

Making the Connection:

Standards of Care for Client-Centered Services

Primary Care

San Francisco EMA

Includes San Francisco City and County,
San Mateo County, and Marin County

February 2002

Prepared for

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Dedication

The Primary Care Standards of Care are dedicated to the clients of the HIV Health Services System, to primary care providers who devote themselves to providing services to others, and to individuals who are both client and primary care providers in the San Francisco EMA.

Acknowledgments

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PRIMARY CARE Standards of Care February 2002

I. Introduction

The Ryan White CARE Act, Title I, provides emergency assistance to Eligible Metropolitan Areas (EMAs) most severely affected by the HIV/AIDS epidemic. As it applies to San Francisco, the CARE Act stipulates that Title I funds should be used to provide access to integrated health services for persons living with HIV/AIDS (PLWHA) who:

- Reside within the San Francisco EMA; and
- Have no third party payment source (uninsured);
- Have limited third party coverage (underinsured); or
- Have been denied coverage by a third party payer (uninsured or underinsured).

In addition, enrollment priorities are as follows:

- First priority: Residents of the San Francisco EMA who have low or no income and are uninsured
- Second priority: Residents of the San Francisco EMA who have low or no income and are underinsured

Finally, CARE funds will be used only for services that are not reimbursed by any other source of revenue.

In addition to these federal guidelines, the San Francisco EMA has developed standards of care for all Title I-funded HIV health services in the San Francisco EMA. These standards, outlined here, are designed to define the minimally acceptable levels of service delivery and provide suggested measures to determine whether service standards are being met.

II. Overview

Primary Care Standards of Care are designed to ensure consistency among the Title I primary care services provided as part of San Francisco's continuum of care for PLWHA. They are not intended to promote a "cookbook" approach to the treatment and care of PLWHA. These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Promote integrated health care services that maximize quality of life, address the spectrum of patients' health care needs, and minimize barriers to accessing services.

- Promote collaborative relationships between clinicians and patients and between service providers to maximize patient health.
- Implement coordinated, patient-centered, and effective service delivery.
- Promote respect for patients.
- Encourage clinicians to remain up-to-date regarding treatment guidelines and to comply with all federal, state and local laws, regulations, ordinances and codes.
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach and as appropriate, conduct HIV risk reduction specifically for HIV-positive individuals (prevention for positives).
- Appropriately address issues of consent and confidentiality for patients enrolled in services.
- Deliver primary care services in a culturally and linguistically appropriate manner, that takes into account the nature of patients' family, social, and community support systems and networks.
- Make available substance abuse harm reduction and primary and secondary prevention education services.

III. Description of Service

Comprehensive medical assessment, evaluation, diagnosis, and treatment.

IV. Unit of Service

A primary care Unit of Service (UOS) is:

- A face-to-face encounter between a patient and a physician, mid-level practitioner, or nurse, lasting a minimum of 10 minutes and occurring during a single visit at a hospital, clinic, shelter, home, or hospice.

V. Standards of Care

A. Administration

Administrative standards ensure all professionals providing primary care services are properly trained and credentialed, have an understanding of the scope of their job responsibilities, and that all programs funded are adequately staffed.

Standard 1: License, credentials, and experience/education.

- All clinicians and staff maintain appropriate licenses and credentials.
- Clinicians must be HIV-experienced.

Measure: Completed forms on file for all participating clinicians, including California Medical License and other appropriate licenses and certifications.

Standard 2: Staffing levels.

Contracted agencies will ensure appropriate staffing levels are reached and maintained to provide contracted services.

Measure: Full and part-time positions funded under contract are filled; OR appropriate actions being taken to fill positions.

Standard 3: Job descriptions.

Staff members will have a clear understanding of their job definition and responsibilities.

Measure: Written job description on file signed by the staff/staff supervisor.

Standard 4: Policies and procedures.

Each funded agency will have a written policies and procedures manual that contains both personnel and program policies and procedures for the following areas:

Personnel Policies and Procedures

- Annual performance reviews
- Staff training and other personnel policies (e.g., behavioral standards)
- Compliance with the “USPHS Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis” at <http://hivatis.org/trtgdlns.html#Occupational>

Program Policies and Procedures

- Patient rights and responsibilities, including confidentiality guidelines (with particular discussion of confidentiality issues for PLWHA)
- Patient grievance policies and procedures
- Patient eligibility and admission requirements
- Nondiscrimination policies for patients with children
- Referral resources and procedures that ensure access to all services listed in Standard 8
- All appropriate consent forms (e.g., consent to share information, treatment consent, Reggie consent form for San Francisco only)
- Data collection procedures and forms, including data reporting
- Quality assurance/quality improvement
- Guidelines for language accessibility
- Plans for accommodating people with disabilities (plans should adhere to ADA standards to the extent possible)

Measure: Written policies and procedures manual.

Standard 5: Staff training.

Staff should be familiar with the most up-to-date information and best practices for the bullet points below. To achieve this goal, all staff should receive training or orientation as appropriate for their scope of practice, previous knowledge/experience, and credentials. **Staff training needs, frequency of training, and methods of training are at the provider's discretion.** Staff training should address the following areas, as necessary:

- Culturally and linguistically appropriate service delivery
- Harm reduction principles
- Primary and secondary prevention education principles
- Prevention for Positives principles
- STDs
- Agency's written policies and procedures (including confidentiality, patient rights, and human resources)
- Data requirements of the local jurisdiction
- Decision-making related to patient eligibility for Title I services, including how to access other sources of funding for patients (e.g., Medi-Cal, (General Assistance) [GA])
- Infection control and universal precautions
- Referral resources

Measure: Documentation of all completed trainings on file.

B. Facility Standards

Facility standards are intended to ensure program safety and accessibility for both patients and staff.

Standard 6: Standard safety requirements.

The program is located in a physical facility that:

- Meets fire safety requirements
- Meets criteria for Americans with Disabilities Act (ADA) compliance
- Is clean and comfortable
- Complies with Occupational Safety and Health Administration (OSHA) infection control practices
- Has emergency protocols for health- and safety-related incidents posted
- Is free from anticipated hazards
- Is equipped for safe, legal, and appropriate storage of pharmaceuticals

Measure: Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.

C. Service Delivery

Standards related to service delivery define the minimum set of activities to be performed and under what parameters.

Standard 7. Clinical procedures.

Clinicians must be familiar with the most recent HIV/AIDS and STD treatment guidelines that are relevant to the population the provider serves. However, use of federal, state, or other guidelines should not preclude clinicians from applying their best clinical judgment with a particular patient or patient population. Relevant treatment and other guidelines can be found at: <http://hivatis.org/>. They include:

- Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents (<http://hivatis.org/trtgdlns.html#Adult>)
- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV-Infection (<http://hivatis.org/trtgdlns.html#Pediatric>)
- Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States (<http://hivatis.org/trtgdlns.html#Perinatal>)
- Management of Possible Sexual, Injection-Drug-Use, or Other Non-occupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy (<http://hivatis.org/trtgdlns.html#Nonoccupational>)
- USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus (<http://hivatis.org/trtgdlns.html#Opportunistic>)
- Prevention and Treatment of Tuberculosis Among Patients Infected with Human Immunodeficiency Virus: Principles of Therapy and Revised Recommendations (<http://hivatis.org/trtgdlns.html#Tuberculosis>)
- Guidance for STD Clinical Preventive Services for Persons Infected with HIV (http://www.ucsf.edu/castd/downloadable/HIV_guidance.pdf)
- CDC Guidelines for the Treatment of Sexually Transmitted Diseases (http://www.cdc.gov/nchstp/dstd/1998_STD_Guidelines/1998_guidelines_for_the_treatment.htm)

Measure: Presence of most up-to-date clinical protocols and treatment guidelines.

Standard 8: The full continuum of services described below is provided directly or through referral.

On-site services:

- Phlebotomist (on site, within walking distance, or referring provider will arrange transportation)
- Information and referral (both verbal and written)
- Provider access to consultation services (agency must have a plan outlining how this will be done, e.g., call SFGH's HIV Consultation Line, or "Warmline," at 1-800-933-3413)

Services on site or through referral:

- All medical diagnostic, screening, and treatment services indicated for PLWHA, including STD screening and treatment and treatment adherence services, and nutrition counseling (for more information on standards for nutrition counseling and support, refer to Standard 7 in the Food Services Standards of Care)
- All HIV-related services in the continuum of care (i.e., other non-primary care Title I services)
- Primary and secondary prevention education
- HIV risk reduction specifically for HIV-positive individuals (prevention for positives)
- Substance abuse harm reduction services
- Child care for patients with children (agency/clinic must either provide child care on site or give information and referrals to child care upon patient request)

Measure: Frequently updated inventory of services provided in house as well as referral resources and protocols.

Standard 9: Intake/Assessment.

During the intake process or during subsequent patient assessments, providers should:

- Inform patient of (1) services available, (2) patient rights and responsibilities (including confidentiality), (3) grievance policies and procedures, and (4) clinic operations/ procedures.
- Provide patient with referral information to other services, as appropriate.
- Collect required patient data for city/state/federal reporting purposes.
- Collect basic patient information to facilitate patient identification and patient follow-up.

- Obtain patient’s signature on the appropriate consent forms, including the Reggie consent form (Reggie consent form for San Francisco only).
- Conduct treatment planning, including creating a treatment plan with patient input, noting the plan in the chart, reviewing the plan regularly with the patient, and updating the plan as indicated. (A separate treatment plan form is not required; detailed progress notes in patient charts are sufficient.)
- Assess patient need for harm reduction and primary and secondary prevention education services.

Measure: Completed intake forms, documented referrals, and signed consent forms on file or in patient charts; detailed notes in patient charts about course of treatment and changes in treatment over time.

Standard 10: Access.

Access to services should be made equal for all individuals.

- A plan for addressing cognitive, social, economic, and other barriers to access for patients should be in place (e.g., issues that cause patients to regularly miss appointments).
- When possible, all patients should have access to a provider of their choice and should be given the option to transfer their care to another provider if they are dissatisfied.
- Practices for reducing barriers to access for patients, including streamlining paperwork, must be in place.
- Providers must have in place objectives for availability (i.e., time from request for appointment to actual appointment) of the following types of visits, as well as a plan for meeting those objectives: initial visits, follow-up visits, and urgent visits.
- Patients must be assisted in determining how to deal with their after-hours medical needs (i.e., how to determine whether symptoms require emergency care, where to access 24-hour emergency care, and who to call for after-hours medical advice). Patients must have access to telephone clinical advice 24 hours a day, 7 days a week (except incarcerated populations).

Measure: Wait time objectives in place for different types of visits; questions about wait times for appointments on patient satisfaction survey; protocol for addressing patient needs after-hours.

Standard 11: Patient education.

As indicated by the needs of the individual patient, education should be made available either by the provider or through referral. At a minimum, all patients should receive education in the following areas:

- Natural history of the disease (what to expect as it progresses, including information on TB and STDs as well as gender-specific information)
- Treatment education (e.g., antiretrovirals) for all patients, including pregnant women, including the benefits and side effects of the available medication regimens
- Health maintenance strategies (e.g., nutrition)
- HIV transmission prevention
- Other services available to them, including HIV continuum of care services, primary and secondary prevention education, and harm reduction services available to patients

Measure: Documentation in patient charts of education topics discussed.

Standard 12: Cultural sensitivity and competency.

- Agency/clinic must have a non-discrimination policy in place regarding hiring and patient treatment that addresses issues of race/ethnicity, gender identity, sexual orientation, disability, and other relevant issues.
- Agency/clinic must show experience with the target population(s) or have a plan for developing staff sensitivity to the target population(s).
- Staff should be ethnically, culturally, and linguistically diverse or reflect the diversity of the population they serve.
- Services are provided using language and methods sensitive to the communities served.
- Services provide opportunities for patients to assist in identifying issues related to culture that may affect how they respond to services (e.g., primary language, spirituality needs, sexual orientation, community identification, family needs, and customs).
- Service providers should have referral relationships that can address gaps in culturally competent services (e.g., if agency does not have Spanish-speaking staff, Spanish-speaking patients can be referred).
- Agency must have a cultural competency plan on file with the San Francisco Department of Public Health (for agencies in San Francisco).

Measure: Adherence to the San Francisco DPH cultural competency requirements for agencies and services in San Francisco; adherence to relevant local county/city cultural competency plan for agencies and services in San Mateo or Marin County.

D. Coordination and Referral

The objectives of coordination and referral are to follow through on the strategies for addressing patient need and referral to needed services.

Standard 13: Coordination and referral.

Coordination and referral includes identification of other service providers or staff members with whom the patient may be working. The agency will:

- Identify and communicate with collateral patient caregivers (with patient consent), including substance abuse and mental health residential and outpatient programs in which their patients are enrolled, to support coordination and delivery of high quality care.
- Provide appropriate referrals to any necessary specialty care in accordance with patient's treatment plan, including mental health and substance abuse treatment services, with patient consent.
- Track referrals into the agency, within the agency, and out to other services and providers.

Measure: Documentation in patient record of referrals made; up-to-date treatment plan in patient's chart documenting necessity of specialty referral, follow-up required, and desired outcome.

E. Quality Assurance and Service Maintenance

The objectives of quality assurance and service maintenance are related to periodic evaluations of patient treatment plans, service delivery, and patient satisfaction with service provision, the results of which lead to service improvement.

Standard 14: Patient satisfaction survey.

Providers will conduct patient satisfaction surveys (or other patient satisfaction activity) at least annually.

Measure: Annual written summary and analysis of the program's patient satisfaction activity.

Standard 15: Quality assurance.

The agency must have an active Continuous Quality Improvement (CQI) program to monitor care provided and identify means of improving care and services.

Measure: Written policies on CQI in place, including how data will be used to improve programs; one report per contract period on improvements made through CQI.

TABLE 1: Summary of Standards of Care Measure

Standard	Measure
1. License, credentials and experience/education.	1. Completed forms on file for all participating clinicians, including California Medical License and other appropriate licenses and certifications.
2. Staffing levels.	2. Full and part-time positions funded under contract are filled; OR appropriate actions being taken to fill positions.
3. Job descriptions.	3. Written job description on file signed by the staff/staff supervisor.
4. Policies and procedures.	4. Written policies and procedures manual.
5. Staff training.	5. Documentation of all completed trainings on file.
6. Standard safety requirements.	6. Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.
7. Clinical procedures.	7. Presence of most up-to-date clinical protocols and treatment guidelines.
8. Continuum of services.	8. Frequently updated inventory of services provided in house as well as referral resources and protocols.
9. Intake/assessment.	9. Completed intake forms, documented referrals, and signed consent forms on file or in patient charts; detailed notes in patient charts about course of treatment and changes in treatment over time.
10. Access.	10. Wait time objectives in place for different types of visits; questions about wait times for appointments on patient satisfaction survey; protocol for addressing patient needs after-hours.
11. Patient education.	11. Documentation in patient charts of education topics discussed.
12. Cultural sensitivity/competency.	12. Adherence to the San Francisco DPH cultural competency requirements for agencies and

	<p>services in San Francisco; adherence to relevant local county/city cultural competency plan for agencies and services in San Mateo or Marin County.</p>
13. Coordination and referral.	13. Documentation in patient record of referrals made; up-to-date treatment plan in patient's chart documenting necessity of specialty referral, follow-up required, and desired outcome.
14. Patient satisfaction survey.	14. Annual written summary and analysis of the program's patient satisfaction activity.
15. Quality assurance.	15. Written policies on CQI in place, including how data will be used to improve programs; one report per contract period on improvements made through CQI.