Ryan White HIV/AIDS
PROGRAM STANDARDS OF CARE

FOR THE OAKLAND
TRANSITIONAL GRANT AREA

June 2016

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ACKNOWLEDGMENTS

These Standards of Care were developed with the insights and hard work of service providers and people living with HIV throughout Alameda and Contra Costa Counties. Their efforts have helped to ensure that people living with HIV within the Oakland Transitional Grant Area receive the highest quality care possible at all times.

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Universal Standards
OF CARE

INTRODUCTION

Recipients of funds through the Ryan White HIV/AIDS Program (RWHAP), including the Oakland Transitional Grant Area (TGA), must follow all policies and laws that apply to the program, according to the federal government. As part of this, they must create and regularly update a local set of "Standards of Care" for each of the service categories for which they receive funding.

This document serves as the foundation for each of the supplemental Standards of Care for each service category funded in the Oakland TGA. Known as the "Universal Standards of Care", it explains the requirements and standards that apply across service categories, and must be followed by any program receiving funding from the RWHAP in any category. Federal standards currently recommend revising this document every three years; however it may be revised at any time. It is based on federal standards, which are subject to change.

This document is not intended as a stand-alone document; rather, it is the first layer of Standards for each of the service categories: Universal. Each service category then has its own Standards of Care document, which details the final two layers of Standards: Requirements, and Recommended Best Practices.

HOW THIS DOCUMENT IS ORGANIZED

Within this document, the Universal Standards are described in terms of (1) Eligibility Procedures, (2) Program Characteristics, (3) Staffing, Training, and Supervision, (4) Other Requirements, and (5) Unallowable Costs.

Staff of service provider contractors and subcontractors must at all times follow and work to enforce city, county, state, and federal workplace laws, policies, procedures, and other requirements aimed at guaranteeing clients safety, full access and fairness in services provided.

ELIGIBILITY PROCEDURES

Services are intended to be fully accessible and barrier free so that eligible clients will be able to use them regardless of age, gender, sexual orientation, race, ethnicity, disability, income, geographical location of residence within the TGA, or other factors unrelated to qualification for service.

RWHAP funds may only be used for the HIV-related needs of eligible individuals. The Oakland TGA and its service providers must be able to make a clear connection between any service paid for with RWHAP funds and the intended client's HIV status, or care-giving relationship to a person with HIV.

In addition, the primary intent of the RWHAP statute is to provide services to low income, underinsured people living with HIV, including those whose illness has progressed to the point of clinically-defined AIDS. As such, RWHAP is always a payer of last resort; if other payer options are available (e.g. Medi-Cal, other patient assistance programs, etc.), those options must be used.

To assure appropriate use of RWHAP funds, all clients must be evaluated for eligibility prior to the start of services. To do this:

> At intake, service providers must document proof of HIV status in the client's chart, including but not limited to:
>
> - A diagnosis note signed by a physician;
> - A photocopy of a laboratory-confirmed HIV-positive diagnostic test result with client's name; or
> - A copy of a CD4 result under 200 cells/mm^3 or a detectable viral load result with the client's name.
>
> Note that re-verification of HIV diagnosis is not required as long as any of the above items remain on file, and neither the CD4 nor viral load test results need be current to be used.

To maintain eligibility for RWHAP services, clients must be recertified at least every six months. The primary purposes of recertification are to confirm that an individual's residency, income, and insurance statuses continue to meet the eligibility requirements and to verify that the RWHAP is the payer of last resort. The HRSA HAB 2011 National Monitoring Standards further clarify the RWHAP expectations for assessing client eligibility and recertification:

> At intake and every 6 months for as long as the client receives services, service providers must document in the client's chart that they continue to meet the following requirements:
>
> - Proof that the client lives in the Oakland TGA, including but not limited to: (1) a copy of a signed lease with client's name and address; (2) a copy of a current or previous month's utility bill or rent receipt with client's name and address; (3) a copy of a Supplementary Security Income (SSI) award letter with client's name and address; (4) a notarized letter from a friend or family member, naming the client and confirming his or her address; or (5) a support letter on official letterhead from a shelter, recovery house, transitional housing facility or other similar housing facility.
> - Proof of annual income that is no more than 300 percent of the federal poverty level, including but not limited to: (1) a copy of a current pay stub with the client's name; (2) a copy of the client's most recent W-2 form; (3) a copy of the client's SSI award letter; (4) a signed, notarized "letter of support" from someone providing the client with financial support; or (5) proof of active Medi-Cal benefits.
> - An assessment of the client's third-party payer capacity, including but not limited to: (1) a copy of the client's insurance card; (2) proof that provider staff have checked the client's status in the Medi-Cal eligibility system; or (3) verification from a private insurance company that includes the date and results, with initials/signature of staff member obtaining the verification.

Note that at the 6-month recertification visit, service providers may accept the client's word for verifying that an individual's income, residency, and insurance status has not changed and still complies with eligibility requirements. Any changes in status, however, must be fully documented. At the annual visit, recertification must be done in person and status of all these items must be fully documented, whether changed or not.

Affected individuals (people not living with HIV) may be eligible for RWHAP services in limited situations; however, these services must always benefit people living with HIV. The circumstances under which affected individuals may receive services paid with RWHAP funds are:

- Services for which the primary purpose is to enable the affected individual to directly care for someone living with HIV.
- Services through which a person living with HIV can receive necessary medical or support services by removing an identified barrier to care.
- Services that promote family stability for managing the unique challenges created by a family member living with HIV.

In these cases, eligibility must be documented with respect to the person living with HIV, and the ways in which the affected person meets one or more of the above requirements.

PROGRAM CHARACTERISTICS

Programs must be culturally competent.

Services must be provided in the client's primary language. If that language is not English, translation services must be provided by a staff member or other means.

- Providers should advertise the availability of these services
- Provider staff must be trained in the use of translation services

Providers should give clients written information about their services, program policies and procedures in English and in their preferred language, and post them as appropriate.

As previously stated, RWHAP funds may only ever be used as the payer of last resort.

Up to 10% of RWHAP funds may be used for administrative support of the services; the remaining 90% must go directly to client service provision.

Across the TGA, total RWHAP funds must be distributed with 75% reserved for core medical services, and 25% allowed for support services. Services funded within the Oakland TGA include but are not limited to the following categories (subject to change):

CORE MEDICAL SERVICES	SUPPORT SERVICES
Outpatient / Ambulatory Health Services	Child Care Services
Oral Health Care	Emergency Financial Assistance
Early Intervention Services (EIS)	Other Support Services (includes Legal Services)
Home and Community-Based Health Services	Health Education / Risk Reduction
Mental Health Services	Medical Transportation
Medical Nutrition Therapy	Psychosocial Support Services
Medical Case Management	Food Bank / Home Delivered Meals
Substance Abuse Outpatient Care	

The following costs are unallowable under the provisions of the RWHAP (this is not an complete list. Payment for other services may not be approved):

- Cash payments to clients;
- General use pre-paid cards (i.e. Visa gift cards, or gift cards for a related group of merchants that are general use and not dedicated to a particular store);
- Clothing;
- Employment and Employment-Readiness Services; and
- Funeral and Burial Expenses.

Property Taxes may not be paid using RWHAP funds.

Client rights and confidentiality standards are critical to the appropriate provision of RWHAP services. To ensure that client rights and confidentiality are respected at all times, the following steps must be taken by RWHAP service providers:

- **CONFIDENTIALITY:** Each agency providing RWHAP services must have evidence of a written agency policy on client confidentiality, available upon request.
- **SECURITY:** Each agency providing RWHAP services must have evidence of a written agency policy on the security of client records, including but not limited to: how staff access to records is restricted (such as by secured areas, locked filing cabinets or password protection) and how electronic records are backed up.
- **MEDICAL INFORMATION:** Each agency providing RWHAP services must have evidence of a written policy about medical information transmission, maintenance, and security which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including agency-specific procedures for release of information.
- **STAFF TRAINING:** Each agency providing RWHAP services must keep documentation of staff training to ensure that all agency staff, volunteers, and subcontractors are oriented to the policies and procedures outlined in the items above and agree to follow these policies.
- **VOUCHERS:** Each agency providing RWHAP services must be able to demonstrate that client confidentiality is protected by ensuring that vouchers used for medications, transportation, utilities, etc. do not reveal that the agency provides HIV-related services.
- **CONSENT:** Appropriate signed and dated consent forms must be signed by clients before any services begin, and made available in client charts. California Law regarding confidentiality and client consent (Civil Code Section 56.10- 56.16 and health and safety code section 120975-121020) must be followed.
  - Consent forms must include language that allows clients to verify that (a) they received a copy of all program policies relevant to the services they will receive, (b) they received a copy of their client rights and responsibilities, including confidentiality and the agency grievance policy, and (c) they understand agency policies related to release of information.
  - In addition to other forms, a signed and dated ARIES Client Share/Non-Share Consent Form must be on file for all clients receiving services.

STAFFING, TRAINING, AND SUPERVISION

Personnel standards ensure all professionals providing HIV/AIDS services in the Oakland TGA are properly trained and licensed as required by state law, have an understanding of the scope of their job responsibilities, and that all funded programs are properly staffed. To this end:

LICENSING: All participating staff must possess appropriate licenses and expertise (as defined by service specific standard of care), with documentation of license and experience kept on file as needed.

SUPERVISION: Interns / students must be supervised by appropriately licensed professionals.

JOB DESCRIPTIONS: All positions (for salaried, hourly, and volunteer staff) must have written job descriptions detailing minimum qualifications.

HIRING: Hiring practices must comply with all related local, state, and federal equal employment opportunity rules and regulations.

TRAINING AND CONTINUING EDUCATION: Written training plans and continuing education documentation must be kept on file for each staff person and volunteer as appropriate. All staff providing RWHAP services must receive initial as well as updated training at least once a year in the following areas:

- Updates related to HIV/AIDS, transmission, treatment, or other issues;
- Review of current agency policies and procedures / service standards;
- Cultural competency and linguistic appropriateness for all services;
- Available options for disabled service access or language accessibility, including information about current agency policies for provision of or referral to interpreters, translated materials, native speakers on staff, cultural awareness training for staff, or other guidelines for language accessibility;
- Bloodborne pathogen exposure, universal precautions, and employee tuberculosis (TB) screening policy; and
- HIPAA compliance and other client confidentiality protections.

SPECIALISTS: Agency staff must work to establish linkages with key specialists to ensure that primary care providers and other service provision staff have access to expert support as needed throughout their work in various service categories.

OVERSIGHT: Service providers are required to have regular supervision to ensure ethical and competent services, to receive support for managing client issues, and to ensure that the standards of care are followed. Supervision will be provided for all staff by an individual with appropriate clinical and supervisory experience, at a minimum of 1 hour every two weeks. This supervision will be documented in agency files.

CLIENT RECORD REVIEW: Supervisors must conduct client record review on a regular basis (at least every 6 months) to assess staff's documentation of client eligibility or other relevant issues.

PERFORMANCE REVIEW: Supervisors must conduct an annual performance review for all employees and volunteers, with results of the review included in writing in the employee/volunteer file.

OTHER REQUIREMENTS

In addition to the standards in the main categories above, there are a number of other requirements that all agencies and staff providing services under the RWHAP must follow:

COMMUNITY REFERRALS: Agencies providing services under the RWHAP must create and maintain an updated list of community resources and distribute this list to staff, clients, and families as appropriate.

- These lists need not be created from scratch; rather, agencies are encouraged to borrow resources from other organizations where possible, including the Alameda County Public Health Department, Contra Costa Health Services, CCPC, and other community agencies. Maintenance of this list helps to ensure that client services are provided in partnership with other agency services and other community HIV service providers, to avoid duplication of efforts and to foster client access to integrated health care.
- Special attention must be given to supporting the needs of formerly incarcerated individuals re-entering the community through the TGA.

COORDINATION OF CARE: Agencies must establish linkages and connections to care within and across organizations, to develop programs, policies, and referral opportunities.

- Whenever possible, these linkages and connections should be formalized through Memoranda of Understanding (MOUs) or other types of documentation.
- Agency policies should ensure that clients are linked to primary care quickly and in a way that encourages a strong connection with the primary care provider.

DOCUMENTATION OF REFERRALS: Agencies must implement and maintain a method for tracking referrals during the course of RWHAP service provision, and make certain that clients successfully complete referrals; if referrals are not used by clients, the agency must have a procedure to follow up at least once with clients, or more times if needed based on the significance of the referral.

INVOLVEMENT OF CLIENTS IN THEIR CARE: Agencies must involve clients in treatment planning, to assist with the improvement of care.

- A client signature is required on each treatment plan developed in concert with their provider.
- All clients must be invited to participate in a consumer satisfaction survey regarding their care at the agency at least once per year.
- Agencies must complete a written summary of consumer satisfaction survey findings, along with a detailed corrective action plan to address shortcomings identified in the most recent survey.

GRIEVANCE PROCEDURES: Clients have a right to file a grievance/complaint if they are not satisfied with services. Providers must post and provide clients with a copy of the agency grievance policy and acknowledge receipt in their consent form. The agency grievance policy must include specific details of how clients can file a grievance, what steps will be taken after a grievance is filed, and how the agency will take steps to protect the rights and quality of treatment of the client after a grievance has been filed.

PHYSICAL PLANT STANDARDS: Physical plant standards are intended to ensure program safety for both clients and staff. To that end, the following standards must be followed:

- Services must be delivered in a secured location with posted hours of operation. This includes having a private, confidential space for clients to meet with program staff, with bathrooms located near offices and located in a geographic area that is as safe as possible, where personal safety is not an issue and illegal drug use is not tolerated on-site. Ideally, services are located with easy access via public transportation.
- Providers must comply with city/county fire regulations, and health and safety regulations, building codes, and zoning regulations, including clearly visible emergency exits, smoke detectors, and carbon monoxide detectors.
- The geographic location of services should be and easily accessible for disabled persons living with HIV/AIDS. Hills and inclines are difficult for persons with wheelchairs and walkers. Access to public transportation should be taken into consideration. Agencies should have visual evidence of wheelchair access wherever appropriate.

QUALITY ASSURANCE AND REPORTING: In order to ensure the highest quality of care/services for people living with HIV in the Oakland TGA, and to assist medical service providers in ensuring that services adhere to HIV clinical practice standards and Public Health Service guidelines, the TGA has set forth a number of standards to promote continued quality improvement of RWHAP services, including:

- Agencies must have a written Quality Management Plan for each RWHAP service they provide, including information about tools used to measure program outcomes, methods for data collection and storage, and how data will be used to improve the program.
- Agencies must have data reporting capabilities sufficient to meet the data reporting requirements of the RWHAP, including computer hardware, software, and staffing as needed to meet expected deadlines.
- All community agencies funded to provide RWHAP services will be monitored by the appropriate county health department, with a minimum of one formal site visit conducted each fiscal year. This visit is for the purpose of evaluating compliance with contracted requirements, program effectiveness and providing technical assistance. The contract agency will be provided a summary of any reports prepared as a result of the visit. Compliance will be reviewed in the following areas:
    - Appropriate documentation of client eligibility for RWHAP services in the client record (file/chart);
    - Consistent documentation of services provided within the client record, and agreement with reported units of service completed / unduplicated client count reported through routine data reporting mechanisms;
    - Accurate invoicing for services provided;
    - Any requests / needs for technical assistance from the Alameda or Contra Costa County Health Departments, HRSA, the CDC, or specialized Capacity-Building Assistance (CBA) organizations; and
    - Any other forms or documentation that are required by the RWHAP Administrative Monitoring Standards (see site visit tool).

RECORD KEEPING, ADMINISTRATION, AND FINANCIAL PROCEDURES: Service providers are responsible for documenting and keeping accurate records of service health outcomes and units of service, as requirements for reimbursement of service expenses. Records should be available only to agency staff directly responsible for filing, charting, and reviewing, and to TGA, State, and Federal representatives as required by law. The client service record must be kept, and should follow the accepted guidelines for record handling and documentation practices for health care records. All documents must be secured in the record and protected from potential damage for a minimum of 5 years. Minors' records must be kept for at least 5 years or until the minor is 19 years old, whichever is longer.

- Agencies must maintain confidentiality for computer files and secure, locked cabinets in locked rooms for paper files with client information. Access must be limited to designated personnel; computerized records must have appropriate safeguards including encryption and password protection.
- Each client receiving RWHAP services must have a separate client record (file/chart) and unique identifying number. Records must follow a standard format, with standardized documents. Documentation must be legible, typewritten, computer-generated, or handwritten in ink. Documentation must always be dated and signed by the responsible staff.
- To ensure RWHAP funds are funds of last resort, agencies must maintain fiscal responsibility by using (a) generally accepted accounting principles; (b) annual independent audit or review according to funding-level requirements; (c) internal control policies and procedures; (d) cost principles for non-profit organizations (per OMB circular A-122).
- Agencies may not request reimbursement higher than the cost per unit of service that is negotiated with the Oakland TGA.
- Agencies must submit annual audit reports and agree to fiscal site visits upon request; at these visits they must be able to demonstrate accurate invoicing, an appropriate system in place to track the RWHAP funding stream separately from other funding sources, and the agreement of the general ledger with the final program invoices.

OTHER

- All providers must provide clients with information regarding the Affordable Care Act.
- Providers must screen for and refer clients experiencing Intimate Partner Violence (IPV).

Medical Case MANAGEMENT

INTRODUCTION

This document describes the "Medical Case Management" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Medical Case Management (MCM).

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices standards for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Medical Case Management consists of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Medical case managers may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.

OBJECTIVE: The objective of MCM services includes improving health care outcomes; services to provide guidance and assistance in improving access to needed services are considered Non-Medical Case Management Services.

GOAL: The goal of MCM services is to move a client to self-sufficiency.

INCLUDED SERVICES: MCM includes all types of case management intended to improve client access to health care including:

- Face-to-face,
- Phone contact, and
- Any other forms of communication with clients.

It also includes Treatment Adherence Services, visits to ensure a client is ready for and adherence to complex HIV treatments.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

EDUCATION/TRAINING/LICENSING: To provide services in this category, providers must have the appropriate training, including:

- Bachelor's Degree in Social Work or related field, up to a Master's or Doctorate in Social Work.
- Three years of short-term assistance experience without a degree in social work or related field is acceptable.
- Positions that require a license will include the following: Licensed Clinical Social Workers, Marriage and Family Therapist (MFT), or Registered Nurse.
- Unlicensed medical case managers must receive clinical supervision at least once per month from a licensed provider as described above.

PROVIDER CATEGORIES:

- A **nurse case manager** may monitor the medical status of the client, and assess the client's functional capacities in relation to medical status. They may also organize:
  - Care in the home with referral for nursing,
  - Attendant and hospice care service, and/or
  - Clinical care for other medical and support services.
- A **medical social worker** coordinates care and may arrange or plan for:
  - Counseling;
  - Emotional and practical support; or
  - Referrals and other assistance to the client and family members, to promote self-management and maintenance in primary care.

KEY ACTIVITIES

Key activities of Medical Case Management include:

INITIAL ASSESSMENT: Determining the client's needs and program eligibility, including whether the client is actively engaged in medical care;

CARE PLAN: Development of a comprehensive, individualized care plan for every client;

COORDINATING CARE: Working with providers to ensure that the client promptly receives referrals to all the types of care that s/he needs, as medically appropriate. This might include many different types of medical care and support services;

MONITORING: Continuous client monitoring to determine if the care plan is working;

EVALUATION AND ADJUSTMENT: As needed, and at least every 6 months, review of the status of the client's engagement in medical care, and adjustment of the care plan;

NEEDS ASSESSMENT: Ongoing assessment of the client's and other key family members' needs and personal support systems. Assessment should include any need for the following services:

- Health care and mental health
- Psychosocial support
- Housing
- Transportation
- Risk reduction
- Partner notification and disclosure
- Legal
- Benefits counseling and insurance coverage
- Substance abuse

TREATMENT ADHERENCE COUNSELING: Ensuring that the client is ready for and adheres to complex HIV treatments; and

ADVOCACY AND REVIEW: Enable the client to access all necessary services, and review their usage of core support services;

ORIENTATION: New clients should be given a complete orientation, including written information about agency services, grievance/mediation services, disclosure/notification services, and other resources in the client's preferred language; and

REFERRALS: Clients should be provided with information and referrals to any medical or support services as appropriate.

CLIENT ACUITY LEVELS AND CLASSIFICATION

Active clients are clients who have had successful contact with Medical Case Management services within the last 3-6 months. Agency caseloads should be largely comprised of active clients.

ACUITY (NEED) LEVELS: Case management services should be provided based on the client's level of need.

- Clients should be assessed at intake using an acuity scale, such as the Cognitive Functional Ability (CFA) Scale used by nurse case managers, or another similar scale.
- Knowledge of a client's level of need may assist agency staff in determining the caseload for a particular medical case manager.

CLASSIFICATIONS: Acuity levels shall be categorized according to the acuity scale used by the agency providing service. They should be categorized in levels 1 – 4 according to client need for case management, and may be based on progression of HIV disease or other issues impacting their HIV care or risk for further HIV transmission. At a minimum, these standards must be met:

- **Level 1** (functioning well). Level 1 clients only have a need for occasional medical case management. These clients may be newly diagnosed and require short-term assistance; have no symptoms or expressed stress or anxiety; or may be seeking a primary care provider or support in accessing health care while maintaining health, employment, and daily living tasks. Case Manager actions appropriate at this level include:
  - Client screening, intake, and identification of needs through a comprehensive assessment;
  - Teaching clients about case management;
  - Developing and reassessing care plans;
  - Collecting and documenting results of the care plan;
  - Providing information, education, and counseling;
  - Arranging for or providing disclosure assistance (Partner Services);
  - Arranging for or providing assistance with clinic navigation;
  - Referring clients to providers as needed; with proper consent, forwarding intake information to other service providers;
  - Coordinating the client's care with multiple providers;
  - Assisting clients in filing for basic benefits; and
  - Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments.
- **Level 2** (needs some assistance). Level 2 clients require repeated contacts. They may have multiple problems and may be experiencing early symptoms of complications related to HIV infection. Case Manager actions appropriate at this level include:
  - All actions appropriate for Level 1 clients;
  - Providing crisis intervention; and
  - Assessing and assigning clients to an appropriate level of medical care and nurse consultation.
- **Level 3** (alternating between severe episodes and periods of functioning well). Level 3 clients must have a nursing assessment to determine their eligibility for nurse case management services and eligibility for Medi-Cal Waiver or other State-funded HIV case management services. Case Manager actions appropriate at this level include:
  - All interventions appropriate for Level 1 and Level 2 clients;
  - Home assessment; and
  - Complete health history.

- **Level 4** (severely impacted). Level 4 clients have considerable health care needs because of the progression of their HIV illness. They may require referrals for hospice care and/or end-stage disease planning. The case management team should provide the psychosocial resources necessary for Level 4 clients not receiving hospice services. However, Level 4 clients who are receiving hospice services should not be denied access to therapists or other providers with whom they have developed a relationship. Case manager actions appropriate at this level include:
    - All interventions appropriate for Level 1, 2, and 3 clients;
    - Spiritual bereavement counseling;
    - In-home care, with attendant/skilled nursing;
    - Pain management;
    - Nutritional supplements; and
    - Durable medical equipment.

Client caseload is determined by level of acuity, service activity, and funding amount for each medical case manager.

INITIAL ASSESSMENT OF SERVICE NEEDS

Services must be offered in a way that addresses barriers to access of medical care and uses resources to support positive health outcomes for clients.

ELIGIBILITY/ASSESSMENT: At the initial intake visit of a new MCM client, agency staff must screen for eligibility and conduct an intake assessment.

APPOINTMENTS: On-site appointments must occur within 5 days of first client contact; off-site appointments must occur within 10 days. Appointments outside these time limits must have the reasons documented in the client file.

- Providers must have a written procedure to link clients who are out of care to primary care within 30 days.

ORIENTATION: Each client enrolled in MCM must receive an orientation to the services; this orientation should be documented in the client file.

REFERRAL: Clients not eligible for MCM services through the RWHAP must be referred to another community-based organization or linked to another safety net provider as appropriate, with documentation of that referral available upon request.

PRIMARY CASE MANAGER: Each client should have one case manager designated as the primary case manager. That staff person will act as the coordinator with other members of the treatment team.

NEEDS ASSESSMENT: After eligibility screening, the provider must conduct a comprehensive needs assessment. The needs assessment will describe the client's current status and identify their strengths and weaknesses, resources, and/or stressors, in order to develop a relevant treatment plan which allows the patient to function and manage their condition as independently as possible. This assessment must be thoroughly documented, and includes:

Level 1 and 2:

- Primary care connection and health status (e.g. labs, etc.);
- Awareness of safer sex practices;
- Sexuality issues;
- Living situation;
- Substance use history;
- Mental health / psychiatric history;
- Financial / program entitlement;
- Family make up;
- Social community supports;
- Self-management skills and history;
- Emergency financial assistance needs and history;
- Spirituality issues; and
- Treatment adherence history.

Level 3 and 4:

- All items above;
- Current health status / medical history;
- Current medications / adherence;
- Home environment / safety check; and
- Nutritional status assessment.

DEVELOPMENT OF A COMPREHENSIVE, INDIVIDUALIZED CARE PLAN

FREQUENCY: An individualized care plan must be developed at intake and updated at least every 6 months.

REQUIREMENTS: Medical case managers developing an individualized care plan will, at a minimum:

- Set realistic goals, objectives, and timelines based on identified needs;
- Develop a "compliance contract," if applicable; and
- Identify resources to attain the goals and objectives, including collaboration with other relevant providers (e.g. substance abuse counselors, physicians, housing specialists).

UPDATES: As the client's status changes, the client and medical case manager will work together to establish new goals, objectives, and timelines.

DOCUMENTATION: Completed individualized care plans must be kept in the client file, signed by both client and provider. Any updates to the plan must also be signed by client and provider.

QUALITY MANAGEMENT AND SUPERVISION: All agencies providing MCM must have a quality management plan in place and conduct clinical supervisory chart review to assess documentation of each client's needs. All supervisor's reviews must be documented with date of review and findings.

COORDINATION OF SERVICES

CLIENT RECORD: All medical case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients, must be recorded in the client record within three working days, including coordination with referral agencies. Documentation of activities must be legible, signed, and dated by the case manager.

CASE CONFERENCING: Case conferences should be held for any client to coordinate care among providers from different fields (disciplines). Memoranda of Understanding (MOUs) or other standardized agreements may be necessary to ensure participation by the multidisciplinary team.

- **DISCUSSION**: During case conferencing, a review of the service plan and an evaluation of the services the client is receiving should be performed, as well as the client's current status (coordinating care, troubleshooting problems with maintaining the client in care, strategies to re-engage client in care, etc.)
- **CLIENT INPUT:** The client and/or his/her caregiver or legal representative may provide input to the case manager during case conference and telephone contacts.
- **DOCUMENTATION:** Appropriate documentation must be kept in the client chart, 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 service outcome.

PERIODIC RE-ASSESSMENT, RE-EVALUATION, and REVISION OF THE CARE PLAN

ASSESSMENT: Medical case managers should routinely review the success in achieving service outcomes as outlined in the service plan, measure progress in meeting goals and objectives, and revise the plan as necessary.

- **For Level 1 and Level 2 clients**, clients must have contact with their medical case managers for RWHAP re-certification every 6 months, though only one meeting per year must be face-to-face.
- **For Level 3 and Level 4 clients**, face-to-face assessments must be made every 60 days (minimally), and the nurse case manager must make telephone contact every 60 days if the client has not been successfully seen by the medical case manager in that timeframe.

DOCUMENTATION: Medical case managers must routinely document the outcome of reassessments and service activities in the client record, program database / client contact form, and outcome log (if applicable).

FEEDBACK: Medical case managers must provide constructive feedback to clients when reviewing the care plan and progress made toward goals and objectives.

CLIENT TRANSFER OR GRADUATION

TRANSFER OF CLIENTS: Transfer of clients between agencies or case managers is initiated when:

- The client notifies the case manager that s/he has moved to a different service area or out of the TGA,
- The client notifies the case manager of his/her intent to transfer services,
- The client has followed the grievance procedure, or
- The agency no longer receives funding.

CLIENT GRADUATION: Agencies must have written protocols to graduate clients into a less-intensive level of care as they become more independent and self-sufficient and their need for case management is reduced.

FILE CLOSURE: Agencies should close a client's file according to the written procedures established by the agency, for reasons including but not limited to (a) death, (b), relocation, (c), transition to another provider, (d) request of the client, (e) discovery of fraudulent documents, or (f) there is no client contact for longer than one year.

- Prior to closure (for reasons other than death), the agency must attempt to inform the client of the re-entry requirements into the system, and make clear to the client the results of closing the case.
- Prior to disenrollment and case closure due to ineligibility (i.e. in the case of discovery of fraudulent documents), the client must:
  - Be given at least 10 days' notice before disenrollment;
  - Be sent a letter that verifies the disenrollment date and reason for the action. This letter must be legible, signed, and dated, and a copy must be kept in the client record;
  - If the client is in agreement with or requests the disenrollment, it is not necessary to provide the 10 day notice.
- Record Maintenance: Medical Case Management files must be held in a secure place for a minimum of 5 years after a case is closed.

RECOMMENDED BEST PRACTICES

PREFERRED PROVIDER QUALIFICATIONS, WHENEVER POSSIBLE

To provide services in this service category, providers should:

Complete initial and ongoing training in Partner Services.

Be trained in de-escalation and conflict resolution.

Have upper-level training in HIV medical care and medical / support resources for people living with HIV in the Oakland TGA.

Be able to serve the client according to the federal Culturally and Linguistically Appropriate Services (CLAS) standards.

Have multiple language capabilities, or know about available translation services to ensure that the needs of clients are being met in their preferred language.

Be familiar with the Affordable Care Act and how it is put into use in California, including Covered California.

Early Intervention
SERVICES

INTRODUCTION

This document describes the "Early Intervention Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Early Intervention Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices standards particular to this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Early Intervention Services (EIS) include counseling individuals about HIV/AIDS; targeted HIV testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, and tests to determine appropriate therapies); referral services to improve HIV care and treatment services at key points of entry; access and linkage to HIV care and treatment services, such as Outpatient / Ambulatory Health Services, Medical Case Management, and Substance Abuse Care; and Outreach Services and Health Education / Risk Reduction related to HIV diagnosis.

These services are meant to actively reach into the community to identify people at the earliest point in their diagnosis of HIV disease. Early intervention services offer information, referrals and treatment to help individuals engage in medical care and access other services as necessary to help them maintain themselves in medical care.

The elements of EIS often overlap with other service category descriptions; this is because EIS is the combination of such services rather than a stand-alone service.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

SERVICE COMPONENTS

Providers offering EIS must include the following four components, either through direct provision or through linkage to another provider who offers the service:

TARGETED HIV TESTING: This component is designed to help those who do not know their HIV status learn whether they are living with HIV, and receive referrals to HIV care and treatment services if they are diagnosed with HIV.

- EIS providers must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.
- HIV testing paid for by EIS cannot take the place of testing efforts paid for by other sources, as RWHAP is always the payer of last resort.

REFERRAL SERVICES: This component is designed to improve HIV care and treatment services at key points of entry; building strong relationships with care and treatment providers able to quickly see new patients is critical to success.

ACCESS AND LINKAGE TO HIV CARE AND TREATMENT SERVICES: This component is designed to ease connection to Outpatient / Ambulatory Health Services, Medical Case Management, and Substance Abuse Care Services. Clear linkages, with documented Memoranda of Understanding (MOUs) when possible, are required to encourage the integration of these service categories.

OUTREACH SERVICES AND HEALTH EDUCATION / RISK REDUCTION: This component is intended to identify those who do not know their HIV status but are at high risk of HIV infection, or know they are living with HIV but are not yet engaged in care.

2. SERVICE CHARACTERISTICS

ELIGIBILITY: Unlike almost all RWHAP services, some EIS services are offered without eligibility determination, such as initial HIV testing, traditional outreach services, and some referral services. These services are provided for a limited time and meant to link those who test positive or have a positive HIV status to longer-term services where eligibility and full assessment services are conducted. Documentation of the contacts between the outreach worker and the individual is recorded on an encounter form along with brief statements assessing the person's immediate need and the plan for meeting the need.

TOOLS: The strategies used to draw people into service may be different from those that are needed to keep them engaged and participating in their care. It is intended that individuals will progress from early and intensive service utilization to less intensive service use and assume more self-management and self-reliance with the transition from EIS types of services to ongoing or continued services. However, EIS does provide continued services through the medical services described in the definition.

OUTREACH: Outreach is a critical part of this service category, as outreach and recruitment identifies and recruits those who are at highest risk for falling out of care. Use of an assessment tool to identify people at highest risk is important, as is using outreach workers who have established trust and communication with the populations whose histories put them at highest risk for not engaging in care.

PARTNER SERVICES: Partner Services (including third party notification) are another critical service to be offered at the same time as EIS, to help prevent further spread of infection.

RECOMMENDED BEST PRACTICES

TRAINING: EIS staff should be trained in the use of a trauma-informed perspective, and have a strong understanding of the barriers to care and possible strategies for reducing barriers among the highest-risk clients. Staff who do not already have this knowledge and experience should be encouraged to participate in training or other continuing education activities.

ENGAGEMENT AND RETENTION: Agencies are strongly encouraged to develop and maintain a strong and standardized protocol for engaging and retaining clients during outreach and testing activities, as those clients most likely to benefit from EIS are also those who are most difficult to retain in ongoing services, linkage, and follow-up.

Home & Community-Based
HEALTH SERVICES

INTRODUCTION

This document describes the "Home and Community-Based Health Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Home and Community-Based Health Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it provides detail about Requirements and Recommended Best Practices standards for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Home and Community-based Health Services are skilled health services. They must be 1) provided to the client in the client's home, 2) based on a written plan of care, and 3) provided by a case management team that includes appropriate health care professionals (registered nurse, licensed vocational nurse, home health aide). Services may include:

Durable medical equipment

Home health aide services and personal care in the home

Day treatment or other partial hospitalization services

Intravenous and aerosolized drug therapy (including prescription drugs given as part of such therapy)

Routine diagnostic testing done in the home

Appropriate mental health, developmental and rehabilitation services.

In-patient hospital services, nursing home and other long-term care facilities are NOT included.

PURPOSE/GOALS

These services will enable clients to safely remain in their homes and reduce hospitalizations, and to improve the quality of health for HIV/AIDS clients while they are home bound.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

To provide services in this service category, providers must:

LICENSING: Maintain a current and valid licensure where appropriate

- MD, DO, PA or NP state licensure
- RN or LVN state licensure
- An Attendant must have either a California Certified Nursing Assistant (CAN) or Certified Home Health Aide (CHHA) certification

PRESCRIBING: Home and Community-Based Care services must be prescribed by a medical provider (MD, DO, PA or NP)

QUALIFICATIONS BASED ON SERVICES: Services must be provided by a qualified practitioner; required qualifications are based on the services to be provided:

- A Registered Nurse **(RN)** provides the highest level of Home and Community-Based Care, including:
  - Skilled nursing care
  - Initial intake/assessment
  - Follow-up visit at least monthly
- A Licensed Vocational Nurse **(LVN)** works under the supervision of an MD or RN to provide skilled nursing care.
- An **Attendant or Home Health Aide** provides non-skilled care; Home Health Aides must be supervised by a nurse at least monthly.

ALLOWED SERVICES: Funds may be used for the following Home and Community-Based Care services:

- Attendant/home health aide services provided by a **Home Health Aide (HHA)** or **Attendant,** including activities of daily living (ADL). Personal Care services may only be provided to clients who need assistance with one or more Activities of Daily Living as determined by an RN during the initial assessment.
  - Bathing and other personal care services, including skin, mouth and hair care
  - Assisting in and out of bed and with walking
  - Medication reminders for any medicines the client takes himself or herself; the home health aide shall NOT administer medications of any kind
  - Meal preparation

- Light housekeeping
- Accompanying the client to medical appointments (attendant may not drive client to the appointment)
- Routine allowable diagnostic testing administered in the home
- Reporting changes in the individual's condition and needs to the supervising nurse or physician
- Completing record regarding services provided

- Skilled nursing services provided by an **RN** or **LVN**:
  - Initial intake and assessment (**RN only**)
  - Supervision of HHA or Attendant (**RN only**)
  - Education
  - Pain management
  - Treatment adherence
  - Infection control
  - IV therapy
  - Dressing changes
  - Operation of durable medical equipment
  - Other activities taught by a health professional, such as changing colostomy bags, changing non-sterile dressings, taking vital signs, and non-sterile bowel and bladder hygiene care

SERVICE CHARACTERISTICS

Initial referral to the agency is made by the client's case manager.

ELIGIBILITY: Home and Community-Based Care services may only be provided to clients using Ryan White funds when they are:

- Unable to reasonably attend healthcare services in a standard facility,
- Unable to pay for medically indicated skilled care through other means, or
- Unable to perform their own house or personal care as a result of illness related to their HIV.

Service provided in this category include the following five treatment steps:

- **Diagnosis and prescription**, requested by the agency and made by the referring provider
- **Initial assessment of care** needed, performed by the RN
- **Goal setting**
  - Written plan of client care
  - Planning team may include RN, case manager (if applicable), provider, and any staff members
- **Performing the intervention/treatment**
- **Evaluations/re-assessments**
  - Also referred to as "prescription refresh"
  - Done by the RN
  - Every 30-60 days or sooner as client condition requires until no longer needed

In general, Home and Community-Based Health Care does not provide 24-hour care. However, it may be included as a part of the written plan of care if the treatment is clearly HIV related and is declared necessary by the attending provider.

RECOMMENDED BEST PRACTICES

PREFERRED PROVIDER QUALIFICATIONS, WHENEVER POSSIBLE

To provide services in this service category, Home Health Aides should have California Certified Home Health Aide Certification.

Medical Nutrition Therapy
SERVICES

INTRODUCTION

This document describes the "Medical Nutrition Therapy Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Medical Nutrition Therapy Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices standards for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Medical Nutrition Therapy Services are provided by a licensed registered dietitian outside of a primary care visit and include the provision of nutritional supplements. Medical Nutrition Therapy provided by someone other than a licensed registered dietitian should be recorded under psychosocial support services.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

To provide services in this service category, providers must maintain a current and valid Registered Dietitian licensure (RD).

SERVICE CHARACTERISTICS

OBTAINING SERVICES: Medical Nutrition Therapy services are offered by provider referral only; however, clients may request Medical Nutrition Therapy via their case manager.

CARE PLAN: Medical Nutrition Therapy requires a coordinated care plan.

- RD must work in concert with other providers
- Regular re-assessment to revisit and revise the nutritional care plan is required
    - May result in the creation of a new care plan, continuation of existing plan, or disenrollment/success

HEALTH HISTORY ASSESSMENT: Provider must conduct a health history assessment, which includes:

- Baseline body weight, measured for normal weight and height without shoes
- Medical history, including current medications, immunity, overall well-being, and any complications or other medical problems (i.e., diabetes, cardiovascular, kidney and liver diseases)
- Assessment of client's nutritional status, including such factors as:
    - Weight changes
    - Current medications
    - Side effects
    - Symptoms
    - Client functioning
    - Change in body appearance
    - Lab work where available
- Nutritional counseling on basic dietary restrictions and menu planning
- Nutrition education that based on the findings of the nutritional assessment. Depending on the client's HIV status, this may include:
    - Education about nutritional needs; ensuring adequate diet with balanced intake of macro-nutrients
    - Safe food handling and preparation
    - Identifying/addressing misinformation
    - Addressing nonspecific symptoms and fatigue
    - Preventing weight loss and potential wasting
    - Exploring the use of alternative therapies, herbals, etc.
    - Provision of adequate calories to diminish effects of malnutrition

RECOMMENDATIONS AND REFERRALS: RD may make additional recommendations or referrals as appropriate.

- Referral to food-assistance programs, emergency food providers, and food stamps, with follow up as appropriate
- Written authorizations for nutritional supplements
- Recommendation for a medication evaluation to the medical provider to address nutrition-specific issues (i.e., loss of muscle and loss of appetite)

RECOMMENDED BEST PRACTICES

PREFERRED PROVIDER QUALIFICATIONS, WHENEVER POSSIBLE

To provide services in this service category, providers should, when possible:

Obtain detailed lab work, including specific nutrient deficiencies, HgA1C, and others, as appropriate

Have some level of knowledge/population skills related to people living with HIV or be willing to obtain these skills via continuing education

Mental Health
SERVICES

INTRODUCTION

This document describes the "Mental Health Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Mental Health Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Mental Health Services are psychological and psychiatric treatment and counseling services for individuals with diagnosed mental illness, held in a group or individual setting, and provided by a mental health professional who is licensed or authorized within the State to provide those services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

PURPOSE/GOALS

To assist clients and their significant others, including family, and friends, in coping with the emotional and psychological aspects of living with HIV disease. These services will minimize crisis situations and stabilize clients' mental health status in order to promote health care maintenance and positive health outcomes.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

LICENSING: Maintain a current and valid licensure where appropriate

- **Psychiatrist**: MD state licensure
- **Psychologist**: State licensure
- **Psychiatric Nurse**: State licensure
- **Other Clinician**:
  - MFT
  - LCSW
  - PhD or PsyD
- **Registered Clinical or Student Interns**: May provide services with licensed supervision

COMPETENCIES: Providers must be competent in trauma/stigma, including LGBTQ related stigma and stress

SERVICE CHARACTERISTICS

Mental Health Services must include the following four components:

SCREENING/INTAKE: This component is designed to screen for both payment options and to perform a comprehensive mental health assessment.

- Clients must be screened for Medi-Cal or other payment sources
  - If a client is eligible for payment through another payor, but no provider is currently available, treatment should be provided until available
  - Preliminary screening may be performed by mental health staff or Medical Case Manager
- Complete a comprehensive mental health assessment using a current mental health assessment tool, which identifies both clinical and non-clinical client needs
  - Diagnosis may relate to DSM-V diagnoses or trauma/stigma

TREATMENT PLAN DEVELOPMENT: The mental health provider wil develop a treatment plan based on the comprehensive assessment.

- Treatment plan should be created with input from clients
- Treatment plan should be reviewed every 90 days
- A variety of culturally and linguistically sensitive (CLAS) and evidence-based treatments must be made available

SUPPORT, REFERRAL, AND COORDINATION OF SERVICES: Services are part of the coordinated continuum of care. Staff provides immediate support and referrals for urgent, crisis, and emergency situations, including violent or suicidal behavior.

- Mental health staff should provide appropriate referrals when clients have acute mental health needs that fall outside of the scope of the funded services or competency of the clinician
- Clients should be referred to support groups when appropriate

- Clients not currently accessing medical care will be referred to a primary care provider
- When allowed by law and necessary for appropriate provision of care, other providers should be aware that the client is accessing Mental Health Services
- Support requests from caregivers must be responded to in a timely manner

CASE CLOSURE: A file should be closed when there has been a request for closure or when there has been no client contact for over six months. Prior to closing the case (with the exception of death):

- Inform client of the reentry requirements
- Make it clear to the client what case closure means

RECOMMENDED BEST PRACTICES

GENERAL SERVICES CHARACTERISTICS, WHENEVER POSSIBLE

Requests for services from caregivers should be responded to within 24 – 72 hours.

Oral Health
SERVICES

INTRODUCTION

This document describes the "Oral Health Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Oral Health Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements.

SERVICE DEFINITION

Oral Health Services include diagnostic, preventative, and treatment services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

PURPOSE/GOALS

The purpose of Oral Health Services is to provide access to routine and emergency dental care for eligible persons living with HIV/AIDS. Through the provision of periodic preventive and educational services, Oral Health Services aims to reduce the incidence of more serious dental and periodontal conditions.

Through the provision of these services, the goal of Oral Health Services is to maintain and improve the oral health of clients and to increase their ability to sustain proper nutrition.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

LICENSING: Maintain a current and valid DDS or dental hygienist state licensure.

SUPERVISION: Auxiliary staff members must be supervised by a qualified dentist or dental hygienist.

INITIAL INTAKE VISIT

SCREENING/ELIGIBILITY: As with all RWHAP services, at the initial intake visit of a new client in this service category, staff must screen for Medi-Cal or other payment sources, and verify eligibility (either directly or via the referring provider). This helps ensure that the client can access the most complete payment source, and also preserves RWHAP funds as the payer of last resort.

HEALTH HISTORY ASSESSMENT: After eligibility screening, the provider must conduct a health history assessment, which includes:

- Prior dental and medical history
- Contact information from primary care providers
- Current medications and changes in regimen
- Known allergies
- Current and past alcohol, tobacco, and other substance use
- Laboratory data, including:
  - CD4 and HIV viral load
  - Hepatitis A, B, and C screening
  - X-rays of the teeth
- Review of any HIV-related oral conditions and treatment modes

TREATMENT PLAN DEVELOPMENT AND IMPLEMENTATION

A treatment plan should be developed with input from the client, with attention paid to:

- Client's level of need, including the determination of emergency versus non-emergency care, triage care, and referral as indicated
- Client-requested services

Written treatment plan will be updated once a year, at a minimum.

ANNUAL DIAGNOSTIC SERVICES

Services to be provided should adhere to the individualized treatment plan, and may include:

An oral exam, including:

- Dental caries examination
- Soft tissue examination

A periodontal exam, including:

- Examination of pocket depths, gingival inflammation, plaque index, fremitus, gingival recession, bleeding assessment, or tooth mobility

A head and neck exam, including:

- Documentation of any of the following: examination of facial symmetry, lymph nodes, thyroid glands, or lips

Any services to diagnose or treat current conditions, or to prevent future conditions, as specified in the treatment plan. These may include:

- Cleanings, one or more times a year as deemed necessary
- Anesthesia services, as needed
- Bridges
- Root canals (non-front teeth)
- Prostheses, dentures, and denture aftercare

ORAL HEALTH EDUCATION

Oral health education should be provided to the client at least annually, and include the following components:

- Preventing cavities (e.g., oral hygiene instruction, dietary counseling)
- Stopping smoking

SUPPORT, REFERRALS, AND COORDINATION

The provider will:

- Identify and communicate with other client caregivers to support coordination and delivery of high quality care
- Provide appropriate referrals to any specialty care necessary for the client's treatment plan
- Track referrals both into the agency and out to other services and providers

Outpatient/Ambulatory
HEALTH SERVICES

INTRODUCTION

This document describes the "Outpatient / Ambulatory Health Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and is a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Outpatient / Ambulatory Health Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it provides detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Outpatient / Ambulatory Health Services should be offered along with medical case management, and provide professional diagnostic and therapeutic services given by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services in the Oakland TGA are HIV-focused, and primarily include diagnostic testing, including laboratory testing; behavioral risk assessment, with counseling and referral as indicated; preventive care and screening for opportunistic infections, tuberculosis (TB), sexually transmitted diseases (STDs), and hepatitis C; physical examination; medical history taking; prescription and management of medication therapy; pediatric developmental assessment; education and counseling on health and prevention issues; and referral to and provision of specialty care related to HIV diagnosis (includes all medical subspecialties).

Services can be provided through this service category either as:

Ongoing and consistent HIV care, or

One-time assessment with a specific procedure and follow-up for that procedure as needed, depending on the needs of the client.

As with all RWHAP services, Outpatient / Ambulatory Health Services are only to be used as the payer of last resort. Clients living with HIV in the Oakland TGA who are able to seek primary care and HIV specialty services from other providers or with other payers must do so; services provided with this funding "complete" coverage to ensure the highest-quality care and best prognosis for all people living with HIV.

Primary medical care for the treatment of HIV infection includes providing care that is consistent with U.S. Public Health Service guidelines. This care must include access to antiretroviral (ARV) and other drug therapies, including preventative therapies, treatment of opportunistic infections, and combination ARV therapies.

Treatment Adherence services provided during an Outpatient/Ambulatory Health Services visit should be reported under the Outpatient / Ambulatory Health Services category; Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

To provide services in this service category, providers must:

Maintain a current and valid MD, DO, PA, or NP state licensure.

Be willing and able to provide access to antiretroviral therapy (ARVs) and treatment for opportunistic infections for their patients.

INITIAL INTAKE VISIT

SCREENING AND ELIGIBILITY: As with all RWHAP services, a the initial intake visit of a new patient in this service category, primary care staff must screen for Medi-Cal or other payment sources, and verify eligibility (either directly or via the referring provider). This helps ensure that the client can access the most comprehensive payment source, and also preserves RWHAP funds as the payer of last resort.

HEALTH HISTORY: After eligibility screening, the provider must conduct a health history assessment, which includes:

- History of diagnosis, including date and believed route of transmission;
- Baseline body weight, measured for normal weight and height without shoes, and vital signs;
- Full medical history, including history of anal pap smears for both men and women;
- Contact information from referring or recent care providers;
- Current medications and changes in regimen;
- The status of vaccinations: including dates of Pneumovax, Hepatitis A & B, varicella zoster (shingles), HPV, influenza and TDAP (tetanus, diphtheria, and pertussis);
- Known allergies;
- Current and past alcohol, tobacco, and other substance use;

- Clients born female should have detailed reproductive history including history of menses, contraceptive methods, pregnancy and childbirth, and pap smear results. Treatment for pregnant women should follow the guidelines for treating non-pregnant adults, as well as for prevention of perinatal transmission. The woman's health status should be prioritized.
- Laboratory data, including:
    - CD4 and HIV viral load
    - Genotype/phenotype (if indicated)
    - An interferon gamma release assay (such as Quantiferon TB gold), or PPD if an interferon gamma release assay is not possible for financial or logistical reasons. If the test is positive, a chest x-ray is required.
        - If the x-ray is negative for active TB, latent therapy must be given.
        - If the patient misses the appointment for the assay, the appropriate follow-up activity should be performed and documented.
    - Hepatitis A, B, and C screening
    - CBC with platelets
    - Comprehensive metabolic panel
    - Complete lipid panel (cholesterol and triglycerides)
    - STD screening for syphilis, gonorrhea and Chlamydia

ANTI-RETROVIRAL THERAPY (ART): ART is now recommended for all patients living with HIV. Viral load (VL) and CD4 count should be measured regularly. See the table below for recommended testing intervals:

		Diagnosis	every 3 - 6mo	every 12mo
Any time	VL	X	X	
	CD4	X	X	
>2 years ART	VL		X	
	CD4		X	
>2 years ART VL suppressed CD4 300-500 (consistently)	VL			X
	CD4			X
>2 years ART VL suppressed CD4 >500 (consistently)	VL			X
	CD4			opt

**NOTE: Flexibility in scheduling may be allowed, depending on patient's health status*

- A screening of any barriers that may affect compliance or adherence to medications and treatment must be performed (e.g., lack of housing, mental illnesses, etc.) at intake as well as at follow-up visits.
- Once the appropriate treatment is decided by the medical provider and patient, that treatment or therapy should be initiated using the most recent guidelines found on the Department of Health and Human Services (DHHS) web site and at the following web site, http://aidsinfo.nih.gov.
- There must be documentation in the patient medical chart of discussions regarding medication(s) side effects, dosing schedule and related adherence issues by the time treatment is initiated.

MENTAL HEALTH AND SUBSTANCE ABUSE: Providers must screen all new clients using a standardized mental health screening tool.

- Referrals to mental health or substance abuse providers must be made promptly using a "warm hand-off."

PARTNER NOTIFICATION: Providers are required to offer support with partner notification (Partner Services) for any client who may not have already disclosed his/her status to any partners at risk, and should discuss sexual and drug-using risk for HIV transmission with all clients.

TREATMENT PLAN: Before the close of the intake visit, the medical provider and client must jointly discuss and agree on a Treatment Plan. The purpose of the Treatment Plan is to guide the provider in delivering high-quality care corresponding to the client's level of need, including the determination of emergency vs. non-emergency care, triage care, and referral as needed. With "patient-centered" treatment planning, the doctor's plan will be listed with notes as to which treatments will be delivered (per client's consent), and how referrals will be made and tracked. The Treatment Plan must include the method(s) of communication between all providers and the client. The Treatment Plan must be signed by both the medical provider and the client before the visit ends.

PROBLEM LIST: In addition to the Treatment Plan, the provider is responsible for discussing and developing a Problem List. This list is separate from progress notes, and clearly prioritizes problems for primary care management. All problems should be listed and dated. The Problem List must also identify:

- History and activity of mental health and substance-abuse disorders, and the integration of treatment for these conditions with the HIV primary medical care;
- The provider of other continuing health care (e.g., mental-health or substance-abuse service provider, or other continuing specialty service) and its location, if different from the outpatient ambulatory health services site; and
- The provider of case-management services, if different from the outpatient ambulatory health services site.

A list of medical diagnoses should be updated in the client's chart as a summary of the client's past medical history.

CHARTING: At the close of the intake visit, the client's chart must contain a complete and signed Treatment Plan, Problem List, and list of medications (if applicable).

FOLLOW UP VISITS

Follow up visits are recommended every three to four months for patients on a stable antiviral regimen; for some patients doing well for long periods of time with long-standing undetectable viral load, the follow up can occur every six months. All patients should have at least 2 visits per year.

STATUS AND UPDATES: Follow up visits should always record and address: (1) temperature, vital signs, and weight, (2) Problem List status and updates, (3) any changing need for support around partner notification (Partner Services).

TREATMENT PLAN ADHERENCE AND UPDATE: Adherence with the Treatment Plan should be assessed and reinforced at each visit, with changes made to the Treatment Plan as needed; these should be determined by the provider and client together. Any changes to the Treatment Plan must be signed by both provider and client.

RESISTANCE TESTING: Resistance testing should be performed (if practical) for all clients. If not performed on all clients, resistance testing should be performed when viral failure to HAART has been demonstrated and/or when viral load suppression is not as expected after initiation of therapy. The most recent DHHS guidelines must be followed when changing therapy.

PROPHYLAXIS: Prophylaxis for opportunistic infections should be offered to each client at the appropriate CD4 count. Refer to guidelines for prophylaxis for opportunistic infections (Bartlett and Gallant 2005-2006:39-47) and the aidsinfo.hiv.gov web site. Documentation of current therapies should be maintained on all patients receiving prophylaxis.

- When the CD4 count drops below 50, the patient should have an ophthalmic examination by a trained retinal specialist at least every six months.

LABORATORY TESTING: At least once per year, all clients should receive the following updated labs:

- TB: An interferon gamma release assay
- STDs: Syphilis serology, and screening for gonorrhea or Chlamydia for persons who may have been at risk for any of those infections
- Hepatitis C
- Women should have a pap smear documented
    - Smears showing severe inflammation or reactive changes should be reevaluated within three to six months
    - Diagnosis of squamous intraepithelial lesions (SIL) or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract
    - Inquire about LMP and contraception, when appropriate

EDUCATION: At least once per year, all clients should receive primary health care education, provided in a language and at a literacy level appropriate to the client. Primary health care education must be documented in the client chart, and include the following components:

- Prognosis/progression of HIV
- How HIV is transmitted, and what client behaviors put others at risk for transmission of HIV (Prevention for Positives)
- How to interpret lab results
- Indications for treatment, goals for treatment, general information regarding side effects of treatment, treatment options, insurance/payment options, and availability of medication adherence support programs
- Smoking cessation, and the interactions between smoking and HIV
- Partner Services options (status disclosure assistance)
- Nutrition information
- Oral health information
- Vision screening resources
- Available clinical trials
- Substance abuse resources
- Support groups and other psychosocial support services available

ADVANCE PLANNING: Advance directives, durable powers of attorney, living wills and other planning documents, including "DNR" (do not resuscitate) status and permanency planning for dependent children should be addressed at the beginning of ARV treatment and at any appropriate time throughout the course of follow-up visits.

REPORTABLE ILLNESSES: Any and all reportable illnesses identified during follow-up visits must be reported to the local health department and included in chart documentation.

SERVICE CHARACTERISTICS

An on-call clinician who provides medical advice must be available to clients by phone 24 hours/day, 7 days/week, 365 days/year.

Initial clinic visits must be available to new patients within one month of scheduling.

Urgent clinic visits must be available to new patients within 3 days of scheduling.

In cases of emergency, patients must be assisted in determining whether their symptoms indicate the need for emergency care, and informed of how to access 24-hour emergency care.

Primary health care site staff must maintain referral relationships with key points of entry within and outside of the HIV system to ensure newly diagnosed clients who are not currently in care are rapidly referred. Key points of entry include but are not limited to:

- Emergency rooms
- Inpatient hospital settings
- Counseling and testing sites

- Substance use treatment programs
- Homeless shelters and Single Resident Occupancy (SRO) hotels
- Community-based case management providers, etc.

Primary health care activities should be provided as part of a care team, including a medical case manager and other providers as appropriate. Case conferencing with this care team to discuss client progress with the Treatment Plan and other health indicators is required at least once per month.

Providers must have a documented plan to follow up with clients who miss initial appointments.

Providers must have a documented plan to follow up and re-link out of care clients to primary care services.

Providers must use standard "new client" information packets that include:

- Patient Rights and Responsibilities
- Grievance procedures
- Availability of mediation services
- ADAP
- Risk reduction information
- Other county-specific information as appropriate

RECOMMENDED BEST PRACTICES

PREFERRED PROVIDER QUALIFICATIONS, WHENEVER POSSIBLE

To provide services in this service category, providers should:

Provide direct, continuous, ongoing care for at least 20 patients living with HIV over the past 2 years, or be supervised on-site by an experienced clinician who meets this criterion.

Complete at least 30 hours of HIV-related CME Category 1 credits over the past two years (including opportunities provided by the AETC), and

Successfully complete the American Academy of HIV Medicine (AAHIVM) Credentialing Examination.

Clinical support staff, if not HIV-certified, must receive in-service and/or continuing education appropriate for their position, on topics related to HIV care.

Substance Abuse
OUTPATIENT SERVICES

INTRODUCTION

This document describes the "Substance Abuse Outpatient Services" category of core medical services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Substance Abuse Outpatient Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Substance Abuse Outpatient Services are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting. They may be provided by a physician or under the supervision of a physician, or by other qualified personnel.

Substance abuse services may involve a variety of mental, emotional, spiritual, and practical skills to deal with addictions and ongoing recovery, as well as clinical treatments and interventions that address the physical causes and symptoms of addiction.

PURPOSE/GOALS

To assist HIV-positive clients and their significant others, including family and friends, in coping with the physical and psychological manifestations of addiction to alcohol, tobacco, and other drugs, and to assist clients in abstaining from substance use or reducing use through harm reduction strategies.

Provision of these services will minimize crisis situations and stabilize client substance use in order to maintain their participation in primary care and support services.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

PROVIDER QUALIFICATIONS

To provide services in this service category, providers must:

Maintain a current and valid licensure where appropriate

- **PSYCHIATRIST**: MD state licensure
- **PSYCHOLOGIST**: PhD or PsyD state licensure
- **PSYCHIATRIC NURSE**: California state licensure
- **CLINICIAN**: MFT, LCSW
- **REGISTERED CLINICAL OR STUDENT INTERNS**: Appropriate supervision
- **CERTIFIED CALIFORNIA ALCOHOL AND DRUG ABUSE COUNSELOR (CADAC)**

Providers must demonstrate a sensitivity to treatment options

- Abstinence vs. harm reduction
- Residential vs. outpatient

Providers must demonstrate a sensitivity to LGBTQ/homelessness issues/stigma and HIV issues/stigma

Providers must understand cultural identity, particularly as it relates to substance use

SERVICE COMPONENTS

Outpatient Substance Abuse Services must include the following four components:

SCREENING/ASSESSMENT: At the initial visit, the provider should do the following:

- Clients must be screened for Medi-Cal or other payment sources
- Complete a comprehensive substance abuse assessment:
  - Current and past substance abuse
  - Current medications and side affects
  - Impact and client's understanding of significance
  - Must include an Addiction Severity Index, Substance Abuse Mental Illness Symptom Screener (SAMISS), Addiction Severity Assessment Medical (ASAM), Drug Dependence Screen (DDS), simple screening instrument or other acceptable assessment tool
  - Comprehensive Substance Use Biophysical Assessment
- Client must be seen by an MD for a comprehensive medical exam within 30 day of intake (medical treatment programs only)

TREATMENT PLAN DEVELOPMENT AND IMPLEMENTATION: the provider will develop a treatment plan based on the comprehensive assessment within 30 days.

- Treatment plan should be created with input from clients
- Treatment plan should be updated every 90 days
- A variety of culturally and linguistically sensitive (CLAS) and evidence-based treatments must be made available

SUPPORT, REFERRAL, AND COORDINATION OF SERVICES: Services are part of the coordinated continuum of care. Staff provides immediate support and referrals for urgent, crisis, and emergency situations, including violent or suicidal behavior.

- Substance abuse staff should provide appropriate referrals when clients have acute substance abuse needs that fall outside of the scope of the funded services or competency of the clinician
- Clients should be referred to support groups, when appropriate
- Clients not currently accessing medical care must be referred to a primary care provider

REASSESSMENT: Face-to-face reassessments will be performed as clients complete their goals, or as needs change and additional resources and providers are indicated.

DISCHARGE/CASE CLOSURE: A file should be closed when there has been a request for closure or when there has been no client contact for over 6 months.

RECOMMENDED BEST PRACTICES

GENERAL SERVICES CHARACTERISTICS, WHENEVER POSSIBLE

HOUSING: Clients in need of housing should be referred to Substance Abuse Outpatient Services first.

ENGAGEMENT AND RETENTION: Agencies are strongly encouraged to develop and maintain a strong and consistent method for engaging and retaining clients during outreach and testing activities, as those clients most likely to benefit from Substance Abuse Outpatient Services are also those who are most difficult to retain in ongoing services, linkage, and follow-up.

Child Care
SERVICES

INTRODUCTION

This document describes the "Child Care Services" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and is a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Child Care Services.

Child Care Services is a funded category in Alameda County only, not in Contra Costa County.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it provides detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Child Care Services are defined as providing care for the children of clients who are living with HIV, while the clients attend medical or other HIV-related appointments, or RWHAP-related meetings, groups, or trainings.

The Child Care Services category does not include child care while a client is at work.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

LICENSING: To provide services in this service category, providers must be a licensed child care provider in the State of California. Services must be delivered according to California State and local child-care licensing requirements, which can be found here: http://www.ccld.ca.gov/pg411.htm.

LOCATION AND PURPOSE: Child care services can be provided either in a traditional day care facility or on-site, to support the participation of eligible clients in HIV-related medical or supportive services.

CONFIDENTIALITY: Though confidentiality is always an important part of RWHAP service provision, it is especially important in delivering child care services, for both programs coordinating child care services and providers of the services. Child care staff must be aware that while they may know a client's HIV diagnosis, other members of the client's family may not, and this information cannot be disclosed or implied in any way.

TRAINING: All child care services must be delivered in a culturally and developmentally appropriate manner, with documentation available to demonstrate staff training in cultural competence, HIPAA, and confidentiality before the start of any service provision.

LANGUAGE: Whenever possible, child care services should be delivered in the language most familiar to the child. If this is not possible, translation services must be available in cases of emergency.

RECOMMENDED BEST PRACTICES

Staff who provide child care services should have the following training whenever possible:

- First aid/cardiopulmonary resuscitation (CPR);
- Fire and electrical safety;
- Cultural awareness and diversity;
- Child development;
- Approved infectious waste disposal procedures;
- Hazardous waste disposal;
- Universal precautions for infection control;
- Child abuse;
- Domestic violence;
- Information on the specific needs of children in families impacted by HIV; and
- Other topics essential to quality child care provision.

Providers should advertise their services to clients.

Providers should inform clients of the details of the service, including:

- How far in advance the service must be scheduled;
- If the service is for respite care;
- If the service is only available to clients while they receive RWHAP core/support services, or can be arranged through other means after RWHAP eligibility has ended;
- Whether the service is provided in-home or at the service site.

Emergency Financial
ASSISTANCE

INTRODUCTION

This document describes the "Emergency Financial Assistance" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Emergency Financial Assistance.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Emergency Financial Assistance consists of providing limited one-time or short-term payments to agencies or establishing voucher programs to assist with an emergency need for paying for essential utilities, housing, food (includes groceries and food vouchers), transportation, and medication when other resources are not available.

GOAL: The goal of Emergency Financial Assistance is to move the client toward self-sufficiency.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

USES: Emergency Financial Assistance may be used for the following expenses, only when 1) other sources of funding cannot be found, and 2) the financial need is critical (i.e. housing or utilities are in danger of being lost as a result of non-payment):

- Housing, including:
  - Rental deposits
  - Motels and hotels, especially when needed for medical reasons
- Utilities as needed to maintain housing, including:
  - PG&E or other gas/electric provider
  - EBMUD or other water and sewer provider
  - Garbage collection
- Food, in the form of food bank access or grocery vouchers
  - When provided, vouchers must be approved prior to distribution by case managers
- Dental care
- Transportation

PROCESS AND DOCUMENTATION: A special needs request must be completed prior to providing emergency financial assistance, with justification of need. Documentation required may include:

- Letter from agency or landlord
- Lease
- W9

CONSENT: Clients must sign a consent form. Form may be unique to this service, or may be incorporated into other consent forms.

RESTRICTIONS: Providers may not make cash payments to clients; payments must be made directly to a landlord or utility agency.

RESPONSE: Providers must have the ability to respond to requests for Emergency Financial Assistance within 3 – 5 days.

DURATION: Emergency Financial Assistance payments are only for a single or limited number of payments. Long term assistance should not be funded through this category.

OTHER: Providers must have written policies to standardize the distribution of benefits.

RECOMMENDED BEST PRACTICES

Agencies are encouraged to provide training in budgeting/money management. Clients may be required to complete a budgeting plan describing their financial plans before receiving funds.

Food Bank/
HOME DELIVERED MEALS

INTRODUCTION

This document describes the "Food Bank / Home Delivered Meals" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Food Bank / Home Delivered Meals.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it provides detail about Requirements and Recommended Best Practices standards for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Food Bank / Home Delivered Meals provides actual food or meals to people living with HIV. It does not include providing cash or other ways to purchase food or meals. Providing essential household supplies such as personal hygiene items, household-cleaning supplies, and water filtration/purification devices is also included within this category, when budgets allow and/or items are donated.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

GENERAL REQUIREMENTS

STAFF TRAINING: Food Service Providers must be staffed with individual(s) trained in safe food handling practices.

PRIORITY CLIENTS: Providers must ensure that clients with the greatest need are able to access food services and congregate meals.

RESOURCES AND REFERRALS: Providers must have a list of alternate food service resources and referrals available for clients.

QUALITY: Providers must provide healthy and balanced meals according to US Dietary Guidelines.

INTAKE AND ELIGIBILITY

REFERRAL: Clients must be referred to Food Bank / Home Delivered Meals services by their medical case manager or primary care provider.

PAYER OF LAST RESORT: Food must be provided using Medi-Cal waivers or other payers when possible, utilizing RWHAP resources only as a payer of last resort.

INTAKE: Upon referral, clients must first complete an intake and assessment before receiving food through a food bank or home delivery. During intake, the provider must:

- Complete all of the agency's intake forms and processes per internal protocol; and
- Determine eligibility for services. To be eligible, the client must meet at least one of the following requirements:
  - Bed bound
  - Unlikely able to stand for more than 15 minutes at a time
  - Unlikely able to walk more than 50 feet at a time
  - Unlikely able to carry a weight of more than 15 lbs.
  - Likely to need physical or other assistance in leaving home
  - Requires 24 hr/day oxygen to treat lung or heart disease
  - Requires someone to help patient prepare/cook food
  - Leaving home may create safety risk or hardship

For Home Delivered Meals, the assessment must include the assessment must include examination of the following:

- Medical considerations (HIV status/prognosis and other conditions)
- Food allergies
- Medicine and food interactions
- Dietary restrictions
- Food preferences
- Nutritional supplements
- Food preparation ability, including whether the client possesses:
  - Microwave;
  - Stove;
  - Refrigerator;
  - Utensils;

- Working utilities; and
- Cooking skills.

After assessment for Home Delivered Meals, an individualized meal plan must be developed by the intake staff, and reviewed by a registered dietician (if the person performing the intake is not a registered dietician).

- Whenever necessary, meal plans must include:
  - Options for soft and/or liquid foods with extra portions;
  - Special diets for diagnostic testing;
  - Extra fluid needs to avoid dehydration and diarrhea; and
  - Supplements for wasting syndrome, if applicable.
- This plan must be signed by both the client and the provider, and maintained in the client file.
- Meal plans must be shared and coordinated with the client's medical case manager and/or primary medical care provider.

CONTINUING SERVICES

All services within this service category must be delivered confidentially; those who prepare, deliver, serve, and distribute food must all be trained in how to protect confidentiality, especially when services are provided to clients in their home.

Clients' individualized meal plans must be re-evaluated at least every 6 months, or more often depending on the health status of the client.

The provider is responsible for ensuring that clients receive all deliveries/pickups of meals or groceries as long as they are receiving the service.

When applicable, the delivery staff is responsible for reporting to the agency any changes in service delivery plans (e.g. if they are unable to deliver three consecutive meals).

If any change in the service plan is indicated, the provider must follow up with the client and/or referring agency to determine next steps regarding the changes.

FOOD BANKS

Food banks distribute safe and nutritious food, groceries, and nutritional supplements, including liquid supplements.

Food must be distributed to clients in pre-packaged boxes according to their written meal plans, developed under the supervision of a licensed nutritionist / registered dietician.

Clients with meal plans can pick food up at the food bank or distribution site two times per month, or arrange for home delivery (see Home Delivered Meals).

FOOD PANTRY SERVICES

Unlike the food bank, where food must be provided in pre-packaged boxes according to a client's official meal plan, with a food pantry clients can choose items up to once per week, from staple foods (proteins, beans, bread, milk, eggs, coffee, and other non-perishable items/canned goods) and variety items (cheese, juices, etc.). When clients are accessing a food pantry, they may be allowed to swap items based on preference.

HOME DELIVERED MEALS

If it is determined to be necessary during intake/assessment procedures, home delivery of food may be provided.

Home-delivered food must be distributed to clients in pre-packaged boxes and meet the needs of the written meal plans, developed under the supervision of a licensed nutritionist / registered dietician.

Food home delivery must be consistent, reliable, and offered on a flexible schedule in order to meet the needs of the client (i.e. various times and days for delivery).

- Delivery at a consistent day and time by the same driver builds a relationship between the client and the driver, helps ensure successful delivery, and improves the sense of respect and community belonging for the client.

If it is medically necessary, up to one meal per day may be delivered hot. In other cases, meals are delivered frozen (up to 7 days of food at a time) or as groceries for client preparation (delivered twice per month).

Food that is delivered to clients' homes must include instructions about how to reheat/cook the food and maintain food safety.

RECOMMENDED BEST PRACTICES

GENERAL SERVICES CHARACTERISTICS, TO BE OFFERED WHENEVER POSSIBLE

Providers should be accessible by public transportation or medical van.

Agencies providing Food Bank / Home Delivered Meals services within the TGA should work together when possible, in order to provide consistent quality and quantity of food offerings for clients.

Variety and options should be offered when possible, including culturally competent food offerings, to be accessed at the client's choice.

Agencies providing food through this service category should implement and routinely utilize a system for client feedback, enabling continuous quality improvement of the service.

Food provisions should include recipes and special items needed for food preparation, such as spices/seasonings/herbs – with a goal to offer "everything you need" boxes that are self-contained and easy to turn into complete meals.

At the time food is furnished/delivered, agencies are encouraged to also supply a reference page that provides information about where clients can obtain other foods at low to no cost, when they find that the food provided in the box is insufficient for their needs.

An extra, optional offering along with the provision of food is nutritionist-organized cooking demos, particularly

highlighting new foods, and cooking with limited kitchens (in SROs, with microwaves, etc.). These types of activities not only improve clients' ability to prepare fresh, nutritious meals, but build community and a sense of self-efficacy as well.

Another way to demonstrate respect for clients and build community is to provide special touches for holidays or birthdays, such as having volunteers make holiday cards and birthday cards. Birthday cakes made from scratch and delivered on birthdays can be incredibly meaningful to clients who may otherwise feel isolated or abandoned by friends and family at that time of year.

CONGREGATE MEALS

In addition to providing food directly to individual clients, another option is to prepare food and offer it to clients in a congregate meal setting. In these cases, it is still critical that food is healthy, with a menu reviewed by a nutritionist or registered dietician. Food served must be balanced (i.e. must include proteins, fruits/vegetables, starches, vegetarian options / low-salt options) and interesting (e.g. include a reasonably healthy dessert!)

Congregate meals should be served on set times and days to promote consistency and expand access by allowing information about the service to spread via word of mouth.

Congregate meals should always be offered in safe spaces with priority placed on developing community and respecting all people attending the meal. This provides connection with peers and the surrounding community for clients, which is one of the main benefits of congregate meal provision.

Meals must always be prepared with excellent kitchen sanitation and meet food preparation safety standards. Supplies for kitchen sanitation can be paid for under this service category if other options for funding or donation are not available.

Congregate meals should cultivate a sense of warmth, respect, and community, and promote health and self-efficacy to eat nutritious food. This can be done through:

- Offering seconds whenever possible, rather than restricting food intake.
- Making the space feel like home. Some options include setting up tables with centerpieces, having volunteers bring service to the table and serve clients, etc. This promotes intimacy and respect for clients.
- Taking every opportunity to refer clients to the Food Bank program and/or link them with a case manager or other service provider as appropriate. Often food service is an entry point to clients who are not already engaged in services.
- Offering client engagement activities, including inviting speakers (i.e. about housing, employment, or other topics) to congregate mealtimes.
- Asking for feedback: How was the food? What would you like us to serve next time, if we can? Then following through to make improvements next time when possible.

Health Education/
RISK REDUCTION

INTRODUCTION

This document describes the "Health Education / Risk Reduction" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Health Education / Risk Reduction.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it provides detail about Requirements and Recommended Best Practices standards for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Health Education / Risk Reduction provides services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes providing information, including information about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

CLIENT IDENTIFICATION: Health Education / Risk Reduction services may not be delivered anonymously.

CONTENT: Important topics for Health Education / Risk Reduction may include:

- Education on ways to reduce transmission, such as pre-exposure prophylaxis (PrEP) for clients' partners, and treatment as prevention;
- Coaching and support around disclosing HIV status, and linkage to Partner Services (self-disclosure, dual-disclosure, and third party notification options) as needed;
- Education on healthcare coverage options (e.g. qualified health plans through Covered California, Medi-Cal, Medicare coverage);
- Health literacy (assessing client knowledge and knowledge gaps, beliefs about various topics related to HIV health education and risk reduction, etc.);
- Treatment adherence education; and
- Information about HIV medical and psychosocial resources and other methods of support in the Oakland TGA.

TYPE OF SESSIONS: Health Education / Risk Reduction can be offered as individual or group sessions, but must be client-centered and non-judgmental at all times.

NUMBER OF SESSIONS: Group activities in this category are ongoing, but time-limited (8-12 sessions). They may also be offered as single-session groups (one time only) when appropriate.

MATERIALS: All materials used as part of Health Education / Risk Reduction training must go through the local materials review board for approval before use.

RECOMMENDED BEST PRACTICES

APPROACH: Health Education / Risk Reduction is best offered as part of a team approach, in coordination with a medical case manager and/or other relevant service providers. Clients should be linked with hepatitis C and STD screening and treatment, which improves the health of the client and also reduces the potential for HIV transmission to others.

SPECIAL GROUPS: Often Health Education / Risk Reduction groups are best organized around member similarities, including:

- Gender;
- Culture;
- Language;
- Recency of HIV diagnosis;
- Region/neighborhood; or
- Age.

PROVIDING OTHER INFORMATION: Health Education / Risk Reduction activities can also include information about wellness (i.e. stopping smoking, diabetes management) and common co-infections (i.e. hepatitis C), as it relates to HIV health and risk reduction.

HARM REDUCTION: Whenever possible, Health Education / Risk Reduction activities should be based on principles of harm reduction.

Medical
TRANSPORTATION

INTRODUCTION

This document describes the "Medical Transportation" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Medical Transportation.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Preferred Service standards particular to this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

SERVICE DEFINITION

Medical Transportation includes transportation services provided, directly or through voucher, to a client iving with HIV so that he or she may access services to improve their health status.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

USE OF SERVICES: Medical Transportation services are prioritized for use to help clients attend medical appointments and other core medical services. However, they may also be used for support services if funding is available.

REQUIREMENTS: Service providers offering Medical Transportation must ensure that it is:

- Reliable;
- Provided by professional, trained drivers with a good driving record and proper driver's license;
- Provided in a safe vehicle, with seat belts and all current safety features; and
- Available with an ADA-compliant option for disabled clients.

Case Managers and other providers must be kept informed of any changes to transportation availability.

Specific routes should be planned that provide access to key sites such as primary care providers, congregate meal sites, and food banks.

EXCLUSIONS: Medical Transportation services may not include:

- Payments for parking or tolls; or
- Cash payments to clients, under any circumstances.

ELIGIBLE TRANSPORTATION: Medical Transportation services may include the following types of transportation:

- Van service, available on-demand or scheduled (pre-booked services require 24-hours' notice); or
- Transportation vouchers, for:
  - Paratransit;
  - Taxi;
  - AC Transit / County Connection;
  - BART; or
- Gas cards, when there is concrete evidence that the client is using his/her own vehicle.

PERSONNEL: In either employee/volunteer records or in agency policies, as appropriate, providers must document the following staffing procedures:

- A copy of each driver's current driver's license;
- Evidence of current automobile insurance coverage;
- A copy of each driver's DMV driving record;
  - No more than 2 years old
  - No more than four points over the past three years
- Service records showing the vehicle is well-serviced and has passed any required safety inspections for vehicles that carry commercial passengers;
- Evidence that all drivers receive training and are knowledgeable regarding HIV;
- Evidence that all drivers have successfully completed a defensive driver's course; and
- Evidence that all drivers have completed CPR and/or first aid courses.

VOUCHER POLICIES: Organizations providing vouchers for external transportation services must have documented policies addressing the following:

- Procedures and a secure location for storage of vouchers;
- Training for staff authorized to issue vouchers, including full knowledge of agency security procedures; and
- Written procedures and staff training regarding the documentation needed when issuing vouchers.

Other Professional
SERVICES

INTRODUCTION

This document describes the "Other Professional Services" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Other Professional Services, including Legal Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it provides detail about Requirements and standards for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

SERVICE DEFINITION

'Other Professional Services' include professional and consultant services provided by members of certain professions who are licensed and/or qualified to offer such services by local governing authorities.

Such services may include and are not limited to legal services, permanency planning, and income tax preparation services. The goal of these services is to stabilize a client's life to enable access to medical care and improved quality of health and life.

Specifically, legal services may include powers of attorney, do-not-resuscitate orders, advance healthcare directives, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality legislation as it relates to services eligible for funding under the RWHAP.

REQUIREMENTS

All service providers receiving funds to provide Legal Services under this RWHAP service category are absolutely required to adhere to the following standards:

EXCLUDED SERVICES: The following services may not be funded under this category:

- **Torts**, such as when the client wishes to sue someone because he/she has suffered an injury;
- **Criminal cases**, when the issue is not related to HIV. In these cases, the agency should refer the client to the public defender and/or a private attorney;
- **Complex litigation**, that is, expensive and time-consuming legal issues. In these situations, the agency should refer the client to a private attorney;
- **Fee-generating cases**. In these situations, the agency should refer the client to the private bar association; and
- **Civil cases unrelated to HIV status** (e.g., divorces, will disputes, etc.).

REFERRALS: When clients need services that cannot be provided under the RWHAP, providers must refer them to other departments, agencies or legal services.

PROVIDER QUALIFICATIONS: HIV legal assistance staff and attorneys will have the skills and ability to specialize in the areas of most critical need to people living with HIV.

- Staff attorneys, licensed by the State of California and members in good standing with the State Bar of California, will coordinate, supervise and/or provide all services.
- Licensed volunteer attorneys, law students, law school graduates and other legal professionals (all under the supervision of a qualified staff attorney) may be used to expand program capacity.
- All legal assistance staff and volunteers on site will complete an agency-based orientation before providing services.

PROVIDER RESPONSIBILITIES: Legal representatives will provide advice, representation, and advocacy necessary to accomplish the client's goals. They must also:

- Inform the client at intake that it is his/her responsibility to keep the legal staff informed of any changes relevant to their legal issue(s), including adverse party, housing, telephone number, hospitalization, and health condition.
- Represent, advocate, and negotiate on the client's behalf, using letters, phone calls, court visits, and agency visits.
- Document all contacts made on the client's behalf (electronically on a computer or using handwritten notes in the client's file).
- Copy and keep in the client's file each written communication sent on the client's behalf (via letter, fax, or other means).
    - All client files shall be kept in locked storage at all times not in the direct possession of the legal representative.
    - All clients shall be given the opportunity to take their personal papers and health records with them at the time of case completion.

MONITORING CASES: Legal cases must be monitored in the following manner:

- The supervising attorney will monitor the progress of client cases.
- The supervising attorney will monitor the work of all non-professional staff members with the assistance of other staff attorneys.

- The supervising attorney will document acceptance of new cases and approve the planned course of action after discussion with the client's non-professional representative.

OTHER STANDARDS: Agencies must have written standards and plans for providing services:

- Caseloads must be reasonable and cases must be accepted on a priority basis.
- If a waiting list exists, the agency must have a written plan to communicate regularly with those clients on the list about wait-list status.
- The agency must have written criteria for services, including:
    - Fee structure
    - Intake process
    - Discharge, transfer and closing procedures
- Clients must be informed of these criteria before receiving services, and documentation must be included in the client's chart.

Psychosocial Support
SERVICES

INTRODUCTION

This document describes the "Psychosocial Support Services" category of support services under the Ryan White HIV/AIDS Program (RWHAP), and serves as a supplement to the "Universal Standards of Care" document also released by the Oakland TGA. It highlights each of the requirements and standards that apply to this category, and must be followed by any program receiving funding from the RWHAP for Psychosocial Support Services.

HOW THIS DOCUMENT IS ORGANIZED

This document is not intended as a stand-alone document; rather, it serves to provide detail about Requirements and Recommended Best Practices for this service category. It is the responsibility of all service providers to also be familiar with the Universal Standards of Care document, which applies to every RWHAP service category.

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Recommended Best Practices.

SERVICE DEFINITION

Psychosocial Support Services include support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It also includes nutrition counseling provided by a non-registered dietitian, but it excludes the provision of nutritional supplements.

REQUIREMENTS

All service providers receiving funds to provide service under this RWHAP service category are absolutely required to adhere to the following standards:

QUALIFICATIONS: To provide services in this service category, providers must have the minimum qualifications required by their job descriptions, and possess the knowledge, skills and experience necessary to competently perform expected services.

ALLOWED SERVICES: Services provided using Psychosocial Support Services funding may include:

- **Individual and group counseling**, including drop-in sessions. These sessions should be:
  - Structured, with a plan or curriculum
  - Designed to move clients toward identified goals
- **Peer counseling or peer support groups** offered by people living with HIV or those with similar life experiences who are knowledgeable about HIV and are culturally sensitive to the special populations. These groups should be:
  - Purposeful, with agendas and a plan
  - Designed to move the group toward identified goals
- Nutritional counseling services for HIV-infected clients that include the provision of education, but do not include the distribution of nutritional supplements
- Caregiver groups: emotional support groups, pastoral care groups, and bereavement counseling groups, provided in a group setting
  - Clients must have a documented relationship to a person living with HIV

DURATION: Services are time-limited:

- Participation in caregiver support groups is limited to 12 sessions in a ten-month period per fiscal year
- Participation in pastoral care groups is limited to 8 sessions in a three-month period per fiscal year
- Participation in bereavement counseling groups is limited to 8 sessions in a three-month period per fiscal year

SUPPORT, REFERRAL, AND COORDINATION OF SERVICES: Services are part of the coordinated continuum of care. Staff provides immediate support and referrals for urgent, crisis, and emergency situations, including violent or suicidal behavior.

- Psychosocial support staff should provide appropriate referrals when clients have acute mental health needs that fall outside of the scope of the funded services or competency of the clinician
- Clients should be referred to other appropriate services, when needed
- Clients not currently accessing medical care will be referred to a primary care provider

OTHER: Providers must offer appropriate group sessions for target populations.

- Groups must be open to any person living with HIV

RECOMMENDED BEST PRACTICES

Service providers should actively recruit and train qualified people living with HIV for staff.