectives:

- Offer accurate and current information to the client

- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions

- Present options to the client from which he/she may select a course of action

- Offer opinion and direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm

- Be available to support and problem solve and to not judge the client in the present or future based upon their decision(s) of the past

- Gather and evaluate information from the client

- In participation with the client, create a care plan that addresses basic

living needs, medical treatment and compliance issues, and other appropriate social service needs

- Promote coordinate and collaborative communication between clients and all persons involved in the client's care

- Educate the client on available resources and assist them in accessing those resources

- Reinforce treatment adherence counseling to ensure readiness for the complex HIV/AIDS regiments, coordination of service and monitoring plan

EDUCATION REQUIREMENTS FOR DESIGNATIONAS MEDICAL CASE MANAGER

Minimum Qualifications

Possession of any health or human services bachelor's degree from an accredited college or university in social work, counseling, psychology, gerontology or licensing/certification as a Nurse Practitioner (NP), Physician Assistant, Public Health Nurse, Registered Nurse or Clinical Pharmacist.

Experience in specialty case management meeting the criteria described below may be substituted for credentialing.

- Full time work in case management activities with direct consumer interaction for a period of no less than three (3) years under the supervision of a health or human services professional

- Individuals without active credentialing or license in their field must receive clinical oversight and supervision by a licensed clinician monthly or more frequently as appropriate.

Monitoring

Education/Experience/Supervision - Credentialing and/or other education or experience meeting the minimum requirements for service provision in this category must be kept in personnel files, with hire date. Availability of clinical supervision for unlicensed medical case managers will be monitored via discussion during site visits.

Training

Initial: All staff designated as a Medical Case Manager and those staff providing affiliate case management services must complete an initial training session specific to providing and coordinating service to HIV afflicted individuals. Training is be completed within 60 days of hire covering at minimum the following topics:

- General HIV knowledge, such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local HIV system of care including ADAP and HOPWA
- Basic case management skills
- Regional health and human services availability within the TGA
- Trauma Informed Care
- Optional topics may include Motivational Interviewing

The above required training does not preclude a contracted ~~Ryan White~~HIV Care Services Program subrecipient ~~employer~~ from determining or otherwise administering additional employer-based training to the provider's work force as appropriate and necessary or attendance at ongoing Medical Case Management training opportunities organized by the Recipient.

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) rticles, (3) home studies, or (4) webinar.

Monitoring

Staff Training- All trainings provided, and dates of trainings must be available for review during site visits or upon request.

MEDICAL CASE MANAGEMENT PROCESS

Medical Case Management must be delivered in a manner that mitigates barriers to accessing effective care while maximizing available resources to support positive health outcomes for enrolled or potential clients. All Medical Case Management services must include, the functions identified in the Purpose of Medical Case Management Required Care Objectives found in this document.

Process standards are identified and addressed in the following areas:

- Intake
- Assessment

- Reassessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- Transfer and Discharge
- Evaluation of Client Satisfaction

Intake

All Medical Case Management services shall be provided in a culturally and/or linguistically competent manner, which is respectful to the client's cultural health beliefs, practices and preferred language.

Each prospective client who requests or is referred for medical case management services will be evaluated through a face-to-face interaction designed to gather information for immediate and future service needs and facilitate informed client decision-making. The service request/referral will be screened for basic admission criteria and assesses whether the client is in a crisis situation and/or requires immediate direct service referral. If immediate intervention is needed, a referral will be expedited to an appropriate entity.

Required intake activity processes are outlined below:

- the ~~Ryan White~~ HIV Care Services Program Intake form will be completed in its entirety

- the client will be assessed with an Acuity scale which will be dated and signed by the medical case manager. The acuity scale will be updated every six months for medical case management clients

- the client's Informed Consent to Participate in the medical case management program shall be obtained

- the client will be informed of their right to confidentiality and information privacy procedures

- the client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities

- release of information form must be updated annually.

- the client will be informed of, and agree to the Client's Rights and Responsibilities form

- the client will be informed of the agencies' as well as the Ryan White Program's Grievance Procedure

- the client will be informed of the role and purpose of medical case management

- anticipating basic eligibility, the client may proceed to formal assessment, or be referred to another case management agency (if the client would be better served based upon their particular need for medical or non-medical case management services)

- create a client file and archive all relevant documents and forms

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Part A/B Services. Clients who are receiving Targeted Case Management through the county (a Medi-Cal services) are still eligible for Non-Medical Case Management from the Ryan White Program as the Targeted Case Management services do not meet the minimum standards of Non-Medical Case Management as defined in this standard. It is recommended that the Ryan White funded case manager coordinate services with the Targeted Case Management case manager to avoid duplication of efforts and confusion for the client.

Assessment

Required assessment process and criteria:

- initial Medical Case Management face-to-face appointments must occur no later than 10 calendar days from the date of referral

- service agency must have in place a process to ensure timely follow-up of no-show clients preferably within 24-hours

- any client ineligible for Medical Case Management must be referred to an appropriate alternate support service through a warm hand off process

- the Medical Case Manager must complete an in-person psychosocial needs assessment within 30 days of the start of Medical Case Management

- assessment base line will encompass client functional status,

strength/weaknesses inventory, stressor points and available resources and future resource needs

- every attempt should be made to develop a complete history for the purpose of care planning recognizing that the client has the right to refuse disclosure and may request deferment of certain information gathering

Assessment content should address:

- Primary care connection
- Connection with other care providers (e.g. dentist, specialists, key social services)
- Current health status / medical history, including last and next medical appointment, most recent CD4 and VL, and any reasons for terminating care (if applicable)
- Oral health and vision needs
- Current medications / adherence
- Immediate health concerns
- Substance use history
- Mental health / psychiatric history
- Level of HIV health literacy
- Awareness of safer sex practices
- Sexual orientation and gender identity
- Sexual history
- Treatment adherence history, including assessment of ability to be retained in care
- Self-management skills and history
- Prevention and risk reduction issues
- History of incarceration
- Family composition
- Living situation
- Languages spoken
- History and risk of abuse, neglect, and exploitation
- Social community supports
- Transportation needs
- Legal issues
- Financial / program entitlement
- Emergency financial assistance needs and history
- Nutritional status assessment
- Partner Services needs

- Cultural issues, including ethnic, spiritual, etc.; and,
- Summary of unmet needs.

Monitoring

Initial Assessment - Performance of a timely initial assessment, along with complete documentation of assessment findings and applicable referrals/linkages, will be monitored via site visit chart review.

CARE PLAN DEVELOPMENT AND IMPLEMENTATION

Required process and components of care plan formulation:

- development is based on an approved acuity scale
- includes any CD4 count and/or viral load tests during the measurement year
- all medical provider visits will be documented as part of the care plan progress note and those visits client self-reported will be verified by the medical case manager inclusive of date through direct contact with the provider, transcript of case conference notes or other corroborating documentation as appropriate.
- individualized holistic with emphasis on medical needs
- includes realistic, measurable goals that are time framed and consistent with ongoing inter-professional assessment
- intervention responsibility is identified be it provider, vendor, facility or service
- is participatory with the client and reflects client concurrence with initial plan and all updates thereafter
- multiagency or inter-professional collaboration is identified and coordinated
- care plan is documented in an approved format that can be of varying medium i.e., paper chart, EMR, ARIES etc.
- care plan is authenticated by both client and medical case manager by

date and signature upon initial implementation and minimally every 6 months or upon each update (change) thereafter

- periodic reassessment is expected to detect changes in health status of the client but in no case shall reassessment extend beyond a 6 month period within the measurement year

- regardless of periodic reassessment the required measurement year 6 month interval reassessment will be comprehensive encompassing all parameters required during the initial medical case management assessment and will be documented as such

- **care plan must be updated, at a minimum, every six months during the measurement year**, unless the ~~client~~ client-initiated services within six months prior to the end of the measurement year (example: The Sacramento TGA fiscal year is March through February. If a client entered services in December, only the initial care plan would be feasible during the measurement year of March – February)

Monitoring

Care Plans - Development of individualized, medically-focused care plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits.

- Case conferencing required components

    - formal case conferences must be held at least once per quarter for all clients to coordinate care among providers from different services, fields, and disciplines

    - case conferencing should be done through a formal meeting with a multidisciplinary team that is appropriate to the needs of the client

    - for clients experiencing significant changes or unexpected absence from care, more frequent case conferences may be necessary

    - during case conferencing, a review of the care plan and an evaluation of the services the client is receiving should be performed, as well as discussion of the client's current status

(coordinating care, troubleshooting problems with maintaining the client in care, strategies to re-engage client in care, etc.)

- the client and/or their legal representative must be given the opportunity to provide input to the Medical Case Manager about their care plan for discussion at the case conference

- appropriate documentation must also be kept in the client chart or record including names and titles of those attending the case conference, key information discussed, and whether the client or legal representative had input into the conference and the outcomes

- Treatment adherence counseling requirements

  - monitor client treatment employing client self-report, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc.

  - determine who has the primary responsibility for giving medication, and shall provide HIV and adherence education to family members or caregivers as applicable

  - refer clients to additional treatment adherence services as needed

  - assess for barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.)

  - communicate any adherence barriers to the client's medical care providers and work to address the barriers, updating the care plan as needed

  - monitor laboratory values as appropriate

The medical case manager shall document all medical visits including any CD4 count and/or viral load tests during the measurement year.

QUALITY ASSURANCE AND SUPERVISION

All agencies providing Medical Case Management must have a quality assurance plan in place describing a supervisory review to critique documentation of client needs and if those needs were addressed.

Required Standards:

- a representative sample of at least 10 percent of charts of active Medical Case Management clients must have a supervisor review annually
- all clients who are discharged from Medical Case Management must also have a supervisor review within 3 months of that discharge
- reviews must be documented in the client chart with supervisor signature, date of review, and associated findings
- the review process must be conducted by a licensed provider
- in lieu of an internal licensed provider the agency must have in place a process in which an external licensed provider is utilized for the required review
- Provider reviewers may not perform a review of their own clients' chart(s).

CASELOAD

Medical Case Managers are expected to main a caseload of between 40 and 65 clients per 1.0 full time employee (FTE) at any given time depending on the acuity of clients.

Monitoring

Caseload – Agencies must submit their written policies and procedures for caseload review and redistribution when warranted, to adhere to caseload standards.

DOCUMENTATION STANDARDS

Client Record:

- all Medical Case Management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record within 48 hours and entered into the State Part B database, ARIES/HIV Care Connect, within two (2) weeks as appropriate.

- all documentation of activities must be legible, signed, and dated by the Medical Case Manager or authenticated in ~~the~~ an electronic manner consistent with an electronic health record or other record system

Memoranda of Understanding (MOUs), Releases of Information, or other standardized agreements may be necessary to ensure participation in the multidisciplinary team by all necessary staff.

~~**Monitor Treatment Adherence:** Lab reports, particularly viral suppression status, are an integral part of understanding a client's adherence to medications and medical care. The Medical Case Manager must determine which method(s) may be helpful for a particular client.~~

Monitor Treatment Adherence: Medical Case Managers shall monitor client treatment adherence. Client self-report, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc. are used to assist with adherence monitoring. Lab reports, particularly viral suppression status, are an integral part of understanding a client's adherence to medications and medical care. The Medical Case Manager must determine which method(s) may be helpful for a particular client. As needed, the Medical Case Manager shall determine who has the primary responsibility for giving medication and shall provide HIV and adherence education to family members or caregivers as applicable. Medical Case Managers shall refer clients to additional treatment adherence services as needed.

To support treatment adherence, Medical Case Managers shall:

- Identify barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.)
- Communicate any adherence barriers to the client's medical care providers and work to address the barriers, updating the care plan as needed.
- Consult the client's current laboratory results regularly for monitoring purposes

Advocacy and Utilization Review
Medical Case Managers must ensure the provision of a basic needs assessment and assistance (through appropriate referrals) in obtaining medical, social, community, legal, financial, and other needed services. Key activities include:

- Assessment of service needs

- Provision of information and/or referrals; referrals should involve a warm handoff whenever possible
- Assistance in obtaining an official identity document (ID) such as a California ID card, if needed

TRANSFER AND DISCHARGE

The agency shall maintain a systematic process addressing transfer of the client to another program or medical case manager.

Conditions for appropriate transfer, discharge or case closure include:

- client achieves self sufficiency
- loss of financial eligibility
- client and/or client's legal guardian requests that the case be closed
- client is found not to be HIV+
- client relocates outside of service area
- client lost to follow-up defined as a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative
- client refuses to participate in care planning, engagement in required responsibilities or exercise of reasonable self-care management
- falsification of required information/documentation
- client behavior patterns that are threatening, abusive or disrupting to the effective, safe and reasonable provision of service or create eminent potential harm to agency personnel

Standards for client transfer, discharge or closure include:

- matters related to transfer, discharge or closure are discussed through in-person interaction with the client or client's representative
- circumstances necessitating service termination outside of routine transfer, discharge or closure require consultation and concurrence with appropriate agency management

- involuntary termination of service requires implementation of an established agency protocol that minimally includes the following components

    - client notification process and complete with timelines
    - notice of appeals process
    - exploration of alternative care that is coordinated with the receiving service
    - process for intermittent suspension of service

- documentation of the reason for transfer, discharge, or closure describes discussion with the client and options for other service provision when applicable (preferably face-to-face) and includes a service transition plan

GRIEVANCE PROCESS

Client conflict or care management disagreement resulting in medical case management services termination will be addressed through the agency's specific grievance procedure.

If a resolution is not mutually resolved between the client and agency, then the case will be reviewed by the Recipient and a written response sent to all parties involved (e.g. agency, client) within twenty (20) working days with a disposition. If an extension is needed, a letter shall notify all parties involved of an extension for an additional ten (10) working days. Final disposition shall occur no later than thirty (30) working days following the initial filing with the Recipient.

Adopted:  Date: ~~06/22/22~~

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Part A and B
Policy and Procedure Manual

Subject: Outpatient Ambulatory Health Services

No.: SSC XX
Date Approved:
Date Revised:
Date Reviewed:

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council, the following Outpatient Ambulatory Health Services Standard will apply to all HIV Care Services Program contracted subrecipients that provide outpatient ambulatory health services.

Descriptions:
This document describes the "Outpatient/Ambulatory Health Services" service category of the Sacramento County's HIV Care Services Program, funded through the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A and B. It serves as a supplement to the Universal Standards document.

This document highlights each of the requirements and standards that apply to Outpatient/Ambulatory Health Services and must be followed by any subrecipient receiving HIV Care Services funding for this service category.

1. Ryan White CARE Act funding is to be used for HIV/AIDS medical care including psychosocial and support services designed to significantly improve client access and adherence to such resources.

Service Definition
HRSA Definition
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits non-HIV related visits to urgent care and emergency room visits are not allowable costs under the Outpatient/Ambulatory Health Services.

Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category, whereas Treatment Adherence services provided

during a Medical Case Management visit should be reported in the Medical Case Management service category.

Key Activities
Allowable activities in this service category include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Objective
Outpatient/Ambulatory Health Services are intended to provide primary medical care for the treatment of HIV infection consistent with the most recent U.S. Public Health Service (PHS) guidelines, also known as Health and Human Services (HHS) guidelines, including access to antiretroviral and other drug therapies such as prophylaxis and treatment of opportunistic infections.

Units of Services
A Unit of Service (UOS) in this service category includes

1) A 20-minute contact between a client and Outpatient/Ambulatory Care staff
2) Providing a laboratory test
3) Providing a single item of durable medical equipment ??
4) Providing medication ??

Requirements
Provider Qualifications
Education/Experience/Supervision
Professional diagnostic and therapeutic services under this service category must be provided by one of the following clinicians licensed by the State of California and operating within the scope of their license:

- Physicians (MD/DO)
- Physician's Assistant (PA)

- Nurse Practitioner (NP)

Other professional and paraprofessional staff may provide services appropriate for their level of training, education, and licensure as part of a care team in coordination with or under the supervision of a clinician in a manner consistent with State of California requirements for licensure or certification. These staff may include, but are not limited to:

- Nurses (RN, LVN/LPN)
- Medical assistants (MA)
- Pharmacists
- Pharmacy assistants

Any non-clinician staff providing services must be (1) supervised by a clinician; (2) hold current licensure as required by the State of California when applicable; (3) provide services appropriate for their level of training/education; and (4) be trained and knowledgeable about HIV as described below.

Monitoring

Provider qualifications – Compliance with minimum qualifications for all providers offering diagnostic and therapeutic services, as well as the required licensure of clinical and non-clinical staff (when applicable), will be monitored during site visits. Availability of clinician supervision for unlicensed providers will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All staff providing Outpatient/Ambulatory Health Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as HIV transmission, care and prevention
- HIV counseling and testing
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Monitoring

Maintenance of all required licensure and certification. Documentation of a training completion and competency assessments as appropriate.

Facility

Any agency providing Outpatient/Ambulatory Health Services must be licensed and Medi-Cal certified by the State of California and must comply with current federal and state standards for such programs.

Monitoring

Facility - Agency compliance with facility requirements above will be monitored through review of facility documentation during in-person site visits.

Service Characteristics

Outpatient/Ambulatory Health Services must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. Subrecipients may provide any or all of the Key Activities included in the *Service Definition* section of this document.

Eligibility Screening: If the Outpatient/Ambulatory Care subrecipient is the client's first contact with HIV Care Services Program, the client must be screened for eligibility as described in the Universal Standards.

Monitoring

Eligibility - All Outpatient/Ambulatory Care clients served using Part B funding must be registered in the State database ARIES/HIV Care Connect; eligibility screening will be monitored via chart review during site visits.

First Outpatient/Ambulatory Care Appointments: For new clients, the first Outpatient/Ambulatory Health Services appointments should be made as soon as possible to avoid potential drop out. Appointments must be offered no later than 10 calendar days after the first client request or referral from another subrecipient but should be scheduled sooner whenever possible. In order to facilitate rapid initiation of antiretroviral therapy, persons newly diagnosed with HIV should have their first appointment occur within 24 hours of diagnosis.

Appointments for existing patients must be scheduled as soon as feasible, but no more than 60 days after client request in order to minimize the need for urgent or emergency services, or the interruption of services. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours. Missed appointments and subrecipient attempts at rescheduling must be documented in the file.

Monitoring

Appointments – The subrecipient will check with the appointment scheduler to see if the third next available appointment for an eligible patient is less than 10-days. Agencies will be asked to submit to HIV Care Services Program procedures for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

First Appointment

If the Outpatient Ambulatory Health Services provider is the client's first contact with HIV Care Services Program, the client must be screened for eligibility as described in the Common Standards. Subrecipients should ensure that any consents and Releases of Information specific to health care are completed and in the client's file. If these documents are missing, subrecipients must take steps to obtain them.

Orientation

Each new client receiving Outpatient/Ambulatory Health Services must receive an orientation to available services at the facility; document this orientation in the client file.

Initial Assessment

- **Medical evaluation:** At the start of Outpatient/Ambulatory Health Services, a baseline medical evaluation must be conducted. This evaluation should be performed in accordance with HHS guidelines and CDPH STD guidelines.
- **HIV education:** Patients should always be provided with information regarding the results of diagnostic tests, prognosis, risks and benefits of treatment, instructions on treatment management and follow up, and treatment adherence. In addition, they should be given HIV risk reduction and prevention education.
- **Partner Services:** HIV Care Services Program subrecipients funded for Outpatient/Ambulatory Care Services must have a process for Partner Services counseling and referral for clients. Partner Services

information should be offered and referrals made for clients according to established processes.

- **Referral / Linkage:** Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request.
- **Documentation:** All patient contacts, findings, procedures, diagnoses, education and other information pertinent to patient care must be recorded in the patient chart.

Monitoring

Documentation - Performance of a timely initial assessment, along with complete documentation of assessment findings, existence of a comprehensive laboratory/diagnostic evaluation, and provision of applicable referrals/linkages, will be monitored via site visit chart review.

Treatment Plan

Outpatient/Ambulatory Care Service subrecipients should create an individualized treatment plan for each patient that identifies and prioritizes the patient's medical care needs and incorporates client input. All treatment plans must be signed and dated by a provider and should follow national guidelines as outlined in the HHS guidelines including review and reassessment of the plan at each care appointment.

Treatment Provision:

Antiretroviral treatment is recommended for all PLWH, regardless of CD4 count, and should be provided as soon as possible after diagnosis. Same-day treatment is encouraged when feasible and where available. If same-day treatment is offered, use of an integrase inhibitor-based regimen is recommended. Treatment regimens should be selected based on HHS guidelines, as stated in the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS.

Tools and Resources

Clinical Guidelines for ARVs, laboratory testing, and other services within the Outpatient/Ambulatory Care Services category are available at: https://hivinfo.nih.gov/hiv-source/medical-practice-guidelines/hiv-treatment-guidelines

2. Ryan White funding will be expended in a cost effective, equitable manner based upon verification of client need

3. Subrecipients may at any time submit to the HIV Care Services Program Recipient requests for interpretation of these or any other Services

Standards adopted by the HIV Health Services Planning Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

4. Subrecipients shall provide a means by which outpatient/ambulatory health care providers can obtain in-servicing and on-call advice related to client medical and other healthcare needs.

5. Coordination with other components of the HIV Care Servies Program system of care is critical and required.

6. All HIV Care Services Program subrecipients of outpatient/ambulatory health services must have an internal grievance process in place. Each client must receive a copy of the agency's grievance policy, and a signed copy of the grievance policy must be maintained in the clients' file. Information about how to access this process must be posted conspicuously in public areas of the agency. It must include provisions for informing clients of its existence, and how to begin the process. Clients also have the right to file a grievance with appropriate state licensing agencies (i.e. Medical Board of California at https://www.mbc.ca.gov/Consumers/file-a-complaint/).

7. All HIV Care Services Program subrecipients of outpatient/ambulatory health services must have a quality assurance program and plan in place that is in compliance with the TGA's Quality Management / Continuous Quality Improvement Plan and requirements set forth by the Quality Management Manager of the Recipient.

Signed: _____ Date:
Richard Benavidez, Chair