STATE OF NEW YORK
DEPARTMENT OF HEALTH Number: AI 08-01
MEMORANDUM Date: 02/26/08

SUBJECT: Revisions to the Standards for the Designated AIDS Centers

This Memorandum supersedes the following Department of Health communications regarding the Designated AIDS Centers:

1) DOHM 86-32 *Request for Applications for Designated AIDS Centers,*
2) DOHM 89-95 *Pediatric and Maternal Human Immunodeficiency Virus (HIV) Services in Hospitals,*
3) DOHM 93-25 *Supplement to DOH Memorandum 86-32 Update of Program Standards For Designated AIDS Center Hospitals.*
4) *Issuance of Revised AIDS Center Program Standard 17-Case Management*

Background

The Designated AIDS Center program was established more than 20 years ago as part of the New York State Department of Health's first response to the AIDS epidemic. The standards for Designated AIDS Centers (DACs), last updated in 1993, do not fully reflect the current programmatic and organizational complexities of providing high quality HIV/AIDS care in today's health care environment.

The disease burden of HIV has shifted the paradigm of HIV health care from an acute to a chronic disease medical model, with patients living longer, healthier lives. There is a need for basic, integrated primary care and preventive services and the availability and accessibility of subspecialty care for disease conditions associated with aging, and long term ARV therapy.

The financial environment for hospitals has also changed. Medicaid Managed Care, including HIV Special Needs Plans, has become the primary payor for Medicaid for many health care organizations. Increasingly, hospitals will be negotiating rates rather than depending on the traditional fee for service methods.

Facilitated by the New York Commission on Health Care Facilities in the 21st Century, health care systems are in the process of rightsizing. Many HIV programs will be faced with reorganization or relocation out of the hospital setting and into off-site clinics, removing the HIV programs from the set of on-site services traditionally required, further complicating the delivery of the expanded set of services needed.

The AIDS Center program was developed and remains a patient-centered program model that can evolve with the needs of the patient in the changing health care environment.

AIDS Centers provide a primary care home for the person with HIV. Patient outcomes improve when care is seamless, coordinated by a care manager utilizing multi-agency, multi-disciplinary health care teams. The most effective care model is patient-centered and is simple to navigate for the needed services. AIDS Centers must enhance coordination with their community-based partners to identify patients at risk, help patients access and remain in care, and understand and adhere to their complicated regimens.

The new emphasis for the AIDS Centers should be on developing integrated care networks, supported by various funding streams, including State, Ryan White and Medicaid. These networks should encompass community-based providers offering COBRA case management, service agencies funded by Ryan White, Medicaid Managed Care Plans including the HIV Special Needs Plans, Adult Day Care and treatment education and adherence programs. All contribute to a comprehensive service package needed by the patient.

Enhancement of our collective capacity and use of health information technology to identify and reach those persons in the community most at risk for HIV and not yet diagnosed is critical. This includes normalizing and streamlining HIV testing and the attendant linkages to care for the newly diagnosed.

Summary of Significant Changes

- Revised and streamlined Standards outline a comprehensive, collaborative, integrated system of service provision that embraces new priorities;
- Developing systems to improve early diagnosis by reaching out to populations at risk and not yet diagnosed;
- Developing mechanisms that assure consumer input in to program planning, implementation and quality management;
- Strengthening Statewide and community-based efforts to increase patient engagement and retention in care;
- Enhancing the coordination with CBOs for extended support to help patients navigate the health care system and remain in care;
- Providing adherence support and treatment education as an integral part of engagement and retention;
- Promoting wellness, health education and health maintenance with an increased focus on risk factors for major chronic diseases, including harm reduction interventions for HIV-infected individuals. education and primary care, to reduce preventable causes of illness and to improve health outcomes:
- Assuring the availability and accessibility of subspecialty care for non HIV-associated medical conditions; and
- Expanding the use of health information technology (electronic data systems) to support quality improvement, evaluation, communication among care providers and cost containment.

Thank you for your participation in the AIDS Center Program. If you have any questions about these Standards, please contact:

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DESIGNATED AIDS CENTER STANDARDS

February 26, 2008

STANDARD 1: ORGANIZATIONAL AND ADMINISTRATIVE SERVICES	
Organization and Administration A DOH Designated AIDS Center (DAC) shall provide comprehensive inpatient and outpatient services delivered by a multi-disciplinary team of clinical and support service professionals led by an HIV Specialist, for persons infected with HIV and organized under a single AIDS Center Administrator and Medical Director. Each patient's Primary HIV Care physician shall meet the qualifications of an HIV Specialist as defined by the NYSDOHAI Office of the Medical Director, and posted on www.hivguidelines.org. Specialty and Sub-Specialty medical care may be accessed through other departments of the hospital, but must be coordinated by the patient's multi-disciplinary team. AIDS Center hospital and clinic staff shall receive training on confidentiality, and basic HIV/AIDS prevention and treatment issues.	**Discussion** The AIDS Center hospital shall develop an Organizational Plan that addresses the coordination of inpatient and outpatient care throughout the hospital for adults, youth, and children , including specialty and subspecialty services, case management services, HIV testing, harm and risk reduction prevention activities and referral to community agencies. The Organizational Plan should include an organizational chart of AIDS Center staffing and its relationship to the overall hospital organizational chart. The Organizational Plan must include descriptions of roles and responsibilities of clinical, case management, administrative and support staff. There must be a policies and procedures manual that details the implementation of the Organizational Plan, which is updated annually. The Organizational Plan should specifically address how the AIDS Center integrates networks of health care and supportive services by the DAC, SNPs, COBRA and other providers, offering a comprehensive package of services that promotes integration and assuring a continuum of care and access to needed medical, mental health, substance use and supportive services. AIDS Center staff are responsible for providing or arranging in-service training for hospital and clinic staff, as well as volunteers. Special emphasis should be given to in-patient and emergency department staff to assist in identifying at-risk individuals for HIV testing. It is critical that all hospital staff assume a role in assisting to identify new patients and provide harm reduction messages for those infected. Where Primary HIV Care physicians do not meet

	the HIV Specialist definition, a plan for staff development to meet this requirement must be developed. All hospital staff shall be trained in accordance with Article 27F of the Public Health Law to ensure that confidential practices are maintained.
Information Technologies AIDS Centers are required to develop health information technology and staffing sufficient to address AI reporting requirements, track patients in care and communicate among care providers.	**Discussion** Each AIDS Center shall employ health information technology sufficient to: • identify the AIDS Center's patient population and their treatment history, including those who have fallen out of care, • identify the hospital admissions of their outpatient clinic population, • identify a patient's primary care provider, • provide the essential laboratory correlates of HIV infection for their clinic patients: e.g., CD4 count, HIV viral load within a specified timeframe, etc. • identify those patients on HIV antiretroviral therapy, • identify timeframes for patients' annual comprehensive visits, • identify patients receiving case management services, including community-based case management services, • identify patients that have declined case management services, • produce demographic information for AIMS and other reporting requirements, • generate data, such as billing data, for financial and strategic planning, • track and submit quality of care indicator data, and communicate with other care providers.
STANDARD 2: HIV QUALITY MANAGEMENT PROGRAM	
A formal quality of care program that embraces quality improvement (QI) philosophy should be developed and implemented, as part of the HIV service delivery program. The five components of the HIV quality program are:	Each HIV quality program should have a comprehensive quality plan that is reviewed and updated annually describing the mission of the quality program, key quality principles and objectives, and the infrastructure of the quality program.

A) Infrastructure for HIV Quality Program The infrastructure of the quality program should be integrated and fully described in the quality plan, with a clear indication of responsibilities and accountability, and elaboration of processes for ongoing evaluation and assessment.	**Discussion:** The infrastructure should specifically: a) outline quality committees including membership, frequency of meeting and reporting mechanisms; b) specify accountability for all quality improvement activities within the HIV program; c) describe processes to evaluate, assess, and follow-up on HIV quality findings; and d) link the HIV quality program to institution's overall quality program. The HIV program should detail the roles and responsibilities of leadership and its commitment of resources for the quality program. Specific programmatic annual goals regarding quality projects and performance measures should be set and shared with program staff. These goals should be formally reviewed and updated by the quality committee at least annually.
B) Staff Involvement in Quality Improvement Activities All AIDS Center staff, both clinical and support service professionals, should be actively involved in the HIV Quality Program and its quality improvement activities. The participation in the quality program should be part of job expectations. Provisions should be made for ongoing education of staff about quality improvement. Where Pediatric Maternal HIV Services are provided, appropriate staff must be part of the Quality Program.	**Discussion:** The involvement of staff in the quality program should be integrated into job expectations and descriptions. Staff should be able to discuss quality program activities. The objectives, progress, and results of quality activities should be routinely communicated to staff to increase participation in the HIV quality program. Members of different professional disciplines and programmatic backgrounds should be included in the quality committee membership. At a minimum, annual education about quality improvement principles, HIV quality program goals and objectives, and performance measurement indicators and results should be provided to staff.
C) Performance Measurement Performance measurement should include clearly defined indicators that address clinical, case management and other services as prioritized by the program. A plan for follow-up of results should be outlined.	**Discussion:** A balanced program of outcome and process measures should be developed and implemented. The quality program should describe its clinical and non-clinical indicators including written definitions, with special emphasis on desired health outcomes, and frequencies of review in the quality plan.

	Indicators should be updated at least annually and reflect current standards of care. The HIV program should routinely measure the quality of care with the involvement of staff and review results in quality committees. An action plan for follow-up should include implementation steps and timetable. Performance data results should be shared with staff, patients, and key stakeholders. AIDS Centers are expected to submit data via HIVQUAL, based on annual specifications from the AIDOH.
D) Quality Improvement Projects Quality Improvement activities should be conducted based on performance data results. Specific quality improvement projects should be undertaken which include action steps and a mechanism for integrating change into routine activities. Quality improvement teams should include cross-functional representation.	**Discussion:** The process of selection and prioritization of quality improvement activities should be clearly outlined and respond to external expectations and internal priorities. Staff should be involved in the selection of quality initiatives. A process of reviewing results of internal quality initiatives and external audits should be integrated into the HIV quality program. The quality committee should oversee and provide feedback to quality improvement projects. Quality improvement teams with cross-functional representation should be formed to address specific quality improvement opportunities and continue to monitor change. Results of quality improvement projects should be presented to quality committees, shared among staff, and used for future planning.
E) Participation in Quality Learning Opportunities AIDS Centers should participate in one or more AI-sponsored Quality Learning opportunities to develop expertise in applying defined, measurable accelerated improvement in the care of individuals living with HIV and contribute to the development of best practices identified through the quality improvement process.	**Discussion:** The AI provides many Quality Learning opportunities that combine the methods and methodologies of rapid change, peer learning, and individualized consultation. The combined goals of these efforts are to improve the quality of HIV care and services within participating facilities, to achieve measurable desired program outcomes, to strengthen the quality infrastructure, to create a peer learning environment, and to rapidly spread improvements throughout the participating organizations.

F) Consumer Involvement Consumers should be included in program planning, implementation and quality-related activities.	**Discussion:** The AIDS Center shall engage consumers in a variety of ways to assure their input about their experiences in the planning and development of services at the AIDS Center. At a minimum, this should include institution of a community advisory board (CAB), participation in quality-related efforts, development of maintenance in care and treatment adherence activities, and the development of harm reduction activities and services.
STANDARD 3: ACCESS TO CARE – CLINICAL SERVICES	
Range of Services The full range of clinical, specialty and supportive services appropriate for the care of patients in the AIDS Center, as described in the AIDS Institute Adult, Pediatric and Adolescent HIV Guidelines and Policies published on www.hivguidelines.org and the AI *Standards for HIV/AIDS Case Management 2006*, shall be provided directly by AIDS Center staff or arranged and coordinated through formal referral agreements at sites accessible to the patient population served. All services must be delivered in a manner that ensures compliance with HIPAA and State Public Health Law with regard to patient confidentiality. AIDS Centers shall have policies and procedures in place that ensure the medical care coordination of all patients.	**Discussion:** All hospitals designated as AIDS Centers must provide the core clinical and subspecialty services. Subspecialty services not available through the hospital must be provided through formal referral agreements to assure the timely delivery of these services in a patient-centered model. AIDS Centers should have an integrated network of providers to address the full range of the patient's medical and psycho-social needs. The AIDS Center must have policies in compliance with HIPAA and Article 27F of the New York State Public Health Law (HIV Confidentiality Law) protecting the confidentiality of all protected and HIV-related information shared or received in the course of providing services, or in conjunction with community based providers and others involved with the patient's care outside of the AIDS Center. Medical care coordination is an essential component of HIV primary care. Medical care coordination focuses on the clinical services of HIV primary and specialty care as well as supportive services including case management. Core functions include coordination of inpatient and outpatient care; referrals to and coordination with specialists; referrals to community services not available in the Center; follow-up on referrals and missed appointments; and conferencing between clinical and community-based case managers.

Emergency Department Services A Designated AIDS Center should have protocols for the Emergency Department to make HIV testing available, conduct timely assessment and management of HIV exposures, and offer post-exposure prophylaxis, if indicated. These protocols can be found at www.hivguidelines.org, Clinical Guidelines. Emergency Service staff should provide needed services to AIDS Center patients, including HIV-positive children and pregnant women, during the times out-patient staff are not available (weekends and evenings). A routine system of communicating emergency service reports on AIDS Center patients should be established.	**Discussion:** HIV testing shall include the availability of rapid testing and other tests able to identify acute HIV infection (AHI) in symptomatic, high risk patients. The Emergency Department of the AIDS Center hospital should effectively promote: a) the continuity of care of all patients being managed by the AIDS Center program, including the Pediatric Maternal HIV Service (PMHS), who are seen on an episodic basis in the emergency service; and b**)** linking persons newly diagnosed with HIV in the ED, in-patient or other hospital services to the AIDS Center's program of comprehensive services. Post-exposure prophylaxis shall be available for patients with non-occupational exposures, including rape and sexual assault survivors. Non-occupational post-exposure prophylaxis (n-PEP) shall be offered, provided and tracked. Once n-PEP is given, referrals for follow up shall be made. In the event of an occupational exposure to HIV, all AIDS Centers must be able to provide immediate post-exposure prophylaxis medication and follow-up for the exposed staff, when appropriate.
Pediatric Maternal HIV Services **A) Range of Services for HIV-Positive Pregnant Women and Mothers** All HIV-positive pregnant women should be co-managed by an experienced HIV specialist and obstetrical provider, both of whom should have current experience in caring for pregnant women with HIV.	**Discussion:** The management of HIV-positive pregnant women should be in accordance with State clinical guidelines and policies posted on HIVguidelines.org, and federal guidelines posted on http://AIDSinfo.nih.gov. When the obstetrical provider does not have experience in caring for HIV-positive pregnant women, the provider should seek consultation from an AIDS Center that has obstetrical staff with this experience. In order to facilitate care for women and their children, services should be family-centered, with coordination of care among the HIV specialist, pediatrician and obstetrician/gynecologist caring for the mother/child.

B) Range of Services for HIV-Exposed Infants and HIV-Infected Infants, Children and Adolescents Care for HIV-exposed infants and HIV-infected infants, children and adolescents, should be in accordance with State clinical guidelines and policies posted on www.hivguidelines.org and federal guidelines posted on http://AIDSinfo.nih.gov.	**Discussion:** Care for an HIV-exposed infant should be provided by a pediatric HIV specialist until the infant's HIV status has been determined. All exposed infants should have complete diagnostic HIV testing to determine infection status. All HIV-infected infants, children and adolescents should be cared for by a pediatric or adolescent HIV specialist, following state or federal guidelines. Where an HIV Specialist is not available, the child's pediatrician should provide care in consultation with a pediatric or adolescent HIV Specialist. Infants, children and youth with HIV need comprehensive HIV- related services provided by an experienced team including the minimum of a pediatric/adolescent HIV specialist, nurse, social worker and case manager. If the AIDS Center does not have these comprehensive services onsite, referral to a center that provides these services should be offered to the family. The exposed newborn's medical record, including maternal ARV use, should be shared with the infant's ongoing pediatrician. Programs caring for HIV infected children/youth must have services in place to transition the child from pediatric to adolescent to adult services. Transition activities should involve staff from pediatric, adolescent and adult HIV services.
Substance Use Services The AIDS Center hospital should offer directly or by referral the full spectrum of alcohol and substance use treatment methodologies as part of the Center's inter-disciplinary team planning. Where provided by referral, formal agreements must be in place.	**Discussion:** The AIDS Center hospital is expected to provide on-site, comprehensive substance use assessment, including laboratory screening. This should include addressing the impact of substance use on the family unit. Programs should address the full spectrum of both licit and illicit substances and incorporate sexual harm reduction services and information. AIDS

	Center staff should be trained to understand the effect and impact of substance use (illicit and prescribed) on the patient's ability to remain in care and engage in treatment adherence and harm reduction activities. The AIDS Center must have collaborative relationships and/or referral arrangements for the full spectrum of alcohol and substance use treatment methodologies including syringe exchange programs (where available) and Expanded Syringe Access Program (ESAP) provider listings.
Oral Health Services Oral health services, including periodontics and oral surgery, shall be provided directly or arranged and coordinated through formal referral agreements.	**Discussion:** At a minimum, routine dentistry should be provided on-site to the extent that they are currently offered to all other patients in the hospital. All hospitals designated as AIDS Centers shall provide emergency and urgent oral health services to HIV-infected patients. Formal referral agreements should be developed when services are not available on site.
Mental Health Services Mental health services are an integral component of HIV care, a psychiatrist or a licensed clinical psychologist must be a participating member of the HIV treatment team.	**Discussion:** The HIV-infected population in the State of New York, as our general citizenry, is aging; eventual cognitive and neurological deteriorations should be anticipated. Mental health conditions impact care and retention activities for individuals infected with HIV. All staff should be trained to understand the relationship between mental health conditions and the patient's ability to remain in care, engage in treatment, adherence and harm reduction activities. An initial cognitive and neuropsychological assessment should be conducted for all patients. Assessment components include: cognitive function, screening for depression and anxiety, including PTSD, psychiatric and medical history and psychosocial evaluation. Periodic updates of each patient's cognitive function and psychological status should be conducted and recorded annually in the patient's medical record.

	Referrals to the team psychiatrist or psychologist should be made as needed. Psychiatric, neurological and radiological services should be coordinated with primary care HIV services for appropriate diagnosis and symptomatic treatment of developing neurologic impairments.
HIV Testing Confidential HIV testing services, including the use of rapid testing technologies, should be readily available in all appropriate hospital inpatient and outpatient settings. The AIDS Center hospital shall ensure that HIV counseling and testing services are provided to all pregnant/delivering patients served at the hospital. Designated AIDS Centers should ensure that new and existing patients receive partner services as appropriate.	**Discussion:** The AIDS Center should facilitate integration of routine HIV screening activities throughout the hospital. This includes the use of rapid testing technologies in other hospital departments, including the emergency department, inpatient units, walk-in clinics and family health centers and the coordination of follow-up care for persons testing positive. Policies and procedures must detail the coordination of follow-up care for evaluation and assessment of individuals testing positive. The DAC shall ensure that HIV counseling with testing recommended is provided to all pregnant patients, and that repeat HIV testing is offered in the third trimester see HIVguidelines.org. • Health care providers of all pregnant women should encourage repeat testing in the third trimester (recommended by the CDC, USPHS, ACOG and the NYSDOH) • All prenatal care providers should be knowledgeable about the signs and symptoms of acute HIV infection, as well as the diagnosis and treatment of pregnant/delivering women with acute HIV infection and their infants. Partner services are essential tools to identify new cases of HIV disease and engage these patients in care. Ideally, arrangements with the City/County or State health departments should be in place to maximize these efforts. Partner services should be available throughout the time the patient remains in care. All hospital staff should be made aware that confidential HIV testing is available on-site and be trained to routinely offer it to patients. All hospital staff conducting HIV testing shall be trained in accordance with Article 27F of the Public Health Law to ensure that confidential practices are maintained in accordance with Public Health Law in testing programs.

Management of Co-morbidities The AIDS Center shall implement specific protocols to assure the appropriate management of HIV-infected patients with co-morbidities. At a minimum these should address Hepatitis A, B and C; TB; STIs; and any other conditions detailed in www.hivguidelines.org, Clinical Guidelines.	**Discussion:** The effective management of diseases that are not necessarily HIV- related, but common among HIV-infected patients, is critical to assure positive outcomes. While there are numerous co-morbidities, the prevention and management of the Hepatides, TB and STIs are of primary importance. The AIDS Center must have specific protocols for the clinical screening, diagnosis, management and when appropriate, treatment, of co-morbid conditions, such as Hepatitis A, B, C, TB, STIs, and other conditions detailed in www.hivguidelines.org, Clinical Guidelines.
Clinical Research Programs The AIDS Center shall facilitate access to clinical research programs, including those for investigational new drugs.	**Discussion:** The treatments for HIV infection and AIDS are dynamic and evolving processes; it is essential that AIDS Centers be linked to state-of-the-art clinical treatments and that AIDS Center staff be knowledgeable about up-to date HIV treatments guidelines, investigational protocols and agents for the treatment of HIV and its associated co-morbidities. Patients should have full access to these treatments when appropriate for their care, and should be educated on this option. Physicians in AIDS Centers should be aware of the HIV/AIDS clinical trial networks funded by the Division of AIDS (DAIDS) of the National Institutes of Health (NIH): • AIDS Clinical Trial Groups (ACTG) • HIV Prevention Trials Network (HPTN) • HIV Vaccine Trials Network (HVTN) • International Maternal Pediatric and Adolescent AIDS Clinical Trial group (IMPAACT) • Microbicide Trials Network (MTN). These NIH funded networks offer research protocols, including those for drugs for compassionate use, both at their sites and other venues for which many patients may be eligible. Those hospitals that do not offer clinical trials should have close professional linkages with institutions in which treatment protocols and agents are available. Appropriate referrals for access to investigational agents should be made if indicated.

STANDARD 4: MAINTENANCE IN CARE	
Engaging and Retaining Patients in Care The AIDS Center shall have policies and plans in place that support interventions to identify patients at risk of falling out of care, engage and retain HIV+ patients in care and ensure they are receiving the necessary medical, psychosocial and supportive services, encompassing both HIV and non-HIV related care issues. Continuity of care for HIV-positive pregnant women, mothers and their HIV-exposed infants and infected infants and children must be ensured.	**Discussion:** AIDS Centers will implement activities to engage newly diagnosed patients and patients lost to follow-up in primary HIV medical care. AIDS Center policies, procedures and protocols shall ensure that HIV+ patients identified through in-patient admissions, Emergency Department testing, routine testing in primary care clinics or admissions to other service departments of the medical facility are linked to HIV primary care appropriate for their needs. In order to facilitate care for women and their children, services should be family-centered, with coordination of care among the HIV specialist, pediatrician and obstetrician/gynecologist caring for the mother/child. All relevant maternal information (including antiretroviral medications taken by the mother and pertinent HIV tests for monitoring viral load) should be transferred to the birth facility if different from the prenatal care site. AIDS Centers should maximize the utilization of other Medicaid, Ryan White or other grant funded programs to engage and retain patients in care. Strong relationships, including referral agreements with community-based agencies, are essential. The AIDS Center must have proactive strategies and procedures to identify, engage and retain in care, patients most likely to fall out of care. These may include specific programmatic interventions for: • Homeless or unstably housed patients, • Patients with a history of substance use or mental illness, • Patients who have a history of being lost to follow-up. The AIDS Center should have protocols in place to provide appropriate follow-up for missed appointments, including collaboration with community-based case managers/organizations.

	Collaborations with community agencies are critical for assistance in retaining patients in care. Policies should outline protocols that describe how AIDS Center staff work with community groups and other funding agencies to assure patient retention and treatment adherence.
Prevention/Harm Reduction/Wellness The AIDS Center shall promote wellness with greater use of prevention to reduce preventable causes of illness and to improve health outcomes, including harm reduction strategies for HIV infected individuals, as well as health education and primary care.	**Discussion:** The AIDS Center shall implement processes to promote healthy lifestyles that contribute to reducing chronic diseases affecting their patient population. AIDS Centers will develop and support prevention activities to prevent re-infection of positive patients and the spread of HIV infection to others. This may include procedures and practices targeted at specific patient needs and behaviors, that: ▪ Integrate prevention discussion as part of routine clinic visits, ▪ Refer patients to harm reduction or other appropriate community programs, ▪ Utilize peers to educate and support positive choices, ▪ Utilize resources and materials distributed by AI, CDC or other experts. At a minimum staff should discuss sexual and substance use practices with patients on a periodic basis. Basic harm reduction services, including the distribution of condoms and referral to syringe exchange programs (where available) and Expanded Syringe Access Program (ESAP) provider listings should be provided.
Treatment Education and Adherence The AIDS Center shall incorporate treatment education and adherence activities into all clinical encounters with HIV-infected patients.	**Discussion:** Clinical and non-clinical staff must incorporate treatment adherence education and support as a critical element of the management of HIV. Staff should conduct the routine measurement of treatment adherence for patients on ARV therapy. The AIDS Center shall use strategies and protocols for achieving maximum adherence to treatment by all of its patients. AIDS Centers should maximize the utilization of resources such as Ryan White and other grant funded programs and Medicaid programs such as COBRA and Adult Day Care, to engage and retain patients in care.

	This may include: ▪ Integrating treatment adherence discussions as part of routine clinic visits, ▪ Referring patients to trained counselors and programs in the community, ▪ Using peer groups to support their efforts, using a variety of proven tools and approaches to maximize results.
STANDARD 5: CASE MANAGEMENT	
AIDS Center staff must assess each patient (in-patient and out-patient) for case management needs and identify the level of services needed. Comprehensive case management services should be offered to all HIV-positive pregnant women and to mothers with children to support them in meeting their own needs and those of their children. For patients receiving case management services, AIDS Center staff must provide, at a minimum, Supportive Case Management services. All patients not receiving case management must be assessed/re-assessed at least annually. The AIDS Center must have formal agreements and establish relationships with community providers to ensure receipt of appropriate support for care. Facilities must staff the case management program sufficiently to be consistent with DOH Medicaid reimbursement requirements and the staffing standards established by the AIDS Institute.	**Discussion:** Guidance for all AIDS Center Case Management requirements is found in the AI *Standards for HIV/AIDS Case Management 2006 at* http://www.nyhealth.gov/diseases/aids/standards/casemanagement/index.htm Detailed policies and procedures must be in place outlining staff responsibilities, coordination and communication between in-patient and out-patient, and assessment of patient needs and service implementation. Successful coordination with community case management partners depends largely on developing policies and procedures for sharing responsibility, clearly defining respective staff responsibilities, scheduling case conferences and reassessments, and monitoring of the shared service plan, including the timely exchange and updating of information. Although some patients will not require or accept case management services, AIDS Center staffing, nevertheless, must be sufficient to meet assessment and reassessment requirements for all patients, crisis intervention needs and all other requirements of the DAC Standards.