2018

Ryan White Part A Service Standards

BOSTON EMA

BOSTON PUBLIC HEALTH COMMISSION

STATEMENT OF PURPOSE

The purpose of every Ryan White Part A program in the Boston EMA is to provide accessible, barrier-free services to eligible consumers. These services are intended to promote positive health outcomes, self-sufficiency, and improve quality of life for People Living with HIV (PLWH). These services are also provided in response to the disproportionate impact of HIV on people who have the least amount of resources. The Boston Public Health Commission (BPHC), as the pass-through agent of Part A funding from the Health Resources Service Administration (HRSA), administers the funds in communities with high rates of HIV infection. Factors in these communities, including social determinants of health, can increase a person's risk of becoming infected with or affected by HIV. No single service is intended to meet or exceed a client's holistic needs; however, Part A services work in tandem to address the myriad of socioeconomic barriers and inequity that often result in poor health outcomes. Addressing these barriers and inequities is also intended to prevent the spread of HIV infection among vulnerable populations.

BPHC has a long-established position to invest in and contribute to efforts in the community that promote health equity. This vision is shared and practiced in the administration of the Part A grant in the Boston EMA. Positive health outcomes are a priority for every person who accesses a BPHC service. The disproportionate burden of HIV and other infectious diseases on vulnerable populations dictates that Part A services prioritize the care of those most affected by the epidemic and assist those to achieve HIV viral suppression.

The Ryan White Services Division (RWSD) is committed to ongoing needs assessments, feedback, collaboration and other mechanisms that explore emerging needs in the community. Information that reveals gaps in the service delivery system is crucial in driving the allocation of Part A funding.

The current service category portfolio in the Boston EMA includes funding for nine services. Core Medical Services include AIDS Drug Assistance, Medical Case Management, Medical Nutrition Therapy, and Oral Health Care. Support Services include Housing, Psychosocial Support, Food Bank, Substance Abuse Residential Services, and Medical Transportation. As the needs of consumers in the EMA are varied, these service categories reflect the diversity of need, as well as the diversity of the population served by Part A funds. Part A funds are intended to be administered as the payer of last resort; all recipients of Part A funds are expected to demonstrate that there are no other reasonable means to cover the cost of services billed to Part A.

The primary goal of this revision of the HIV/AIDS Standards of Care is to maintain the integrity and quality of all Part A services offered in the Boston EMA while clearly following the guidance of HRSA Policy Clarification Notices (PCN), the National Monitoring Standards, and the Ryan White Legislation. The expectation is that programs in the Boston EMA will adapt to meet HRSA's policy changes and updates to the National Monitoring Standards.

The following standards align with HRSA Policy 16-02 to meet the most current definition of service categories under Ryan White Part A. All allowable activities are to be categorized under the appropriate service category and monitored by the guidance of the Standards of Care.

Collaboration on this document includes subrecipients of Part A funding, consumers of HIV services, stakeholders, and members of the community at large. This document would not be complete without the crucial feedback and approval from the Boston EMA Ryan White Planning Council.

The intention is for the Standards of Care to be used to ensure uniform quality of all Part A services in the Boston EMA, regardless of the location where a person accesses services. If a standard is not met, subrecipients must implement a plan to meet the standard promptly.

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SECTION 1: UNIVERSAL SERVICE STANDARDS

The Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS services funded by Ryan White Part A. The Standards of Care establish the ***minimum standards*** intended to help subrecipients meet the needs of their clients. ***Subrecipients may exceed these standards.***

The objective of the Universal Service Standards is to help achieve the goals of each service type by ensuring that programs:

- Have policies and procedures in place to protect clients' rights and ensure quality of care;
- Provide clients with access to the highest quality services through experienced, trained, and when appropriate, licensed staff;
- Provide services that are culturally and linguistically appropriate;
- Meet federal and state requirements regarding safety, sanitation, access, public health, and infection control;
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review;
- Comprehensively inform clients of services, establish client eligibility, and collect and store client information through an established process;
- Effectively assess clients' needs and encourage informed and active client participation;
- Address client needs effectively through coordination of care with appropriate subrecipients and referrals to needed services;
- Are accessible to all PLWH in the designated 10 counties that constitute the Boston EMA.

1.0 ELIGIBILITY

The purpose of these measures is to ensure Ryan White funds are used only for individuals who qualify for the service. This applies to all Part A services, regardless of setting. The eligibility requirements are outlined by HRSA. Any subrecipient of Part A funding that is found to provide a service to a person who is not eligible for that service will be found non-compliant.

Subrecipients of Part A services in the Boston EMA are required to document the minimum eligibility, detailed below, for all clients who access a service and are reported to Part A. All subrecipients will receive annual compliance visits by the recipient.

#	STANDARD	MEASURE
1.1	Part A services are provided only to persons living with HIV.	• All eligible clients must present proof of HIV diagnosis. Acceptable forms should be on letterhead and signed by a medical professional who has the ability to diagnose HIV. A lab report indicating viral load and CD4 count is acceptable. • HIV status must be filed and verified by the recipient at time of monitoring visit.
1.2	Services will be provided to PLWH who earn < 500% Federal Poverty Level.	• Subrecipients will document clients' income and FPL at intake and every six months thereafter. Acceptable forms of income include benefits statements, pay stubs, income tax documents, or a document that states how a client meets their basic needs. • Income verification must be filed and verified by subrecipient at the time of a monitoring visit.
1.3	Subrecipients will comply with payor of last resort principal.	• Any billable service delivered by a subrecipient will be billed to clients' insurance. • Services performed by a credentialed employee in a facility with billing capabilities cannot be billed to Part A without justification. • Documentation of clients' current insurance status will be collected, filed, and updated every six months. • Proof of Insurance must be filed and verified by recipient at time of a monitoring visit.
1.4	Services will be provided to eligible persons who reside in the EMA.	• Subrecipients will collect documentation of clients' address at intake and every six months thereafter. Proof of address includes any document with a formal, current address. Examples include, but are not limited to: a lease, an energy bill, correspondence from insurance or other entity, a valid state issued ID, or other appropriate justification of where a client resides. • Proof of address must be filed and verified by the recipient at the time of a monitoring visit.

#	STANDARD	MEASURE
1.5	Eligible persons will receive client-centered services that are appropriate to their needs.	• Subrecipients will deliver client-centered services as determined appropriate by an intake and needs assessment. • Should a client need a service not offered by subrecipient, an appropriate referral will be made.

2.0 POLICY & PROCEDURES

The objectives of the standards for Policies and Procedures are to:

- Guarantee clients' confidentiality, ensure quality care, and provide a fair process to address clients' grievances;
- Ensure that services are available and accessible to all eligible clients;
- Inform clients of their rights and responsibilities as consumers of HIV/AIDS services.

Clients who access any Part A service must be provided with a ***Client Rights and Responsibilities*** document that includes, at a minimum: the subrecipient's confidentiality policy, the subrecipient's expectations of the client, the client's right to file a grievance, the client's right to receive no-cost interpreter services, and the reasons for which a client may be discharged from services, including a "due process" for involuntary discharge. "Due process" refers to an established, step-by-step process for notifying and warning a client about unacceptable or inappropriate behaviors or actions and allowing the client to respond before discharging them from services.

Clients are entitled to access their files with some exceptions. Agencies are not required to release psychotherapy notes, and if there is information in the file that could adversely affect the client (as determined by a clinician) the subrecipient may withhold that information but should make a summary available to the client. Agencies must provide clients with their policy for file access. The policy must address, at minimum: how the client should request a copy of the file (in writing or in person), the time frame for providing a copy of the file (cannot be longer than 30 days), and what information, if any, can be withheld.

Confidentiality assures protection of the release of information regarding HIV status, behavioral risk factors, or use of services. Each subrecipient will have a client confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will provide a Release of Information Form describing the circumstances under which clients' information can be released (name of subrecipient/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature). Clients shall be informed that permission for release of information can be rescinded at any time, either verbally or in writing. Releases must be dated and are considered no longer binding after one year. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization.

A ***Grievance Procedure*** ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each subrecipient will have a policy identifying the steps a client should follow to file a grievance and how the grievance will be handled. The final step of the grievance policy will include information on how the client may appeal the decision if the client's grievance is not settled to their satisfaction within the subrecipient agency.

#	STANDARD	MEASURE

2.1	Rights and Responsibilities	• Subrecipients must have a policy. At minimum, the policy must include:
		  ○ The right to access services
		  ○ The responsibility to respect staff and space
		  ○ The right to file a grievance
		  ○ The agency's right to refuse services, and under what circumstances
		• A signed document must be stored in clients' file and reviewed by recipient at time of a monitoring visit.
		• Subrecipients may use an existing policy that covers all services offered at their agency.

2.2	Confidentiality	• Subrecipients must have a policy to protect the release of sensitive client information, including HIV status. At minimum, the policy must include:
		  ○ A commitment to provide services in a confidential setting
		  ○ A commitment to confidential storing of client files
		  ○ Staff acknowledgment of confidentiality policy
		  ○ A commitment to document all approved releases of information
		• A signed document must be stored in clients' files and reviewed by recipient at the time of a monitoring visit.
		• Subrecipients may use an existing policy that covers all services offered at their agency.

2.3	Grievance Procedure	• Subrecipients must have a policy that includes, at minimum:
		  ○ How to file a grievance
		  ○ Who to direct grievance toward
		  ○ Timeline to resolve grievance
		  ○ Step-by-step process if grievance remains unresolved
		  ○ Client and staff signatures
		• A signed and dated policy must be stored in clients' files and reviewed by the recipient at the time of a monitoring visit.

2.4	Intake and Ongoing Assessment	• Subrecipients must define a process for determining eligibility and conducting an intake and ongoing needs assessment for clients enrolled in services. • Pertinent documents are stored in clients' file and updated, at minimum, every six months.

#	STANDARD	MEASURE
2.5	Transition and Discharge	• Subrecipients must have a policy for transition and discharge from the program. The policy must include process to terminate services if a client is in violation of rules. • Each client file must contain a signed copy of the policy.

3.0 PERSONNEL STANDARDS

The objectives of the Personnel Standards are to:

- Provide clients with access to the highest quality of care through qualified staff;
- Inform staff of their job responsibilities; and
- Support staff with training and supervision to enable them to perform their jobs well.

A subrecipient awarded Part A funding will submit to the recipient job descriptions and resumes for staff who are selected to be on the Part A budget. Subrecipients will define supervisory roles for their programs. Staff will receive a minimum amount of administrative and clinical supervision related to their job. Subrecipients are responsible to provide staff with supervision and training to develop the skills needed for effective job performance. At a minimum, all staff should be able to:

- Provide appropriate care to PLWH;
- Appropriately document the services delivered to clients; and
- Have relevant experience in the appropriate service/treatment modality.

Clinical staff must be licensed or registered as required for the services they provide. See the attached service-specific standards for additional competencies for some service categories.

Subrecipient staff will receive consistent administrative supervision (minimum of two hours per month). Administrative supervision addresses issues related to performance, policy, documentation, reimbursement, scheduling, training, quality enhancement activities, and the overall operation of the program and daily activities. In addition to administrative supervision, direct care staff will receive consistent clinical supervision (minimum of one hour per month). Clinical supervision addresses any issue directly related to client care and job-related stress (e.g., boundaries, crises, and burnout). Clinical supervision can occur in a group setting and must be provided by a third party who is not associated with the funded Ryan White program. The clinical supervisor may be employed by the subrecipient organization but must be impartial to the service(s) provided. Staff in need of clinical supervision must have two separate supervisors for clinical and administrative supervision.

Subrecipients that employ staff who deliver billable services must explore and utilize other sources of payment before accessing Part A funding. Subrecipients must comply with payor of last resort principals.

#	STANDARD	MEASURE
3.1	Proficiency and licensure	• Subrecipient staff must possesses qualifications congruent with the job description.

#	STANDARD	MEASURE
		• Job descriptions, resumes, and licensure must be filed and up-to-date.
3.2	Training and Onboarding	• Subrecipients must develop and execute a training plan that outlines expectations and requirements of Part A services.
3.3	Cultural Competency	• Subrecipients' physical space, recruitment practices, and onboarding and training policies must reflect an intention to provide accessible services in a manner most appropriate to the population served. • Subrecipients will provide documentation, in the form of a mission statement or other document, that reflects a commitment to provide appropriate services to the target demographic.
3.4	Supervision	• Subrecipients will define the supervision structure at their programs. • All staff will receive a minimum of two (2) hours of administrative supervision per month. • Direct care staff will receive one (1) hour of clinical supervision per month. Clinical supervision may happen in a group setting. • Supervisors will maintain quality assurance of client files. A supervisor's signature and date indicates a review. The supervision schedule will be made available upon request.

4.0 DOCUMENTATION AND DATA MANAGEMENT

The objectives of the Standards for Documentation and Data management are to:

- Establish minimum reporting requirements, both to the recipient and to HRSA, for all subrecipients of Part A funding;
- Establish minimum requirements for the storing and handling of client information, both electronic and paper;
- Ensure all subrecipients are aware of reporting obligations related to the specific service for which they are funded.

Any subrecipient that delivers HIV/AIDS services in the Boston EMA must meet their obligation to all mandatory reporting. These reporting requirements include documenting all interactions between clients and providers in progress notes, needs assessments, and the development of service plans for clients. Subrecipients are also responsible to complete regular data entry and outcomes measure reports.

Subrecipients will determine a client's eligibility for Part A services, and then conduct and document an intake and initial assessment. For applicable service categories, subrecipients will create an individual service plan for each client and update the assessment and service plan every six months.

Every subrecipient must establish a system for recording client utilizations in the form of progress notes. These notes must be stored in client files and will illustrate approved activities for the indicated service category.

Clients may access their files and the information stored in the file. For more information, see the Policies and Procedures section.

All subrecipients must protect client information by establishing a secure system to manage and store client information. All files should be protected by a lock or password, and access to the information should be limited to relevant staff who provide client services or supervise staff who provide services.

#	STANDARD	MEASURE
4.1	File Security	• Subrecipient must ensure that client records are locked, or password protected. Access to records is limited to relevant staff. • The recipient will observe the process for file security during monitoring visits.
4.2	Client Access to File	• Clients are granted access to their records upon request and in accordance with the policy developed by subrecipient.

#	STANDARD	MEASURE
		• The policy must be signed and dated by the client and stored in the client file.
4.3	Subrecipients must satisfy documentation requirements as expected by the recipient, HRSA, and the specific service category.	• Subrecipients must complete data entry and reporting requirements for the recipient and for HRSA on schedule and with complete and accurate data. • Subrecipient staff must verify that all obligations have been met through e2Boston.
4.4	Progress notes	• Subrecipients must record and store progress notes that detail all client encounters. Encounters must be congruent with approved activities for the service category. • Progress notes will be reviewed by the recipient at the time of a monitoring visit.
4.5	Chart Review	• Subrecipients must develop a protocol for regular chart review for compliance with Part A standards.
4.6	Archiving	• Subrecipients must archive client files for a minimum of seven (7) years, and the archiving policy must identify the location of the stored files. This may include using a vendor such as Iron Mountain.

5.0 SAFETY

The objectives of the Standards for Safety are to:

- Require each subrecipient to establish policies and procedures to protect the physical safety of staff and clients, both on-site and in the community;
- Establish a minimum requirement that eliminates harassment in the workplace;
- Define a process for staff to respond to emergencies that involve clients.

The care and safety of any client that receives Part A services must be prioritized, both when a client is at a subrecipient location, or when receiving services at their home or in the community. Additionally, any person employed by a subrecipient that delivers Part A services has an expectation of safety and support to manage any crisis that may occur during the workday.

#	STANDARD	MEASURE
5.1	Safety protocol for staff and clients	• Subrecipient must have a protocol that is signed by staff members and made available to recipient.
5.2	Policies against bullying, discrimination, and sexual harassment	• Subrecipient must have a policy with language that protects staff and clients, regardless of how they identify. • The policy must be available to the recipient upon request.
5.3	Policy for staff safety on community and home visits	• Subrecipient must have a policy that is signed by staff members. • The policy must be made available to the recipient upon request.
5.4	Protocol for incident reporting	• Subrecipient must have a protocol • Protocol must be made available to the recipient upon request.

SECTION 2: CORE SERVICES

AIDS DRUG ASSISTANCE PROGRAM

Policy Definition

The AIDS Drug Assistance Program (ADAP) is a state-administered program to provide FDA-approved medications to low-income PLWH with limited or no health care coverage. Funds may be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. Programs must assess and compare the aggregate cost of health insurance versus the full cost of medications and other appropriate HIV medical services to prove cost-effectiveness.

Goal

The goal of the ADAP service category is to ensure that all PLWH have access to and are able to adhere to HIV and other prescribed medical regimens.

Objective

The objective of this service category is to ease the financial burden of medical costs for PLWH by providing financial assistance for prescription medication.

1.0 Eligible and Unallowable ADAP activities:

#	STANDARD	MEASURE
1.1	Subrecipients must use a medication formulary that meets the minimum requirements from all approved classes of medications according to HHS treatment guidelines **Guidelines can be found at: https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0*	• Subrecipient must provide documentation that the ADAP program meets HRSA/HAB requirements.
1.2	Subrecipient must have policies and procedures for accessing and monitoring medications that are stored on site.	• Policy is on file and available upon request.
1.3	Subrecipients must have a policy that indicates Part A funds make up 5 - 10% of the state's total ADAP funding.	• Policy is on file and available upon request.
1.4	Subrecipients must have a process to secure the best price available for all products, including 340B pricing or better for medications.	• Subrecipient must report on the number of individuals served, the medications provided, and the cost at which they were covered.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Subrecipient must have a policy to determine eligibility, including proof of client's prescription drug coverage and proof of an attempt to receive medical coverage from other sources.	• Policy is on file and available upon request.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Subrecipients must obtain documentation of clients' ADAP eligibility at least every six months, including documentation of availability of other potential coverage options.	• Eligibility is documented in each client file.

HEALTH INSURANCE PREMIUM & COST-SHARING ASSISTANCE (HIPCA)

Policy Definition

Health Insurance Premium and Cost Sharing Assistance (HIPCA) provides financial assistance for eligible PLWH to maintain health insurance coverage, or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. This service provides financial assistance for the following:

- Health insurance premiums and pharmacy benefits that cover comprehensive HIV outpatient care and a full range of HAART;
- Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients;
- Cost sharing payments on behalf of the client.

Goal

The goal of this service category is to improve adherence to HIV medical care by reducing the financial barriers to comprehensive medical care for PLWH.

Objective

The objective of this service category is to provide cost-sharing services to eligible PLWH to reduce the financial burden associated with medical care and increase continuity of health insurance coverage and pharmacy benefits.

1.0 Eligible and Unallowable HIPCA activities:

#	STANDARD	MEASURE
1.1	Allowable costs include: • The purchase of health insurance that provides comprehensive primary care and pharmacy benefits, including a full range of HIV medications. • Assistance for co-payments and deductibles, including co-payments for prescription eyewear for conditions related to HIV infection. • Assistance for Medicare Part D true out-of-pocket (TrOOP) costs. • Standalone dental insurance premium assistance.	• Subrecipients may only use Part A funding for allowable activities. Subrecipients must demonstrate an attempt to access other funding sources before using Part A funding.

#	STANDARD	MEASURE
1.2	For health insurance premium assistance, the following documentation is required: • A health insurance plan that includes, at a minimum, at least one drug in each class of core ART medications from the Department of Health and Human Services (HHS) treatment guidelines. • A health insurance plan that covers comprehensive HIV outpatient ambulatory services. *Guidelines can be found at: https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf*	• Subrecipients must have a policy to evaluate suitability of health insurance plans for PLWH.
1.3	For health insurance premium assistance ***OR*** standalone dental insurance assistance, subrecipients must ensure that purchasing health insurance is more cost-effective than providing financial assistance for the full cost of medications or medical care.	• Subrecipients must demonstrate that they have completed a cost-benefit analysis.
1.4	Funds may not be used for liability risk pools, or Social Security.	• Subrecipient will not submit invoices to recipient for these services.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Subrecipient has policies ensuring that Ryan White funding is the payer of last resort for health insurance. Policy must include: • A statement that Part A resources are to be used to supplement, not replace, existing federal, state, or local funding for similar services; • Requirement that subrecipients conduct an annual cost-benefit analysis that demonstrates the cost of an insurance plan does not exceed the full cost of services to be covered by the insurance plan.	• Policy is on file and available upon request.
2.2	Subrecipients must have clear policies on the payment of premiums, co-pays, and deductibles.	• Policy is on file and available upon request.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Subrecipients must adhere to payor of last resort policy.	• Subrecipients must document efforts to pursue all health coverage options for which a client is eligible.
3.2	Documentation of the following: • Annual cost-benefit analysis; (See 3.3) • All insurance premiums covered by Part A contain comprehensive primary care and drug formulary with a full range of HIV medications; • Evidence that funds were not allocated to liability risk pools or Social Security; • Evidence of coordination with the Centers for Medicare & Medicaid Services (CMS), including entering into appropriate agreements to ensure that funds are appropriately included in TrOOP or donut-hole costs; • If funds are used to cover co-pays for prescription eyewear, subrecipients must document a physician's written statement that the eye condition is related to HIV infection.	• Documentation is stored and made available upon request.
3.3	The cost-benefit analysis should evaluate the client's financial need for this service and include the following: • Client income; • Review of all other potential payment resources; • Cost of co-pays; • Cost of deductibles; • Cost of recommended medications.	• Documentation is stored and made available upon request.

MEDICAL CASE MANAGEMENT

Policy Definition

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

In addition to providing the medically oriented services above, Medical Case Management may also connect clients to eligible benefits programs, including, but not limited to, health insurance and pharmacy benefits.

Medical Case Management services take place in or have a linkage with a medical setting where the client can receive medical care.

Goal

The goal of Medical Case Management is to engage clients who face significant challenges to successful HIV treatment.

Objective

The objective of Medical Case Management is to improve health outcomes for PLWH.

1.0 Eligible and Unallowable Medical Case Management Activities

#	STANDARD	MEASURE
1.1	Needs Assessment	• Subrecipient must complete an initial intake and ongoing needs assessments. Assessments must be stored in clients' files. • An ongoing assessment of clients' needs must include, at minimum, assessment of: ▪ Health care ▪ Mental health ▪ Transportation ▪ Sexual health & risk reduction ▪ Substance use ▪ Legal needs ▪ Support systems ▪ Nutrition ▪ Housing ▪ Insurance
1.2	Individual Service Plan (ISP)	• Subrecipient must develop an ISP with clients that are informed by the needs assessment.

#	STANDARD	MEASURE
		• Treatment plans must be updated every six months, at minimum. Treatment plans must be stored in clients' files.
1.3	Coordination of Care	• Subrecipients must link clients to appropriate care, as identified by the needs assessment. • Subrecipients must review clients' use of services and evaluate progress toward goals on the ISP. • Subrecipient must maintain progress notes that detail encounters with clients and client progress. • Subrecipient must document all referrals.
1.4	Treatment Adherence Services	• Subrecipient must screen clients for barriers to treatment adherence.
1.5	Coordination and follow-up of medical treatments	• Subrecipients must document clients' progress and any change in need. • Subrecipient must make necessary referrals and identify resources until clients' needs are met.
1.6	Client-specific advocacy and/or review of utilizations of services	• Subrecipient must review clients' use of services and evaluates progress toward goals. • Treatment goals are marked as complete or updated indicating changes.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Administrative and clinical supervision	• Subrecipient must have policy for administering supervision to staff. • Staff must receive one hour of administrative and one hour of clinical supervision (direct care staff) per month.
2.2	Caseload	• Subrecipient must have a procedure to determine caseload assignments, including managing and tracking caseloads. • Subrecipients must have a policy to manage a wait list for services if necessary.
2.3	Inactive/Discharge Policy	• Subrecipients must have a written procedure to determine when a client is inactive. This includes a discharge procedure.

#	STANDARD	MEASURE
2.4	Quality Management	• Subrecipients must routinely evaluate medical case management services, including client charts. • Subrecipients must participate in quality management activities, including data entry and chart reviews.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Initial assessment of service needs	• Initial assessment of clients' needs must be completed within 14 days of initial contact.
3.2	Development of a comprehensive Individual Service Plan (ISP). This includes: • Continuous monitoring to assess the efficacy of the plan or change in need; • Timely and coordinated access to health and support services and continuity of care; • Re-evaluation of the ISP with adaptations as necessary	• ISPs must be completed within 30 days of initial contact with a client. • Re-evaluation must be completed every six months, at minimum.
3.3	Service coordination. This may include: • A range of client-centered services that link clients with health care, psychosocial support, and other services; • Treatment adherence counseling to ensure readiness for and adherence HAART; • Client-specific advocacy and/or review of utilization of services.	• Subrecipient must document referrals and linkages to care. • Subrecipient must document progress notes, including description of encounter, duration, date, etc.
3.4	Transitioning Clients	• Subrecipients must accommodate a client who requests to transition services in no more than 10 days. • Subrecipients must document details of the transition in a client's file.

#	STANDARD	MEASURE
3.5	Discharging Clients	• Clients may be discharged from a Medical Case Management program for the following reasons: ▪ Client requests discharge; ▪ Client transfers out of care; ▪ Client is referred to another case manager; ▪ Client's needs have been met; ▪ Client violates program rules and regulations; or ▪ Case manager is unable to make contact with client for one (1) year. • Subrecipients must document the discharge in clients' files.
3.6	Re-engagement	• Subrecipients must have a procedure to re-engage clients who are discharged or inactive. If new contact is made, subrecipients must complete a full intake assessment.

MEDICAL NUTRITION THERAPY

Policy Definition

The Medical Nutrition Therapy service category includes the following services for PLWH:

- Nutrition assessment and screening;
- Dietary or nutritional evaluation;
- Food and/or nutritional supplements per a medical provider's recommendation;
- Nutrition education and/or counseling.

These services can be provided in individual or group settings, at community organizations or medical facilities.

Program Guidance: All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by a registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

Goal

The goal of this service category is to optimize immunity, reduce weight loss and nutritional deficiencies, and improve the overall wellbeing for PLWH.

Objective

The objective of this service category is to identify and treat nutritional deficiencies in PLWH through the provision of medical nutrition therapy. This includes nutritional counseling and the prescription of dietary regimens by a physician or licensed nutritionist or registered dietician.

1.0 Eligible and Unallowable Medical Nutrition Therapy Activities:

#	STANDARD	MEASURE
1.1	Eligible activities include: • Nutrition screening and assessment; • Dietary/nutritional evaluation; • Food and/or nutritional supplements per medical provider's recommendation; • Nutrition education and/or counseling.	• Subrecipients will only request funding for allowable services. Documentation of allowable activities will be stored in clients' files.
1.2	Activities must be initiated by a referral from a medical provider and based on a developed nutritional plan.	• All client files must include a referral from a medical provider and a nutritional plan.
1.3	Any service **not provided** by a licensed nutritionist or registered dietitian is unallowable and must be delivered under	• Client files will contain evidence of services provided by a licensed nutritionist or registered dietician only.

#	STANDARD	MEASURE
	the Psychosocial Support category. *(See HRSA PCN 16-02)*	

2.0 Staffing & Licensure

#	STANDARD	MEASURE
2.1	Staff are appropriately licensed and credentialed to provide approved services.	• Subrecipient must file copies of licenses and credentials in employee records.

3.0 Policy and Procedures

#	STANDARD	MEASURE
3.1	Nutritional plan must include, at minimum: • Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food; • The signature of the referring medical provider and registered dietician who render service, including the date of service; • Date of initiation and termination of medical nutrition therapy; • Date of reassessment; • Any recommendations for follow up; • Planned number and frequency of sessions.	• Subrecipient must file nutritional plan in each client record and make available to the recipient upon request. • Subrecipient must have a procedure to complete acceptable nutritional plans.

4.0 Subrecipients Practice Standards

#	STANDARD	MEASURE
4.1	Nutritional plan is drafted for each client and updated every six months.	• Subrecipient must maintain documentation in clients' records.

ORAL HEALTH

Policy Definition

The Oral Health category provides outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienist, and licensed dental assistants to eligible PLWH.

Goal

The goal of the Oral Health service category is to prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care for eligible PLWH.

Objective

The oral health category aims to increase awareness of the importance of oral health to overall health and well-being, increase the acceptance and adoption of effective preventive interventions, and reduce disparities in access to effective preventive and dental treatment services. *(Healthy People 2020)*

1.0 Eligible and Unallowable Oral Health Services

#	STANDARD	MEASURE
1.1	Administer current HIV/AIDS Treatment Guidelines.	• Subrecipient must follow updated HIV/AIDS Treatment Guidelines. • Guidelines must be on file.
1.2	Clinical decisions that are supported by the American Dental Association Dental Practice Parameters.	• Subrecipient will document delivery of approved ADA Dental Practice Parameters. • ADA Dental Practice Parameters will be on file.
1.3	Services rendered must fall within specified service caps, expressed by dollar amount, type of procedure, limitation on the number of procedures, or a combination of any of the above, as determined by the planning council or recipient.	• Subrecipient must have a policy to determine allowable services.

2.0 Staffing & Licensure

#	STANDARD	MEASURE
2.1	Participating dentists possess appropriate license, credentials, and expertise.	• Subrecipient must maintain subcontracted dentists' qualifications on files. This must contain a Board of Dentistry license number.

#	STANDARD	MEASURE
2.2	The subrecipient program director has training and experience in clinical aspects of oral hygiene, dental treatment planning, and dental care.	• Subrecipient must submit program director's qualifications to recipient upon request.

3.0 Policy and Procedures

#	STANDARD	MEASURE
3.1	Subrecipient has written policy regarding management of waitlist for services.	• Subrecipient must submit policy to recipient upon request.
3.2	Subrecipient ensures that treatment is provided with the written consent of the client.	• All subcontracted dental practices must have a signed contract with the subrecipient program, including a statement that clients will provide written consent for treatment.
3.3	Subrecipient has an appeal process in place in the event a client's treatment plan is not approved.	• Subrecipient must submit policy and procedure to recipient upon request.
3.4	Subrecipient has grievance and anti-discrimination policies and procedures.	• Subrecipients must have a policy in place, which includes notification of State Board of Dentistry in cases of reported discrimination.
3.5	Subrecipient has process for the recruitment and training of contracted dental providers.	• Subrecipient has a procedure to recruit and onboard dental providers to offer Part A services at their practices.

4.0 Subrecipients Practice Standards

#	STANDARD	MEASURE
4.1	Treatment Plan is developed based upon the initial examination of the client.	• Subrecipient must file treatment plans in each client record. The plan must be submitted by a dentist and reviewed and approved by dental program director.
4.2	Treatment plan is reviewed and updated as deemed necessary by the dental provider or dental program director.	• Subrecipient must file updated treatment plans in client files. The plans must be submitted by a dentist and revised and approved by dental program director.

SECTION 3: SUPPORT SERVICES

EMERGENCY FINANCIAL ASSISTANCE

Policy Definition

This service provides limited, one-time or short-term payments to eligible clients. The payment is administered by a subrecipient and may include a voucher program.

Goal

Emergency Financial Assistance (EFA) helps eligible PLWH meet basic needs. Qualifying needs include, but are not limited to: cost of medication, housing, utilities, food, or transportation.

Objective

Subrecipients will assess clients' emergency needs related to food security, housing, utilities, transportation and cost of medication, as well as provide appropriate assistance.

1.0 Eligible and Unallowable Emergency Financial Assistance Activities

#	STANDARD	MEASURE
1.1	Direct cash payments to clients are not permitted.	• Subrecipients will not provide clients with cash payments to cover eligible costs.

1.2	Payments must be one-time or short-term.	• Subrecipient must have a policy that outlines:
		  • Reasonable limits on assistance;
		  • Reasonable duration of assistance;
		  • Acceptable documentation of emergency and need.

1.3	Subrecipients must pursue alternative options before accessing EFA funding. This includes accessing other RWHPA services to meet a need, such as Housing, ADAP, and Food Bank/Home-delivered meals.	• Subrecipients must provide evidence of attempts to refer a client to other resources before accessing EFA.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Subrecipients must have a policy that defines time limits, amounts, and frequency of assistance, per client and per family.	• Subrecipients must submit policy to the recipient and follow the policy to administer funds.
2.2	Subrecipients must define *emergency* as it pertains to the use of EFA funds. All approvals for EFA must follow the policy.	• Subrecipients must demonstrate, through invoicing and documentation in clients' files, that the policy is followed.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Documentation in client records must detail the need for assistance, type of assistance given, date of assistance and method.	• Subrecipients must maintain accurate progress notes in clients' records.
3.2	Subrecipients must collect documentation that illustrates eligibility for EFA. Examples include proof of past due bill, inability to pay bill, proof that client accessed other sources of funding, and any extenuating circumstance.	• Subrecipients must maintain accurate records.

FOOD BANK/HOME DELIVERED MEALS

Policy Definition

Food Bank/Home Delivered Meals is the provision of actual food items, hot meals, or a food voucher program for eligible PLWH. This also includes the provision of the following essential non-food items:

- Personal hygiene products;
- Household cleaning supplies;
- Water filtration/purification systems in communities with documented water sanitation issues.

Goal

The goal of this service category is to prevent hunger and malnutrition among PLWH.

Objective

The objective of this service category is to improve access to food and improved nutrition for PLWH who face food insecurity.

1.0 Eligible and Unallowable Food Bank/Home Delivered Meals Activities

#	STANDARD	MEASURE
1.1	Allowable activities include provision of: • Personal hygiene products; • Household cleaning supplies; • Water filtration/ purification systems.	• Subrecipients will only be reimbursed for the provision of allowable items.
1.2	Unallowable activities include provision of: • Permanent water filtration systems; • Household appliances; • Pet food; • Other non-essential products.	• Subrecipients will not use Part A funds for the provision of unallowable items.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Subrecipients must have policies that address the following: • Amount of food distributed per client; • Frequency of food items/meals provided; • Mechanism to assess clients' food security need and ongoing needs assessment.	• Subrecipients must develop a policy and submit policy to the recipient. • Each client who accesses the program must be assessed for food security needs.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Subrecipient must document and track services provided by type of service, number of clients served, quantity provided, date and time of service.	• The documentation system must be available to the recipient. The system must be accurate and updated regularly.

HEALTH EDUCATION/RISK REDUCTION

Policy Definition

Health Education/Risk Reduction is the provision of education to PLWH about HIV transmission and how to reduce the risk of HIV transmission. This includes information on how to access medical and psychosocial support services. Education sessions may cover the following topics:

- Strategies to prevent HIV transmission, such as pre-exposure prophylaxis (PrEP) and PEP (post-exposure prophylaxis);
- Education on health care coverage options;
- Health literacy;
- Treatment adherence education.

Goal

The goal of this service category is to reduce the risk of HIV transmission.

Objective

Activities in this category provide education on various topics related to reducing the risk of HIV transmission. Providers also assist clients to identify resources in the community that complement and support risk reduction.

1.0 Eligible and Unallowable Health Education/Risk Reduction Activities:

#	STANDARD	MEASURE
1.1	Subrecipients deliver education about available medical and psychosocial support services.	• Client records will indicate the delivery of approved information and evidence of referrals.
1.2	Subrecipients deliver education on HIV transmission and risk reduction strategies.	• Subrecipients must develop appropriate content and resource guides for their programs.
1.3	Subrecipients deliver one-on-one or group sessions on how to improve health status and reduce the risk of HIV transmission.	• Subrecipients must document evidence of support sessions. The documentation must be made available to the recipient upon request.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Subrecipients must develop system to deliver approved Health Education/Risk Reduction activities.	• Subrecipients must have a policy and procedures for service delivery.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Subrecipients must develop a mechanism to assess participants' knowledge and learning. Examples include: • A pre /post-test for education sessions; • A quiz that illustrates retention of information; • Data that illustrates improved health outcomes or reduced HIV transmission rate.	• Subrecipients must maintain a record of evaluations at their site.

HOUSING

Policy Definition

Housing services is the provision of transitional, short-term, or emergency housing assistance to enable a client or their family to gain or maintain medical services. This may include housing referral services, or financial assistance for transitional, short-term, or emergency housing.

Goal

The goal of Housing services is to assist a client to gain or maintain medical care by reducing the barriers to permanent shelter and provide linkages to permanent housing. Providers are required to have documentation that indicates stable housing would contribute to positive health outcomes for clients who access this service.

Objective

Eligible clients will receive assistance in the form of individual sessions with a housing search advocate, or in the form of financial assistance for a housing unit.

1.0 Eligible and Unallowable Housing Activities

#	STANDARD	MEASURE
1.1	Subrecipients will provide financial assistance (under Housing Assistance) to eligible clients and for eligible types of shelter.	• Subrecipients must provide assistance for transitional, short-term, or emergency housing only. • Part A funds may not be used for mortgage payments, security deposits, or units with rent that exceeds the Fair Market Rent (FMR) for the geographic region.
1.2	Subrecipients will provide allowable housing advocacy (under Housing Search Services) for eligible clients.	• Allowable activities include housing needs assessment, housing service plan, search for appropriate housing, placement, and advocacy. • Subrecipients must have comprehensive knowledge of local, state, and federal housing programs for which clients may qualify.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Payment process	• Subrecipients must develop and follow specific payment procedures for Housing Assistance funds. • Subrecipients must not make payments directly to clients. • Part A funds cannot be used for security deposits or mortgage payments.

#	STANDARD	MEASURE
2.2	Allowable use of funds	Subrecipients must develop program policies with detailed algorithms that define: • Use of funds, including time limits, maximum amount per client per contract year, and the reapplication process; • Reasonable assessment of housing needs related to imminent loss of housing, current state of unstable housing, and housing impact on access to medical care; • Adherence to FMR prices for the geographic region; • Instructions on how award is to be applied, including unallowable costs and non-duplication of services.

3.0 Subrecipients Practice Standards

#	STANDARD	MEASURE
3.1	Program Application	• Clients must complete a program application to access Housing services.
3.2	Housing Needs Assessment	• Subrecipients must complete a housing needs assessment for clients who access Housing services.
3.3	Individual Service Plan (ISP)	• Subrecipients must complete an ISP for clients who access Housing Search Services. • The ISP must identify budget, tenancy goals, and barriers to housing. • Clients must agree to be engaged in services for six months after they are placed in a housing unity. Clients must update the subrecipient on housing stability.
3.4	Housing Certification	• Subrecipients must document medical necessity of housing in each client's file.
3.5	Inactive Clients	• Progress notes that document attempts to reach the client • Client records will become inactive for clients with no contact for six months
3.6	Inactive or Discharged Clients	• Subrecipients must have a discharge policy for completion or termination of services. • Subrecipients must have a process to mark clients as inactive when necessary.

MEDICAL TRANSPORTATION

Policy Definition

Medical Transportation services provide non-emergency transportation which allows eligible clients to be retained in core medical and support services.

Goal

The goal of this service category is to maintain clients connected to core and support services that contribute to positive health outcomes.

Approved activities include a voucher system, contract system with a taxi company, mileage reimbursement system (non-cash), volunteer driver system, or approved purchase or lease of organization vehicle.

Objective

The objective of this service category is to provide allowable transportation resources to eligible clients who otherwise could not access the core and support services needed to meet medical needs and support needs.

1.0 Eligible and Unallowable Medical Transportation Services

#	STANDARD	MEASURE
1.1	Approved transportation methods will include: • Contract with transportation service, public or private; • Volunteer drivers; • Purchase of a vehicle, with pre-approved from recipient; • Voucher system; • Rideshare.	• Subrecipient must document and invoice recipient for approved methods of transportation services.
1.2	Subrecipients will not provide use Part A funds for unallowable transportation costs.	• Subrecipient will not invoice the recipient for the maintenance or fees of a vehicle, vehicle loan payments, registration or license fees.
1.3	Subrecipients will not provide cash payments or cash reimbursements to clients.	• Subrecipients will not invoice the recipient for cash reimbursements.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Subrecipients must provide transportation that is appropriate to clients' needs.	• Subrecipient must have a procedure to assess best method of transportation based on need.
2.2	All drivers contracted to transport clients must be aware of their responsibility in the event of an accident.	• Subrecipient must maintain documents that detail contracted driver's responsibilities, obligations, and liabilities.
2.3	Subrecipients must have a procedure to determine types of transportation to be provided, that each method is of reasonable cost, and how to document and administer each method.	• Subrecipient must have documented policies and procedures on file.
2.4	Subrecipeint must demonstrate that Part A funds are used as payer of last resort.	• Subrecipient must be able to justify use of Part A funds.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Clients that cannot be accommodated are referred to other programs.	• Clients not provided transportation are referred to other transportation options.
3.2	Subrecipients must meet outlined contract requirements about service delivery description.	• Reimbursement methods will not involve cash payments. • Mileage reimbursements will not exceed the federal reimbursement rate. • Volunteer drivers will provide proof of insurance. • Vehicle purchase will require prior approval from the recipient.
3.3	Subrecipients must maintain required records and documentation.	For all transportation methods, subrecipient must document: • Type of transportation and number of trips provided; • The reason for each trip; • Trip origin and destination; • Client eligibility;

		• The cost per trip.
3.4	Subrecipients must maintain documentation for the administration of vouchers.	• Subrecipient must have a procedure to administer transportation vouchers. • Transportation vouchers must be stored in a secure, confidential location.

NON-MEDICAL CASE MANAGEMENT

Policy Definition

Non-Medical Case Management Services (NMCM) provides and improves access to medical, social, community, legal, financial, and other needed services for PLWH. Non-Medical Case Management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. This includes insurance programs, drug assistance programs, and other state or local programs.

Goal

The goal of non-medical case management services is to enhance access to and retention in essential medical and social support service for PLWH.

Objective

The objective of Non-Medical Case Management is to improve access to medical and social support services for PLWH.

Eligible and Unallowable Non-Medical Case Management Activities

#	STANDARD	MEASURE
1.0	Needs Assessment	• Complete initial intake and ongoing needs assessments must be stored in clients' files. • Referrals and applications to benefit and entitlement programs must be stored in clients' files.
1.2	Individual Service Plan (ISP)	• Subrecipient must develop an ISP with each client. • The ISP must be informed by the needs assessment. • The ISP must be updated at least every six months and stored in clients' files.
1.3	Coordination of Care	• Subrecipients must review clients' use of services and evaluate progress toward goals on the ISP. • Subrecipient must maintain progress notes that detail encounters with clients and client progress. • Subrecipient must document all referrals.
1.4	Documentation of all referrals	• Subrecipient will make and document all referrals to meet clients' needs within 30 days of drafting the action plan. • Documentation in the form of progress notes and referrals in client files.

2.0 Policy and Procedures

#	STANDARD	MEASURE
2.1	Administrative and clinical supervision	• Subrecipient must have policy for administering supervision to staff. • Staff must receive one hour of administrative and one hour of clinical supervision (direct care staff) per month.
2.2	Caseload	• Subrecipient must have a procedure to determine caseload assignments, including managing and tracking caseloads. • Subrecipients must have a policy to manage a wait list for services if necessary.
2.3	Inactive/Discharge Policy	• Subrecipients must have a written procedure to determine when a client is inactive. This includes a discharge procedure.
2.4	Quality Management	• Subrecipients must routinely evaluate NMCM services, including client charts. • Subrecipients must participate in quality management activities, including data entry and chart reviews.

3.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
3.1	Initial assessment of service needs	• Initial assessment of clients' needs must be completed within 14 days of initial contact.
3.2	Development of a comprehensive Individual Service Plan (ISP). This includes: • Continuous monitoring to assess the efficacy of the plan or change in need; • Timely and coordinated access to health and support services and continuity of care; • Re-evaluation of the ISP with adaptations as necessary	• ISPs must be completed within 30 days of initial contact with a client. • Re-evaluation must be completed every six months, at minimum.

#	STANDARD	MEASURE
3.3	Service coordination. This may include: • A range of client-centered services that link clients with support services; • Client-specific advocacy and/or review of utilization of services.	• Subrecipient must document referrals and linkages to care. • Subrecipient must document progress notes, including description of encounter, duration, date, etc.
3.4	Transitioning Clients	• Subrecipients must accommodate a client who requests to transition services in no more than 10 days. • Subrecipients must document details of the transition in a client's file.

3.5	Discharging Clients	• Clients may be discharged from a Medical Case Management program for the following reasons:
		  • Client requests discharge;
		  • Client transfers out of care;
		  • Client is referred to another case manager;
		  • Client's needs have been met;
		  • Client violates program rules and regulations; or
		  • Case manager is unable to make contact with client for one (1) year.
		• Subrecipients must document the discharge in clients' files.

3.6	Re-engagement	• Subrecipients must have a procedure to re-engage clients who are discharged or inactive. If new contact is made, subrecipients must complete a full intake assessment.

PSYCHOSOCIAL SUPPORT

Policy Definition

Psychosocial Support services are group or individual counseling sessions between a PLWH and facilitator. The topic of the session is a behavior or physical health concern, including but not limited to, bereavement counseling, child abuse and neglect counseling, HIV support groups, nutrition counseling and pastoral counseling services. Other relevant topics may include substance use, domestic violence, coping with comorbidities, and family support issues, among others.

Goal

Psychosocial Support services will decrease isolation for PLWH and provide a level of peer engagement and support distinct from other professional services.

Objective

Subrecipients of Psychosocial Support services will conduct group and individual counseling sessions on approved topics in a welcoming environment routinely visited by PLWH.

1.0 Eligible and Unallowable Psychosocial Support Services

#	STANDARD	MEASURE
1.1	Unallowable activities include: recreational activities, gym memberships, and nutritional supplements.	• Subrecipients will not purchases these items with Part A funds.
1.2	Pastoral counseling must be available to all clients.	• Subrecipient will not deny pastoral services to any client.
1.3	Services may be provided by those who are infected with or affected by HIV.	• Subrecipients will employ qualified peer advocates for their programs.

2.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
2.1	Subrecipients will provide allowable services to eligible clients.	• Subrecipients must document evidence of service delivery in clients' files.
2.2	Psychosocial Support Group sessions will be defined as three or more people.	• Subrecipients will report only sessions with 3+ people as a PS group.
2.3	Group and individual PS sessions will have a topic or curriculum.	• Subrecipients will record notes for individual and group counseling sessions that include the topic, duration of the session, and name of the peer advocate.

#	STANDARD	MEASURE
2.4	PS sessions will be facilitated by a person living with HIV ***OR*** a person with relevant skills, life experience, and knowledge.	• Peer advocates will meet the requirements of the job description.

SUBSTANCE ABUSE SERVICES – RESIDENTIAL

Policy Definition

Substance Abuse Services (Residential) is the provision of services meant to treat substance use disorder in a residential setting. These services include screening, assessment, diagnosis, and treatment.

Goal

The goal of this service category is to allow clients coinfected with substance use disorder and HIV to access low threshold services in a residential setting which will stabilize acute substance use needs and contribute to HIV viral suppression.

Objective

The objective of this service category is to provide the following services: pretreatment, harm reduction, counseling, relapse prevention, medication-assisted therapy, and detoxification where appropriate. These services must be delivered in a residential setting that has the appropriate state license and accreditation, as well as properly trained and licensed staff, to address a client's substance use disorder:

1.0 Eligible and Unallowable Substance Abuse Services – Residential

#	STANDARD	MEASURE
1.1	Eligible programs will provide the following services: • Pretreatment • Harm reduction • Counseling • Relapse prevention • Medication assisted therapy and pharmaceuticals • Detox, where appropriate	• Subrecipients must have policies and procedures to deliver eligible services. • Subrecipients must document service delivery in clients' files.
1.2	Inpatient detoxification in a hospital setting is an unallowable activity.	• Subrecipients will not report use Part A funds for inpatient detoxification services.
1.3	Subrecipients are licensed or certified to provide substance use services.	• Subrecipients must submit and maintain resumes, licenses, and job descriptions for staff. • Training modules will reflect ongoing education for subrecipient staff.
1.4	Services are delivered in a facility that is licensed by an appropriate state agency to provide substance abuse services.	• Subrecipients must comply with statewide regulations, including licensing requirements.

		• The agency's licenses and appropriate accreditation must be made available to the recipient upon request

2.0 Subrecipient Practice Standards

#	STANDARD	MEASURE
2.1	Subrecipients must document a clinical referral for each client served.	• Referrals are documented in clients' files. • Clinical referral may be submitted by a provider with any of the following qualifications: *MD, NP, PA, RN, LMHC, LICSW, LADC, CADAC*