RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT OF 2009

SERVICE STANDARDS

NEW ORLEANS EMA

Providing Quality Care and Services for People with HIV/AIDS

New Orleans Regional AIDS Planning Council & Office of Health Policy and AIDS Funding

FY 2017

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INTRODUCTION

The Service Standards, also known as the Standards of Care were initially developed by the Medical Team, Inc., in 1998, with input from community focus groups, in response to a need identified by the New Orleans Regional AIDS Planning Council (NORAPC) and the Office of Health Policy and AIDS Funding (OHP), with revisions completed by NORAPC's Standing Committees and Support Staff, in October 2001. Ongoing revisions occur as necessary. The objective of this document is to provide a standard of service delivery for each service category that will facilitate quality services for persons with HIV and AIDS in the New Orleans Eligible Metropolitan Area (EMA).

THE PROCESS

These standards represent consensus among service providers and consumers regarding quality of service delivery that will enhance the lives of people infected with and affected by HIV/AIDS. In the original document, an initial draft of each service category was prepared utilizing various resources, including service category definitions provided by the New Orleans Regional AIDS Planning Council (NORAPC), standards from other Eligible Metropolitan Area (EMAs), policies and procedures of existing service providers and standards of relevant professions. The draft was reviewed by a focus group of interested parties: consumers, service providers, administrators, advocates and neutrals. The final language for each standard was discussed at length, edited and negotiated as appropriate by the group.

Currently, the responsibilities of updating the standards reside with the Comprehensive Planning Committee of the Planning Council. Once completed, the standards are then forwarded to the Council for approval. Upon council approval, the standards are implemented in conjunction with OHP.

THE STANDARDS

The Universal Standards were developed first during focus groups in June 1997, which included service providers and consumers. For the most part, items addressed in the Universal Standards, which apply across all service categories, are not incorporated into each service standard. These policies are, however, very critical to all services and their applicability cannot be over-emphasized.

The definition and description of "services provided" for each service category were directly taken from the NORAPC service category definitions, which have been developed by the Standing Committees of NORAPC. While there may occasionally be a difference in the language found in service category definition and the standards, they should be substantively the same.

Finally, Standards of Care (SOC) are a living document, which will evolve with changing needs and realities of the affected community and the capacity of the service delivery area. During 2000, such changes were made to reflect the highest level of professional standards consistent with Medicaid guidelines and best practices for medical services, including USPHS guidelines. The Standing Committees of NORAPC and Support Staff continually update the SOC and propose revisions as needed. In 2001, NORAPC revised several SOC to incorporate language mandated by the reauthorization of the CARE Act in October 2000 and newly identified needs of PLWHA in the EMA. In 2005, the standards were again revised to achieve a better service delivery system. Changes were made based on recommendations from experts from the field representing each service category, along with examples of Standards of Care from other EMAs around the United States. This resulted in a more concise, easy to ready and complete document. Some changes include:

- The "Indicators/Evidence" section was renamed to "Measure". The Measure sections are guidelines for acceptable measurements for compliance with the SOC.
- New SOC were added: Health Education/Risk Reduction, Referral for Health Care/Supportive Services, and Treatment Adherence Counseling
- Each standard clearly states who can do referrals to other Part A services.
- Definitions of each service category were updated to reflect the changes made by the Health Resource and Services Administration (HRSA).
- Eligibility requirements were standardized in the Universal Standards of Care section unless otherwise stated in each category.

Since the reauthorized Ryan White legislation in the Ryan White HIV/AIDS Treatment Extension of 2009, the Comprehensive Planning Committee continues to review and make recommendations to the SOC as necessary. The passage of the Affordable Care Act in 2010 has likewise brought about changes in the SOC as the committee continues to align the Ryan White Part A standards with significant changes to the broader system of care.

Any comments regarding this document or considerations for future revisions should be directed in writing to NORAPC, 2601 Tulane Avenue, Suite 400, New Orleans, LA 70119 or by emailing info@norapc.org. All Comprehensive Planning Committee meetings are open to the public. For the Comprehensive Planning Committee meeting schedule, call (504) 821-7334 or check the website at www.norapc.org.

UNIVERSAL SERVICE STANDARDS

(Approved by Planning Council 4/17/17)

I. DEFINITION/OVERVIEW

To ensure that the best interests of the client govern the provision of services in a supportive and non-discriminatory manner; eliminate conflicts of interests; and establish a conflict resolution forum to address ethical concerns and client grievances related to the provision of services and compliance with these standards. And, to ensure appropriate use of funds designated for People Living with HIV.

II. SECTIONS

In this document, you will find:

- Code of Ethics
- Eligibility Verification & Intake Standards
- Quality Assurance
- Orientation
- Training
- Subcontracting of Services

III. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1	**Code of Ethics**	
1.1	Services will be provided to all Part A qualified individuals without discrimination based on HIV infection, race, creed, color, age, sex, gender, marital or parental status, sexual orientation, religion, ancestry, national origin, physical or mental handicap (including substance abuse), immigrant status, political affiliation or belief, ex-offender status, unfavorable military discharge, membership in an activist organization, or any basis prohibited by law. U.S. Department of Health and Human Services, Office of Minority Health, CLAS Standards should be administered by provider agencies	Agency has statement/policy onsite.

#	Standard	Measure
1.2	All services provided under Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009 will serve the best interests of the client/consumer emphasizing confidentiality, respect for the client's rights and protect the client's dignity and self-esteem.	Agency has statement/policy onsite.
1.3	Services will be provided without interference by conflicts of interest.	Agency has statement/policy onsite.
1.4	A potential conflict of interest exists where relationships might allow a party to influence the delivery of services for personal and/or professional gain for an individual or organization.	Agency has statement/policy onsite.
1.5	All potential conflicts will be disclosed in writing to the parties involved. The Agency will monitor the provision of services in a potential conflict situation to ensure that services are provided in an equitable manner and decisions are not influenced by the relationship creating the potential conflict.	Agency has statement/policy onsite.
1.6	All Agencies shall maintain a grievance procedure, which provides for the objective review of client grievances and alleged violations of universal and service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for so doing.	Agency has statement/policy onsite.
1.7	Some service categories may have additional code of ethics to which providers must adhere.	Each provider maintains a Code of Ethics on file, as appropriate.
2	**Eligibility Verification & Intake Standards**	
2.1	Policies and procedures shall exist to ensure compliance with program requirements including all requirements communicated by OHP and the Service Standards.	Agency's written policies will be kept on-file to ensure compliance with program requirements as communicated by OHP and the

#	Standard	Measure
		Service Standards.
2.2	Each Provider shall verify the eligibility for services under Part A of individuals presenting for services.	Each provider maintains a completed Client Eligibility and Review Verification form and all current supporting documentation for each client on file.
2.3	HIV Status: Verification of HIV+ status shall be in written form.	Documented in client's file. The following are acceptable documents: HIV Lab Result or a written statement from a physician or medical record.
2.4	Financial: Client must meet financial eligibility requirements as defined by the New Orleans Regional AIDS Planning Council, currently 500% poverty level, unless indicated otherwise.	Documented in client's file. The following are acceptable documents: Benefit award letter, pay stub, letter from employer, tax forms, Dept. of Labor letter, prison release paper, self-attestation certificate.
2.5	Residence: Client must reside in the EMA which includes the following parishes- Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, and St. Tammany.	Documented in client's file. The following are acceptable documents: LA ID or Driver's License, utility bill, benefits award letter in name of client showing address, voter registration, lease or mortgage in client's name, Self-Attestation, or verification, on

#	Standard	Measure
		letterhead, from residential program.
2.6	Services shall be accessible by public transportation or through arrangement with transportation service providers.	Provider is in an area accessible by public transportation, or by documented special arrangement with transportation providers
2.7	Upon intake, each client will be informed of third party payer application requirements. Minimally, clients must apply for Louisiana Medicaid or a marketplace insurance plan – or have a documented denial from Medicaid dated within the prior 12 months.	Client's central file reflects discussion of Louisiana Medicaid application requirements or contains prior-denial documentation.
2.8	Affected clients are not eligible for Core Services. Affected clients can be deemed eligible for Psychosocial Support Services. The allowable service must be to enable the affected individual to participate in the care of a person living with HIV.	Client's chart documents relationship to an infected Ryan White Part A client
3	**Quality Assurance**	
3.1	Provider/Agency shall be accredited/licensed to deliver services.	Evidence of current unconditional license and /or certification is on file for each provider and for organization as a whole, where applicable.
3.2	Policies and procedures shall exist to ensure compliance with program requirements including all client eligibility requirements communicated by the Office of Health Policy and the Universal Service Standards.	Provider maintains policies and procedures designed to ensure compliance with client eligibility requirements. Client files contain

#	Standard	Measure
		required eligibility data.
3.3	Provider's physical plant will comply with appropriate building, zoning, health and safety codes and be clean, well-ventilated, properly lighted, heated, air conditioned, maintained and handicapped accessible.	Appropriate certificate of compliance.
3.4	Agency shall monitor for programmatic compliance on a periodic basis.	Provider has documentation of self-monitoring for programmatic compliance.
3.5	Coordinate with, and maximize the use of, other available sources of assistance (e.g. Medicare, Medicaid, private insurance) and ensure the needs of the patient are met.	Documentation in client's file.
3.6	Service providers shall have an established quality assurance/performance improvement plan which shall include: Patient satisfaction data collection process, record review process, policy/procedure review of ethical issues, procedures established to initially evaluate and intervene in all incident or client complaints reported or received by the agency/service provider	Maintenance of quality assurance program documents. Patient satisfaction data is regularly evaluated.
3.7	As required by the 2009 Ryan White HIV/AIDS Treatment Extension Act, service providers must agree to work with OHP and NORAPC toward measuring client health outcomes including, but not limited to, the following: Perinatal transmission rates, client morbidity and mortality, CD4 counts and viral load measurements.	Agreement on work with OHP and NORAPC toward the measurement of client health outcomes is submitted with grant application and as additionally required.
4	**Orientation**	
4.1	Service providers shall have an established, detailed staff orientation process.	Orientation program educates staff

#	Standard	Measure
	Orientation must be provided to all staff providing direct services to clients within ten (10) working days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum: USPHS guidelines for the treatment of people with HIV: - HIV Basic Science and Psychosocial Issues - Clinical protocols and standards for treatment (including interventions and mechanisms to maximize adherence to treatment) - Infection control - Client rights and responsibilities - Listing of current community-based and other resources - Employee rights and responsibilities - Programmatic requirements	on above described required subject matter and documentation of orientation components in maintained. Personnel file reflects completion of orientation and signed job description.
5	**Training**	
5.1	Staff participating in the direct provisions of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services annually, as determined by agency personnel policy. Staff salaries that encompass 25% of Ryan White Part A funds must complete eight (8) hours. Appropriate and professional training priorities should include (but are not limited to): current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, etc.), and cultural sensitivity. After first year, professionals are required to complete eight (8) hours of Continuing Education per year. An accredited appropriate professional entity will provide semi-annual training.	Personnel files of client reflect eight (8) hours of training annually. OHP will monitor attendance at all biannual training sessions.
6	**Subcontracting of Services**	

#	Standard	Measure
6.1	All subcontractors shall adhere to all local, state and federal regulations within their field of service delivery.	Documentation on site at Part A funded agency.
6.2	The Ryan White Part A funded agency must keep documentation from any subcontracted agency on file, including: current contracts, current professional licenses, current board certifications.	Documentation on site at Part A funded agency.
6.3	HIV training opportunities will be made known to non-HIV-specific subcontractors.	Documentation of communication with subcontractor about training opportunities.

AMBULATORY / OUTPATIENT MEDICAL CARE

(Approved by Planning Council 4/17/2017)

IV. DEFINITION/OVERVIEW

The provision of professional diagnostic and therapeutic services rendered by a physician, physician assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, physical examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well–baby care, continuing care and management of chronic conditions, and referral to specialty care (includes all medical subspecialties). Primary Medical Care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

V. SERVICES

Outpatient-based medical care given to Persons Living with HIV by or under the direction of a licensed physician, physician assistant, nurse practitioner, registered nurse, medical social worker, or licensed health care worker. Services focus on timely/early medical intervention, continuous health care, and disease care over time.

VI. SECTIONS

In this document, you will find:

- → Personnel
- → Treatment

VII. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	Individual clinicians shall have documented Louisiana State licensure/certification in	Appropriate licenses/ certifications

#	Standard	Measure
	his/her particular area of practice.	are maintained.
1.2	Service providers shall employ clinical staffs who are knowledgeable and experienced regarding their area of clinical practice as well as in the area of HIV clinical practice. All staff without direct experience with HIV shall be supervised by one who has such experience.	Personnel files/resumes/applications for employment reflect requisite experience/ education.
2.0	**TREATMENT**	
2.1	Provider shall fully inform clients about its agency's services.	Clients receive information at intake regarding the range of services available from the provider.
2.2	Treatment shall be offered and delivered per most recent USPHS clinical guidelines for the treatment of people with HIV and as indicated by the Office of Health Policy.	Current standards of clinical practice on HIV care are readily available and/or on site and accessible to all clinicians within the organization.
2.3	Providers shall educate clients on treatment adherence within the first two visits and periodically thereafter, and will document these efforts in the clients' charts/records. Acceptable providers to counsel clients include: Physicians, Registered Nurses, Licensed Practical Nurses, Nurse Practitioners, Case Managers, Pharmacists, Home Health Staff, Health Education Peers, and Health Educators. Methods of addressing treatment adherence may include: individual counseling, group teaching, provision of written instructions with discussion, referral to health educators or pharmacists, scheduling early follow-up appointments.	Documentation of adherence plan and appropriate interventions in client chart. Acceptable documentation includes: chart notes by an MD, pharmacist, Case Manager, health educator, RN or other nurse detailing adherence discussion, or notes from a home health agency regarding medications.

#	Standard	Measure
2.4	Provider/organization shall evaluate clients for treatment protocols in a thorough and individualized manner, making all reasonable efforts to accommodate the clients' informed preferences.	Treatment protocols reflect thorough and individualized evaluation of client's condition, options, and preferences.
2.5	An initial comprehensive multi-disciplinary plan of care shall be formulated for each client and periodically reviewed and updated as conditions warrant or at a minimum of every six (6) months. Multi-disciplinary in this context shall mean a team consisting of a physician, nurse, and social service professional.	Client chart contains comprehensive multi-disciplinary plan of care, updated at least every 6 months.
2.6	Informed consent shall be obtained prior to initiation of all treatment. Clients shall be informed of all treatments, medications and protocols that are considered experimental and written informed consent to participation in any experimental treatment will be expressly obtained.	Client chart contains documentation of client's informed consent
2.7	Each grantee providing primary medical services or medications shall have a written policy or plan that addresses medication adherence.	Documentation of annual acknowledgement of the written adherence plan by clinicians providing care. Alternatives include in-service presentations to the clinical staff on medication adherence or inclusion of the adherence plan in the organization's policies and procedures, with at least an annual review.

EARLY INTERVENTION SERVICES

(Approved by Planning Council 8/27/07)

I. DEFINITION/OVERVIEW

Early Intervention Services (EIS) for Part A are the provision of a combination of services that include the following services as related to HIV/AIDS: counseling, testing, referrals, and other clinical and diagnostic services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care. These services must focus on expanding key points of entry and documented tracking of referrals.

Counseling, testing, and referral activities are designed to bring HIV positive individuals into Primary Medical Care. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found to be HIV negative should be referred to appropriate prevention services.

II. SERVICES

Early Intervention Services will act as a mechanism for effective linkages between the local Ryan White system of care and points of entry within the EMA. EIS providers will partner with community based access points to identify and refer HIV positive clients not in care into the health care system.

Services may include test decision counseling for HIV, provision of information on living with HIV disease, counseling on modifying behaviors that compromise one's own health status or the health status of others, diagnostic tests to assess the extent of immune deficiency and referrals into primary care, case management, and legal services for individuals with positive (including preliminary positive) test results, as well as referrals to prevention and other appropriate risk reduction counseling and intervention for those with negative test results. Services also include follow-up on all referrals into primary care and case management. It is recommended that diagnostic tests not duplicate those covered by primary care (i.e. if diagnostic screenings are conducted under EIS, those test results must be forwarded to client's primary care provider; Ryan White funds should not be used for duplicative testing procedures).

HIV Counseling and Testing Services Include:

Pre-test counseling without test: Work with client to develop an individual risk reduction plan that is realistic and incremental based on individual client needs and abilities.

Pre-test counseling with test: Administer an FDA approved HIV test and work with client to develop an individual risk reduction plan that is realistic and sensitive to individual client needs and abilities.

HIV negative post-test counseling: Test results will be given in a confidential and client-centered approach. Referrals should be provided to prevention services and clients encouraged to access those services in an attempt to meet the goals of their risk reduction plan.

Indeterminate post-test counseling: Counselors will discuss with clients the meanings of "indeterminate" test results, and establish a plan to establish client's infection status in an attempt to meet client risk reduction goals.

HIV positive post-test counseling: Test results given in a confidential and client-centered approach. Referrals provided to HIV primary medical care and case management and legal services. Provision of information that both educates the individual about the importance of seeking care and motivates them to do so.

Post-test Follow-Up: Follow-up activities should be conducted with agencies to assess client adherence with arranged referrals and appointments, and with client to re-establish referral plan if the client does not adhere to initial primary care, case management, or follow-up service appointments.

For individuals with a preliminary positive HIV test result, services may also include other tests to diagnose the extent of immune deficiency or to provide information on appropriate therapeutic measures.

a) Confirmatory HIV test – To confirm positive HIV test result by using Western blot or immunofluorescence assay
b) Baseline labs – Tests to be conducted as specified in standard clinical guidelines (including a CBC, electrolytes, glucose, BUN, creatinine, liver function tests (LFTs), lipid studies, urinalysis, and toxoplasma serology)
c) Viral load – Virologic test to be performed to determine viral load (e.g. HIV RNA pending results of confirmatory HIV positive test).
d) Resistance Assay – Pending baseline and viral load results: For treatment naïve clients or those with acute HIV infection, consider drug resistance testing (for example genotyping); recommended in all pregnant women and for those considered at high risk for acquisition of drug resistant HIV, e.g. adolescents.
e) Tuberculosis Testing (PPD) – When appropriate, tests may be conducted prior to referral to primary medical care. Note: This is strongly

recommended.
f) Hepatitis A serology- Hepatitis A antibody total - When appropriate, tests may be conducted prior to referral to primary medical care.
g) Hepatitis B serology- Hepatitis B surface antibody, surface antigen, and core antibody - When appropriate, tests may be conducted prior to referral to primary medical care.
h) Hepatitis C serology- Hepatitis C antibody - When appropriate, tests may be conducted prior to referral to primary medical care
i) Pap smear - When appropriate, tests may be conducted prior to referral to primary medical care
j) Pregnancy test - When appropriate, tests may be conducted prior to referral to primary medical care
k) Syphilis serology - Tests may be conducted prior to referral to primary medical care

III. ELIGIBILITY

1. For HIV Counseling, Testing and Referral (CTR), only residential eligibility applies.
2. For all other diagnostic services, financial and residential eligibility apply.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Part A services
- → General Standards
- → Occupational Health
- → Coordination and Referral

NOTE: The standards and measures for Counseling, Testing and Referral (CTR) and Other Diagnostic Tests (ODT) have been separated for applicable sections of the standards (i.e., Standard #.# A for CTR and Standard #.# B for ODT).

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	**Both CTR & ODT**: Service providers will employ staff that is knowledgeable and experienced regarding HIV Counseling and Testing, as well as skilled in educating clients	Employee personnel file shall reflect appropriate education, expertise

#	Standard	Measure
	about the importance of accessing medical care.	and experience appropriate to their area of practice as well as in the area of HIV/AIDS practice.
1.12 A	**CTR:** Individuals providing EIS HIV Counseling, Testing and referral services shall be certified and up-to-date in all requirements established by the Louisiana Office of Public Health, HIV/AIDS Program (OPH/HAP).	Office of Public Health (OPH) HIV Counseling, Testing, and Referral (CTR) Certification/licensure in employee file.
1.12 B	**ODT:** Individuals performing other clinical diagnostic tests shall have documented unconditional licensure/certification in his/her particular area of practice. (e.g., registered nurse, nurse practitioner, licensed physician, etc.	Appropriate certification/licensure in employee file.
1.13 A	**CTR:** Testing personnel will have all requisite experience/education as required by Centers for Disease Control and Prevention (CDC) standards to administer tests and counsel clients.	Testing personnel files/resumes/applications for employment reflect requisite experience/education as required by State and Federal law for administering HIV tests and counseling clients.
1.2	**Orientation**	
1.21	**Both CTR & ODT:** Service providers shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to clients within ten (10) working days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum: a) HIV Basic Science and Psychological Issues b) HIV Counseling and Testing techniques and procedures c) Infection control	1. Presence of an orientation program that educates staff on above described required subject matter. 2. Personnel file reflects completion of orientation and signed job description.

#	Standard	Measure
	d) Client rights and responsibilities e) Confidentiality f) Client relations g) Cultural competency/sensitivity h) Safety in the workplace i) Professional ethics j) Employee rights and responsibilities k) Programmatic requirements including applicable Standards of Care l) General understanding of available resources m) List of current resources n) CDC and United States Public Health Service (USPHS) guidelines	3. Presence of CDC and USPHS regulations and guidelines on HIV counseling, testing and referral will be kept on file at EIS site
1.22 B	**ODT:** In addition to the above, orientation must also include: a) USPHS guidelines for the treatment of people with HIV/AIDS b) Clinical protocols and standards for treatment (including interventions and mechanisms to maximize adherence to treatment)	1. Presence of an orientation program that educates staff on above described required subject matter. 2. Personnel file reflects completion of orientation and signed job description.
1.3	**Training**	
1.31	**Both CTR & ODT:** Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services and/or Continuing Education (per license requirements) per year, as determined by agency personnel policy.	Agency will track staff certifications and will be responsible for staff's continuing education and other updates as necessary. OHP will monitor compliance with training and continuing education requirements. Failure to comply with training components may

#	Standard	Measure
		result in suspension and could result in subsequent loss of funding.
1.32	**Both CTR & ODT:** Ongoing training must be provided to appropriate staff to maintain current knowledge about CDC guidelines for HIV Counseling and Testing and other Early Intervention Services, including updated information regarding options for care provision.	Staff files will contain documentation of updated training for all staff to maintain a high level of knowledge regarding CDC guidelines for HIV Counseling and Testing and other Early Intervention Services.
1.4	**Supervision**	
1.41	**CTR:** A supervisor must have a counselor number provided by OPH.	Documentation of training certification and counselor number of supervisory staff must be kept on file.
2.0	**REFERRAL TO PART A SERVICES**	
2.1	**Both CTR & ODT:** Newly identified HIV positive individuals will be referred to a HIV primary medical care (PMC) provider and/or Part A case management provider. EIS providers are encouraged to make a Part A case manager available at the EIS site, either through cross-departmental staffing or a sub-contractual agreement. Immediately linking HIV+ individuals to case management is key to a successful transfer to/retention in primary medical care.	Written referral log or client specific documentation.
2.2 B	**ODT:** With client consent, results of preliminary labs will be forwarded to Primary Medical Care provider.	Documentation of file forwarding and signed consent form in client file.
4.0	**GENERAL STANDARDS**	
4.1 A	**CTR:** Sites will meet State and Federal requirements for HIV testing.	Documentation of OPH testing site certification will be on site.

#	Standard	Measure
4.1 B	**ODT:** Provider/Agency shall be accredited/licensed to deliver services.	Evidence of current unencumbered license and/or certification is on file for each provider and for organization as a whole, where applicable.
4.2 A	**CTR:** Services must be consistent with Centers for Disease Control and Prevention guidelines for HIV counseling, testing and referral. Part A funded providers must collaborate with CDC and other funded entities for HIV counseling and testing to reduce duplication of efforts and gaps in service in the New Orleans Eligible Metropolitan Area (EMA). Additionally, the agency must comply with State and Federal laws and guidelines regarding HIV counseling, testing, and confidentiality.	a. Copy of current CDC guidelines will be maintained on-site. State site unit number or documentation of complete training from CDC-compliant entity reflects compliance with CDC guidelines. Memorandum of Understanding (MOU) with appropriate CDC-funded agencies will be kept on file. b. Current certification on file for each staff conducting HIV counseling and testing. Confidentiality statements signed by employee will be kept in the employee's personnel file.
4.2 B	**ODT:** Treatment shall be offered and delivered according to most recent USPHS clinical guidelines for the treatment of people with HIV/AIDS and as indicated by the Mayor's Office of Health Policy and standard precautions.	Current standards of clinical practice on HIV/AIDS care are readily available and/or on site and accessible to all clinicians within the organization.
4.3	**Both CTR & ODT:** Special emphasis is placed on the provision of Early Intervention	Documented consumer recruitment

#	Standard	Measure
	Services to high-risk, low-income, uninsured individuals, including historically underserved communities, throughout the New Orleans EMA.	plan should demonstrate methods to reach high risk target populations.
4.4	**Both CTR & ODT:** Agencies must assure that test results are registered with OPH/HAP as required by State regulations.	a. Policies regarding referrals and follow-up will reflect timely and effective procedures. b. Linkages with Federal/State certified laboratories must be documented by an MOU or contractual agreement. Communications with laboratories will be monitored for efficiency and effectiveness. c. CDC regulations and guidelines on HIV counseling, testing and referral will be kept on file at EIS site. d. Documentation showing that all records of HIV test results have been sent to the State surveillance program in a timely manner shall be kept on-site.
5.0	**OCCUPATIONAL HEALTH**	
5.1	Tuberculosis (TB) tests for all staff are required annually.	Documentation of annual TB test will be kept in staff's personnel file.
5.2	Occupational Safety and Health Administration (OSHA) guidelines must be met to ensure staff and client safety.	A copy of OSHA guidelines will be kept on site.

#	Standard	Measure
6.0	**COORDINATION AND REFERRAL**	
6.1	Services shall be provided at community-based points of entry readily accessible to populations at high-risk for HIV. Points of entry include, but are not limited to: public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification programs, adult and juvenile detention facilities, family planning clinics, STD clinics, homeless shelters, migrant and community health centers, and HIV disease counseling and testing sites.	Memorandum of Understanding (MOU) and other formal documentation of linkages between points of entries.
6.2	Early Intervention Services (EIS) will act as a mechanism for effective linkages between the local Ryan White system of care and points of entry within the EMA. EIS providers will partner with community based access points to identify and refer HIV positive clients not in care into the health care system. Providers must establish formal and documented referral relationships and linkages to primary care, case management, and other services in the HIV continuum of care, as well as to services outside the HIV continuum for those testing negative but requiring further prevention counseling. Provider linkages/relationships must maintain a feedback mechanism for receiving information from health and social service providers to which clients are referred in order to ensure a good faith effort is made to link HIV^+ consumers into primary care. These linkages will assure access to HIV-specific laboratory tests, medications and case management. After a good faith effort is made to link HIV positive consumers into care it is ultimately the consumer's responsibility to get into care. A provider must: a. Provide a referral to primary medical care and/or case management, including set an appointment, b. Contact the primary medical care/case management service provider to confirm	A. As applicable, linkage agreements and MOUs with primary care, case management, prevention and/or HIV counseling, testing and referral sites and non-ASO community based access points will be documented and kept on file with appropriate updates and signatures at EIS site. B. Signed consent allowing the EIS provider to follow-up with client. C. Post-test follow-up will be documented in the client's file.

#	Standard	Measure
	that the client arrived for the appointment, and c. Provide post-test follow-up to contact an HIV+ person who missed their initial primary medical care/case management appointment and set another appointment. d. Document good faith effort to link client to primary medical care/medical case management and the transition into full primary medical care services within six months from the time of diagnosis	

EMERGENCY FINANCIAL ASSISTANCE

(Approved by Planning Council 1/25/16)

I. DEFINITION/OVERVIEW

Emergency financial assistance is the provision of short–term payment for essential utilities and other essential items necessary to link, maintain and improve health relating to HIV. This category excludes emergency rental assistance (see Housing Assistance). Medication assistance is provided to prevent disruption of medication treatment during the application process for Louisiana Health Access Program (LA HAP) or other third party payers.

II. SERVICES

A) Covers limited financial assistance (not to exceed $500 per client per grant year) to pay essential utilities (including, but not limited to electricity, gas, water/sewerage, and heating oil) and basic telephone service (not including optional and long distance charges). Late fees may be paid subject to documentation of extreme circumstances.

B) Financial assistance for non-medication requests (not to exceed $300 per client per grant year) is also available to provide other essential items. These may be supported with justification by case manager and approval from case manager supervisor. The connection to retention in care or patient safety must be clearly explained.

C) Financial assistance for medication needs unable to be addressed through LPAP, HIA, or LDAP. Cost for prescribed medications to treat eligible individuals. Medications coverage includes medications listed on the Ryan White Part A Formulary. Expenditures are not to exceed the monthly medication cap of $3,000 per client.

III. ELIGIBILITY

Per requirements of Eligibility in the Universal Standards of Care for All Ryan White Part A Services section.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Emergency Financial Assistance
- → Intake Emergency Financial Assistance
- → Assessment/Reassessment
- → Limitations on Assistance
- → General Standards
- → Coordination and Referral

V. SERVICE STANDARDS AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Bachelor degree preferred.	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.2	**Orientation – See Universal Standards Tier X Staff**	
1.3	**Training – See Universal Standards Tier X Staff**	
2.0	**REFERRAL TO EMERGENCY FINANCIAL ASSISTANCE**	
2.1	Program shall be accessed by referral from Ryan White Part A provider.	Documentation of eligibility verification provided by referrer is maintained in client's file.
3.0	**INTAKE INTO EMERGENCY FINANCIAL ASSISTANCE**	

#	Standard	Measure
3.1	Client has been properly screened for other available assistance programs and is ineligible, requires additional assistance, or there are no other resources.	a. Copy of documentation of application for other assistance, if applicable. b. Letter documenting need and attempts at locating other available resources signed by Case Manager.
4.0	**ASSESSMENT/REASSESSMENT**	
4.1	An assessment of the presenting problems/needs of the client with HIV-related emergency financial issue.	Documented in the referral and in measure 3.1b.
5.0	**LIMITATIONS ON ASSISTANCE**	
5.1	Requests for assistance must be related to the client's HIV status.	As documented in application.
5.2	Emergency Financial Assistance payment must be made to the appropriate vendor. No payment may be made directly to clients, family member, or household members.	Copy of check in file except for medications services (which would be documented on a monthly pharmacy invoice).
5.3	No funds may be used for any expenses associated with the ownership or maintenance of a privately opened motor vehicle.	Not applicable.
6.0	**GENERAL STANDARDS**	
6.1	Client can receive medication under the following provisions, not to exceed a period of one month (30 days) unless approved by the Office of Health Policy: a. To prevent ARV interruption as documented by case manager or primary care provider	Documentation of short-term need in client's file.

#	Standard	Measure
	b. Due to health status, client cannot wait to begin ARV as documented by primary care provider.	
6.2	Appropriate use of funds: a. Misappropriation of funds for a purpose other than that for which the funds were requested may affect future funding. b. Any abuse of Emergency Financial Assistance services may result in the denial of all future assistance.	a. Documentation of misuse in monitoring report. b. Documentation in client file.
6.3	Denials of assistance may be appealed using the agency's grievance procedure.	Agency written grievance procedure.
6.4	All completed requests for assistance shall be approved or denied within two (2) business days. a. Provision of medication to client within one (1) business day of request approval. b. Payment to the vendor shall be issued in response to an essential utility need (as identified by Case Manager and Agency) within three (3) business days of approval of request. c. Payment to the vendor shall be issued in response to other needs within seven (7) business days of approval of request.	As documented in file.
6.5	The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g. utility) is in another person's name, it directly benefits the client.	A) Copy of invoice/bill paid. B) Copy of check for payment.
7.0	**COORDINATION AND REFERRAL – See Universal Standards**	

FOOD BANK / HOME DELIVERED MEALS

(Approved by Planning Council 7/31/06)

I. DEFINITION/OVERVIEW

Food Bank/Home Delivered Meals involves the provision of actual food, meals, or nutritional supplements. The provision of essential household supplies, such as hygiene items and household cleaning supplies should be included in this item.

This category includes the provision of actual food (food bank or home delivered meals) or meals (as distinguished from money to purchase same, which is not available). Provision of fruit, vegetables, dairy, canned meats, staples, and personal care products in a food bank setting or nutritionally balanced meals and supplemental nutritional products (not inclusive of vitamin and mineral products) through home delivery to eligible individuals. Also, includes nutritional information upon request.

II. SERVICES

1. **Food Bank**:
   Food Bank services are the provision of actual food and personal care items in a food bank setting. Provision of fruit (fresh preferred), vegetables (fresh preferred), nutritional balanced supplements and nutritional products (not inclusive of vitamin and mineral products) and staples in a food bank setting in a cost-effective way. No direct payment to clients to purchase food is allowed.

2. **Home Delivered Meals**:
   Provision of nutritional supplements and nutritional products (not inclusive of vitamin and mineral products), home delivered meals for persons HIV symptomatic or have AIDS who are homebound or cannot shop for or prepare their own food. This service includes the provision of both frozen and hot meals.

III. ELIGIBILITY

In addition to requirements of Eligibility under the Universal Standards section:

1. Client meets the financial eligibility requirement of 200% or below the poverty level for Food Bank Services.
2. Eligibility is valid for a six month period.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Food Bank/Home Delivered Meal
- → Services
    1. Food Bank
    2. Home Delivered Meals
- → Licensing & Regulations
- → Coordination and Referral

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Semi-annual training of staff must be conducted by a Licensed Dietician, specializing in the special needs of HIV+ clients.	Contractual agreement between provider and Licensed Dietician, specializing in HIV, must be on file.
1.12	A consultancy agreement must be established with a Licensed Dietician, specializing in HIV, regarding special needs of clients. The Dietician will make recommendations based on the American Dietetic Association's standards and be available to educate and evaluate clients and their needs.	Proof of qualification of Licensed Dietician, specializing in HIV, must be on file, such as: a. Copy of License b. Resume or Curriculum Vitae
1.2	**Orientation**	
	Agency shall establish an orientation for staff and volunteers addressing, as applicable, topics pertinent to the task at hand, such as:	Personnel files reflect completion of applicable orientation.

#	Standard	Measure
	1. Safe food handling procedures 2. Confidentiality issues for delivery personnel 3. Sensitivity to the HIV/AIDS Client 4. HIV nutrition, based on American Dietetic Association guidelines 5. Cultural competency	
2.0	**REFERRAL TO FOOD BANK/HOME DELIVERED MEAL**	
2.1	Food services shall be accessed by referral from case managers/primary care providers. Referring agency shall provide the following verifications upon referral of a client for food services.	Documentation is maintained on eligibility verification provided by referring agency.
2.2	**Home Delivered Meals** a. Client is homebound or cannot shop for or prepare their own food, and b. Client must have a current AIDS diagnosis along with a letter of justification from their Case Manager stating need for this service and, when possible, will certify that a home visit has been conducted to assess client's need for services. c. Clients with an HIV+ diagnosis must have a letter of justification from their Primary Care Provider stating the need for this service. d. Eligibility is valid for a six month period.	As documented in application.
2.3	**Food Bank** a. Client is HIV+ with justification of need for this service. b. Client resided in the New Orleans EMA. c. Client meets the financial eligibility requirements of 200 percent or below the poverty level. d. Client has been properly screened for other available food assistance programs. e. Eligibility is valid for six months.	As documented in application.

#	Standard	Measure
2.4	Independent requests for service. 1. Clients independently requesting or inquiring about food services, who have not yet been referred for same, shall be referred by the food service provider to agencies that are equipped to conduct intake and refer eligible clients back to the provider in a timely manner. 2. However, clients whose referrals are complete may access food services directly through the providing agency, if permitted by agency procedure. 3. Clients who discontinue the program may be required to re-establish eligibility before resuming service.	Agency written policy on client access to service.
3.0	**SERVICES**	
3.1	Menus and choices available to clients will reflect community and cultural preferences, the nutritional needs of persons with HIV/AIDS, and special client needs.	a. All menus are reviewed by the contracted Licensed Dietician on a quarterly basis. b. Special dietary needs are accommodated. c. Provider's policies and procedures reflect above listed requirements.
3.2	**FOOD BANK**	
3.21	Provider must specify criteria, policies and procedures for utilization of food pantry services.	Provider written policy and procedures on utilization of services.
3.22	Provider must have a mechanism in place to secure donations of food, groceries, and additional funding for the pantry.	Provider written policy and procedures on donation of food

#	Standard	Measure
		and grocery.
3.23	Provider policies and procedures for grocery allocations and for accommodation of special client needs shall be communicated to clients.	Provider written policy and procedures regarding accommodation of special client's needs.
3.3	**HOME DELIVERED MEALS**	
3.31	A meal shall be defined in accordance with the guidelines of the American Dietetic Association.	American Dietetic Association guideline.
3.32	Clients will be given a delivery time period within which they can expect to receive their meal.	Provider written policy on meal delivery.
3.33	Menus shall reflect the nutritional needs, appropriate supplements and special diets of HIV/AIDS clients.	Documentation in client's file of special needs.
4.0	**LICENSING & REGULATIONS**	
4.1	Provider must maintain all licenses and permits required by law to operate the particular food services program(s) involved.	Provider licenses required to operate.
4.2	Provider must comply with all applicable health department regulations and food service standards to ensure safe and high-quality products.	Health department regulations are available on site. Provider has policies and procedures in accordance with same.
4.3	All drivers delivering meals must hold a valid driver's license and automobile insurance consistent with state minimum requirements.	Personnel files of paid and volunteer drivers contain documentation that each is licensed to drive.

#	Standard	Measure
5.0	**COORDINATION AND REFERRAL**	
5.1	Provider shall have ongoing collaborative relationships with other food pantries/home delivered meal providers and inform clients of other sources of assistance, as appropriate.	Documentation that client has attempted access to community resources must be on file.

HEALTH EDUCATION/RISK REDUCTION

(Approved by Planning Council 12/17/12)

I. DEFINITION/OVERVIEW

Health Education/Risk Reduction is the provision of services that educate clients about HIV transmission. It also includes the provision of information dissemination about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

II. SERVICES

Services may be delivered one-on-one and/or in small groups. Health educators may encounter clients in a venue comfortable for the client, not limited to HIV service sites. These services are intended to be available to clients of all Ryan White Part A funded agencies.

III. ELIGIBILITY

Per requirements of Eligibility in the Universal Standards of Care for All Ryan White Part A Services section. Ryan White Part A funds are funds of last resort.

Specific target populations most appropriate to receive these services may include individuals exhibiting risk behaviors. Risk behaviors may include, but are not limited to: engaging in risky sexual behavior with multiple partners, practicing unprotected intercourse, substance use, failure to be connected to medical care or loosely connected to medical care, and recent diagnosis of HIV and/or Sexually Transmitted Infections (STIs).

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Health Education/Risk Reduction
- → Intake into Health Education/Risk Reduction
- → General Standards
- → Coordination and Referral
- → Discharge/Transition

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	*Minimum Qualifications:* ▪ 18 years of age or older ▪ High School diploma or GED ▪ Completion of HIV related education training course from a grantee approved training program ▪ Basic knowledge of and service delivery skills related to the following: o Communication skills o Cultural sensitivity *Preferred:* ▪ Basic computer skills (particularly Microsoft Word and Excel) ▪ Person Living with HIV/AIDS (PLWHA) ▪ Bilingual Spanish/English capacity ▪ Basic knowledge of and service delivery skills related to the following: o Clinical science of HIV/AIDS o Human sexuality, including diverse lifestyles and sex practices o Mental health and substance use/abuse o Client confidentiality o Knowledge of available health and social services	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.2	**Orientation**	
1.21	The objectives of staff orientation are: ➢ To educate staff on general policies, procedures and expectations for the position. ➢ To ensure health educators are knowledgeable about available medical and support services. ➢ To ensure health educators know and understand programmatic requirements, including the Standards of Care.	N/A
1.22	**General Staff Orientation**: Orientation of at least eight (8) hours must be provided to all staff within ten (10) working days of employment, including, at a minimum: a. Confidentiality with signed confidentiality agreement	Personnel file reflects completion of orientation and signed job description.

#	Standard	Measure
	b. Documentation in case records c. Consumer rights protection and reporting of violations d. Consumer abuse and neglect reporting policies and procedures e. Professional ethics f. Client rights and responsibilities g. Employee rights and responsibilities h. Emergency and safety procedures i. Data management and record keeping j. Infection control and universal precautions k. Eligibility verification procedures l. Review of job description	
1.23	Additional orientation of sixteen (16) hours is required during the first thirty (30) days of employment. Topics covered must include orientation to the HIV service delivery system in the New Orleans Eligible Metropolitan Area (EMA), including but not limited to: a. List of current resources and sources for updated information b. Programmatic requirements, including Ryan White Part A Standards of Care c. Health education concepts d. Interviewing, counseling and interpersonal skills e. HIV and STI Basic Science and Psychological Issues f. Harm reduction techniques, such as safer needle sharing and safe sex guidelines	Personnel file reflects completion of additional orientation.
1.3	**Training**	
1.31	The objective of staff training is to ensure a standard level of knowledge and skill among health educators to support the provision of quality care to PLWHA.	N/A
1.32	To ensure provision of quality services, health educators (including supervisors) must be knowledgeable and skilled in the topic areas listed below. Basic training in the following areas is required during the first ninety (90) days of employment. Training provided to new staff by the agency must be provided by an individual with demonstrated knowledge of the training topics: a. Motivational interviewing b. Treatment adherence	Documented in personnel file.

#	Standard	Measure
	c. Medications resistance d. Treatment as Prevention (TasP) strategies e. Health outcome measures f. Health literacy g. Psychosocial issues of the client/affected family h. Cultural sensitivity i. Multi-disciplinary team communications j. National HIV/AIDS Strategy (NHAS)	
1.33	Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services annually, as determined by agency personnel policy. Appropriate and professional training priorities should include, but are not limited to: current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, etc.), and cultural sensitivity.	Personnel files reflect eight (8) hours of training annually.
1.4	**Supervision**	
1.41	*Minimum Supervisory Qualifications:* An appropriate supervisor must meet the *minimum* qualifications for education and experience listed below: ▪ A bachelor's (required) or master's degree (preferred) in a human service field which includes: psychology, education, counseling, public health, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two (2) years of paid post degree experience in providing health education/risk reduction and/or HIV-related services. ▪ OR a registered nurse. AND ▪ Demonstrated knowledgeable about health education and risk reduction interventions (required). *Thirty (30) hours of graduate level course credit in the human services-related field may be substituted for the two (2) years of required paid experience. All experience must be obtained after completion of the degree or licensure and must be professional level*	Personnel files/resumes/applications for employment reflect requisite experience/education. Chart will show evidence of supervisor's knowledge related to Health Education and Risk Reduction interventions.

#	Standard	Measure
	experience.	
1.42	Each supervisor must maintain a file on each health educator supervised and hold supervisory sessions on at least a weekly basis. The file on the Health Education/Risk Reduction specialist must include, at a minimum: date, time, and content of the supervisory sessions, results of the supervisory case review addressing, at a minimum, completeness and accuracy of records, compliance with standards and effectiveness of recruitment for and delivery of services.	Documentation of supervision provided Supervisors' files on each health educator reflect ongoing supervision, supervisory sessions and case review.
2.0	**REFERRAL TO HEALTH EDUCATION/RISK REDUCTION**	
2.1	Any member of the multidisciplinary care team (including, but not limited to physician, nurse, prescriber, case manager, clinician, and patient) can recommend referral into services. Referral to this service requires a current CERV.	Client's file reflects referral
3.0	**INTAKE INTO HEALTH EDUCATION/RISK REDUCTION**	
3.1	Proper referral form from case management	Documentation in client's file.
3.2	Staff informs client of HIV service delivery related policies and procedures: a. Confidentiality and release of information b. Statement of Consumer Rights and Responsibilities c. Agency grievance/complaint procedures	A. Agencies will maintain documentation of the above for each patient. B. Patient Satisfaction Surveys will be conducted periodically. C. Providers will retain client sign in lists with dates, check-in and check-out times noted.
3.3	To promote a multidisciplinary approach, all relevant forms and assessments should be forwarded from the referring provider to the health educator upon client consent to release information. Information to be shared should include copies of the CERV and comprehensive assessment. The reason for the referral should be documented.	Client chart contains documentation
4.0	**GENERAL STANDARDS**	
4.1	Policies and procedures shall exist to ensure compliance with program requirements including all client eligibility requirements communicated by the Mayor's Office of Health Policy and the Universal Standards of Care.	Provider maintains policies and procedures designed to ensure compliance with client eligibility

#	Standard	Measure
		requirements. Client files contain required eligibility data.
4.2	Agency shall monitor for programmatic compliance on a periodic basis.	Provider has documentation of self-monitoring for programmatic compliance.
4.3	Agency will assure that educational materials and messages are relevant, culturally sensitive and language-and age-appropriate.	Provider has sample copies of materials on file.
4.4	Agency will maintain a written policy and personnel procedures that address stress and burnout.	Provider has policy and procedure on file.
4.5	All services will be provided in such a way as to overcome barriers to access and utilization, including efforts to accommodate linguistic and cultural diversity.	Provider maintains a list of interpreters. There is documentation of staff training to explain information in plain language and with cultural sensitivity.
4.6	Provider's physical plant will comply with appropriate building, zoning, health and safety codes and be clean, well-ventilated, properly lighted, heated, air conditioned, maintained and handicap accessible.	Appropriate certificate of compliance.
5.0	**COORDINATION AND REFERRAL**	
5.1	Providers must demonstrate adequate linkages with AIDS services organizations and community based organizations providing HIV services.	Agencies will provide documentation of previous or current contracts or Memorandums of Understanding.
5.2	Agency will maintain written procedures for the referral and tracking of clients to appropriate services outside of the agency.	Provider maintains written procedure on file.
5.3	Services shall not duplicate other existing efforts in the community.	Provider maintains evidence of communication and collaboration with other providers.

#	Standard	Measure
6.0	**DISCHARGE/TRANSITION**	
6.1	Provider will have written policy for discharge, transition and referrals.	Provider written policy for discharge, transition and referrals.
6.2	Clients should not be terminated from services until it is clear that a mutually agreed upon discharge/transition plan is appropriate. If the client falls out of service, then the provider will follow-up for 30 days. A case closure summary will be completed for each client upon cessation of services.	Documentation of attempts to contact client will be in client chart. Client chart will include signed and dated case closure summary.

HEALTH INSURANCE ASSISTANCE

(Approved by Planning Council 1/25/16)

I. DEFINITION/OVERVIEW

Health Insurance Assistance (HIA) is funded to assist eligible individuals with their continuity of health insurance, including medical care and medication co-payments, insurance deductibles and premiums, as required under their individual insurance coverage. HIA can only be used to pay for services at least partially covered by client's health insurance.

II. SERVICES

This program provides timely payment to cover the cost of copayments for medical care, dental care, vision care; and medication; to pay insurance premiums for medical plans, dental plans, and dental plans with vision; and to pay insurance deductibles. Copayments, deductibles, and premiums are provided to eligible persons who have health insurance. The program provides for "Coverage Completion," coordinating the use of Ryan White funds to fill in gaps left by other funding sources (e.g., Marketplace, Medicaid). Client service needs which are not fully met through HIA may potentially be served though other service categories (e.g. dental care or mental health), as long as there is no duplication of service.

Qualifying individuals may include those who are ineligible for assistance through Part B's Louisiana Health Access Program (LA HAP) and those awaiting a decision from other insurance programs. Individuals who are eligible for assistance through Part B's LA HAP may also seek assistance through HIA, but only on a limited basis for the purposes of maintenance of insurance. HIA cannot duplicate services provided by Part B. There is a cap limit of $3,000/month.

III. ELIGIBILITY

Per the requirements outlined in Eligibility under the Universal Standards of Care for All Ryan White Part A Service Providers section. See above Services section.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral into Health Insurance

→ Intake into Health Insurance
→ General Standards
→ Coordination and Referral
→ Discharge/Transition

V. SERVICE STANDARDS AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Bachelor degree preferred.	Personnel files/resumes/ applications for employment reflect requisite experience and education.
1.2	**Orientation – See Universal Standards Tier X Staff**	
1.3	**Training – See Universal Standards Tier X Staff**	
2.0	**REFERRAL INTO HEALTH INSURANCE ASSISTANCE**	
2.1	Program shall be accessed by referral from Ryan White Part A provider.	Documentation of eligibility verification provided by referrer is maintained in client's file.
3.0	**GENERAL STANDARDS**	
3.1	HIA provider agencies must maintain individual client files which contain the following: bills of payment being requested, Explanation of Benefits (EOBs), disposition approving/denying the request, the timeline of payment, and copy of check to vendor except. Medication services will be documented on a monthly pharmacy invoice.	Documentation in client's file.

#	Standard	Measure
3.2	HIA provider will respond to all completed requests for assistance with a pending, or approved disposition to the referring agency within two (2) business days.	Documentation in client's file.
3.3	A copy of the check will be provided to the referring agency upon request. NOTE: Direct disbursements to clients are prohibited; payments are to be made payable to vendors.	Documentation in client's file.
3.4	Annual HIA costs should not exceed the cap limitation. In the event of justifiable service need in excess of the cap, exemptions must be approved by the Office of Health Policy (OHP) via the HIA Cost Allowance procedure.	Client's file contains documentation of disposition.
3.5	The service provider agency shall conform to the reporting requirements of the City of New Orleans, Office of Health Policy (OHP) by implementing and using data collection and reporting systems, with timely submission of such data and invoices on a monthly basis as directed by OHP.	As monitored by OHP.
3.6	Informed consent shall be obtained prior to contact with client's potential health care providers.	Documentation in client's chart. Each client's chart contains documentation of client's informed consent.
3.7	Provider should have policy in place for self-monitoring for programmatic compliance.	Documentation in client's chart. Provider has documentation of self-monitoring for programmatic compliance.
4.0	**COORDINATION AND REFERRAL—See Universal Standards**	
5.0	**DISCHARGE/TRANSITION—See Universal Standards**	

HOME HEALTH CARE

(Approved by Planning Council 5/22/2017)

I. DEFINITION/OVERVIEW

Home health services are therapeutic, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician, physician assistant, or advanced practice nurse. Home health services include the following:

- **Para–professional care** is the provision of services by a home health aide, personal caregiver, or attendant caregiver. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.
- **Professional care** is the provision of services in the home by licensed health care workers such as nurses.
- **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies.

The Home Health Care Service Standard refers to service providers operating under contract with the Office of Health Policy and AIDS Funding as well as those entities subcontracted to provide services by a Ryan White Part A funded agency. In addition, **all Part A service providers who subcontract services with non-Part A providers, should refer to Section 6 of the Universal Service Standards**, which detail requirements and recommendations for all Ryan White Part A subcontractors.

II. SERVICES

Home Health Care provides for the availability of: skilled nursing, home health aides, personal care attendants, physical therapy, social work, medical supplies, and the purchase or rental of non-motorized durable medical equipment.

III. SECTIONS

In this document, you will find:

- → Personnel
- → Referral to Home Health
- → Intake into Home Health
- → Assessment/Reassessment

→ Discharge/Transition
→ Licensing and Requirements

IV. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	All nursing staff, home health aides, personal care attendants, physical therapists, and social workers will meet the appropriate licensure requirements set forth by Louisiana Medicaid.	Personnel files/resumes/applications for employment reflect requisite education.
2.0	**REFERRAL TO HOME HEALTH**	
2.1	Medical providers can refer clients to home health services.	Client's central file reflects Medical Provider orders.
2.2	Upon receipt of a medical provider's order, case managers can refer clients to home health services.	Client's central file reflects Medical Provider order.
2.3	The referring medical provider must provide orders in writing to the agency prior to the initiation of care, act as that client's primary care provider, maintain a consistent plan, and communicate changes from the initial plan directly to the agency. If this is not possible, the primary care provider must be willing to transfer the client to the care of a willing primary care provider. (If verbal orders are given to the agency, written orders must follow within 48 hours.)	Client's central file reflects written Medical Provider orders.

#	Standard	Measure
2.4	Refusing a Referral. The home health agency may elect to refuse a referral for the following reasons only: 1. Based on the agency's perception of the referred client's condition, the client requires a higher level of care than would be considered reasonable in a home setting. The agency must document the situation in writing and immediately contact the client's medical provider. 2. The agency has attempted to complete an initial assessment and the referred client has been away from home on three occasions. The agency must document the situation in writing and immediately contact the referring provider.	Client's central file reflects the agency's decision and written communication to the referring provider and appropriate monitoring entity.
3.0	**INTAKE INTO HOME HEALTH**	
3.1	The funded home health agency will perform the general intake processes already in place for every new admission. This includes presentation of confidentiality, release of information, and grievance procedures.	Client's central file contains the appropriate intake documentation required of the agency.
3.2	Home health services will begin within 24 hours, or at the nearest possible time, after the receipt of the medical provider's referral, unless otherwise specified.	Client's central file contains documentation of services initiation.
3.3	Upon intake, each client will be informed of third party payer application requirements. Minimally, clients must apply for Louisiana Medicaid or a marketplace insurance plan – or have a documented denial from Medicaid dated within the prior 12 months.	Client's central file reflects discussion of Louisiana Medicaid application requirements or contains prior-denial documentation.
4.0	**ASSESSMENT/REASSESSMENT**	
4.1	The home health agency must conduct a first visit with the referred client and develop a written plan of treatment. Progress notes will be kept and the client's eligibility must be recertified for the program every 12 months. Home healthcare providers will update the plan of treatment (HCFA Form 485) at least every 60 days. The agency will maintain ongoing communication with the medical provider and case manager in compliance with	Client's central file contains written documentation of plan of treatment, progress notes, and communication logs.

#	Standard	Measure
	Louisiana Medicaid and Medicare Guidelines.	
4.2	The home health agency (nursing staff) must be available for consultation on a twenty-four hour, seven day per week basis.	Client's central file contains documentation.
4.3	The home health agency will certify upon intake, and throughout the course of the treatment plan, that the client is not in need of acute care.	Client's central file contains documentation.
5.0	**DISCHARGE/TRANSITION**	
5.1	Discontinuing Services. The agency may discontinue services in only the following circumstances: *All services discontinued must be accompanied by a referral to an appropriate service provider agency.* 1. The client is not stable enough to be cared for outside of the acute care setting as determined by the agency and the client's medical provider; 2. The client no longer has a stable home environment appropriate for the provision of home health services as determined by the agency and the case manager; 3. The client no longer desires home healthcare; 4. The client no longer medically requires home healthcare as determined by the agency or the client's referring medical provider; 5. An employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a client's home, in the company of an escort or not. The agency may discontinue services or refuse the client for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within 24 hours and followed by a written report. A copy of the police report is sufficient, if applicable.	Client's central file reflects the appropriate documentation.
6.0	**LICENSING AND REQUIREMENTS**	
6.1	Home health providers must be appropriately licensed by the State of Louisiana and able to bill Medicare, Medicaid, private insurance, and/or other third party payers.	Evidence of current unconditional license and /or certification is on file for each provider and for the organization as a whole.

HOUSING ASSISTANCE

(Approved by Planning Council 2/24/14)

I. DEFINITION/OVERVIEW

Housing Assistance is the provision of limited financial assistance for housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for emergency housing must be linked to medical and/or health-care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

II. SERVICES

Emergency housing assistance will be short term in nature and is for the purpose of maintaining an individual or family in a long-term, stable living situation. The housing strategy plan will be conducted at intake to identify, assist in relocation, and/or ensure the individual or family is moved to, or capable of maintaining a long-term, stable living situation.

Funds in this category are intended to link clients into primary medical care by paying for up to the value of two months of rent at HUD Fair Market Rent upper range for clients who have unmet housing needs and do not qualify for another subsidy.

III. ELIGIBILITY

Per requirements of Eligibility in the Universal Standards of Care for All Ryan White Part A Services section. Ryan White Part A funds are funds of last resort. Contractors are responsible for doing routine screening for third party payer.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral Housing Assistance
- → Intake into Housing Assistance
- → Assessment/Reassessment
- → Emergency Housing Assistance Program
- → Coordination and Referral

→ Discharge/Transitions
→ General Provisions
→ Requirements

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Service providers shall employ staff who are able to comprehend various housing assistance available in the EMA with a general understanding of the system of health care delivery within the EMA.	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.2	**Orientation**	
1.21	**Orientation**. Service providers shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to clients within ten (10) working days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum: a) Psychosocial issues of the HIV infected client/affected family b) Confidentiality c) Documentation d) Consumer rights protection and reporting of violations e) Consumer abuse and neglect reporting policies and procedures f) Professional ethics g) Emergency and safety procedures h) Data management and record keeping i) Infection control and universal precautions j) Review of job description k) Programmatic requirements including applicable Standards of Care l) Ryan White Part A services and other services available in the community	Orientation program educates staff on above described required subject matter. Personnel file reflects completion of orientation and signed job description.

#	Standard	Measure
1.3	**Training**	
1.31	Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services annually, as determined by Agency personnel policy. Staff salaries that encompass 25% of Ryan White Part A funds must complete eight (8) hours. Appropriate and professional-training priorities for training should include but not limited to: current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, etc.), and cultural sensitivity.	Personnel files of sub-contractors staff reflect eight (8) hours of training annually.
2.0	**REFERRAL TO HOUSING ASSISSTANCE**	
2.1	Referral into Housing Assistance shall be accessed by referral from a Ryan White Part A case manager.	Documentation in client's file.
2.2	Referring agency shall provide the following verifications upon referral of client for Housing Assistance services: a) Client resides in the New Orleans EMA b) Certification of need for housing services for purposes of medical care must be documented c) Proof of HIV+ status, symptomatic or AIDS diagnosis supported by a physician statement is needed	Documentation of eligibility verification provided by referring agency is maintained in client's file.
2.3	Independent requests for service: • Clients independently requesting or inquiring about housing assistance services, who have not yet been referred for services, shall be referred by the service provider to case management agencies that are equipped to conduct intake and refer eligible clients back to the provider in a timely manner.	Documentation is maintained on eligibility verification provided by referring agency and provider.

#	Standard	Measure
3.0	**INTAKE INTO HOUSING ASSISTANCE**	
3.1	The funded housing provider will perform the general intake processes already in place for every new admission. This includes presentation of confidentiality, release of information, and grievance procedures.	Client's central file contains the appropriate intake documentation required of the agency.
4.0	**ASSESSMENT/REASSESSMENT**	
4.1	Initial assessment protocols shall provide screening of individuals to determine needs and appropriate service plan.	Documentation individual client service plan.
4.2	The Agency shall arrange **24-hour crisis response** by qualified crisis intervention staff for active clients who may experience emotional emergencies. The protocol will require documentation in client's file.	Agency written protocol for crisis intervention.
4.3	A **service plan** shall be completed within 30 days that is specific to individual client needs. The service plan shall be prepared and documented for each client. Individual, and family case records will include documentation of the following: a. Eligibility b. Housing or emergency financial assessment of needs c. Verification of ineligibility and/or inability to access assistance through non-Ryan White resources. d. Strategy to achieve or ensure a long-term stable living situation e. Referrals f. Discharge summary	Documentation in client's file.
5.0	**EMERGENCY HOUSING ASSISTANCE PROGRAM**	
5.1	Emergency Housing Assistance is defined as rental assistance only. Housing Assistance funds cannot be used for mortgage payments. Assistance cannot be permanent and must be accompanied by a strategy to ensure a long-term stable living situation.	A. Documentation in client's file. Include justification by case manager of necessity of housing service for purposes of the client's

#	Standard	Measure
		medical care
5.2	Housing assistance must be temporary in nature and cannot be provided in excess of twelve months' of assistance.	Documentation in client's file.
5.3	Emergency rental assistance payment is made out to the appropriate vendor and authorized for pick up by the client or the client's case manager. No payment may be made directly to clients, family or household members.	The Agency providing emergency rental assistance must maintain the following documents in each client's case file, in addition to any other documentation which may be required by the Standards of Care. a) Copy of completed CERV form and all supporting materials as required by the Office of Health Policy; b) Copy of housing strategy/plan for stabilization c) Copy of invoice/bill paid; d) Copy of check for payment; e) Copy of documentation of application for other assistance, if applicable; f) Letter documenting need and attempts at locating other available resources signed by Case Manager.

#	Standard	Measure
6.0	**COORDINATION AND REFERRAL**	
6.1	Provider shall have written linkage agreements with all Ryan White Part A funded providers of Case Management services. The linkage agreement should include the following elements: a) process for referrals, outlining the responsibilities of each party; b) timeliness and form of response to requests for assistance; c) protocols for follow-up communications between providers; d) protocols to communicate and coordinate related to the client's housing strategy plan, individual service plan, and discharge/transition planning; e) protocols to coordinate to avoid and address issues of client abuse of funds.	Documentation reflects collaboration and referral system.
7.0	**DISCHARGE/TRANSITION**	
7.1	Provider will have a written plan regarding discharge and/or transition of client from services.	Written plan on file.
8.0	**GENERAL PROVISIONS**	
8.1	Provider must specify criteria, policies, and procedures for utilization of housing assistance services.	Provider's policies and procedures reflect above listed requirements.
9.0	**REQUIREMENTS**	
9.1	Provider's physical plant will comply with appropriate building, zoning, health, and safety codes and be clean, well-ventilated, properly lighted, heated, air conditioned, maintained, and handicapped accessible.	Provider has certificate of occupancy reflecting compliance.

LEGAL SERVICES

(Approved by Planning Council 8/27/07)

I. DEFINITION/OVERVIEW

Legal services are the provision of HIV related services to individuals related to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. Not included are any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. Ryan White Part A funds cannot be used to address criminal matters.

II. SERVICES

Legal may assist the client in one or more of the following services:

1. Documents relating to personal and estate planning, such as Wills, Living Wills or Powers of Attorney
2. Simple succession matters
3. Matters of discrimination, including housing and employment
4. Provision of notarial services
5. Assistance with debtor problems
6. Public benefits, as well as insurance and employee benefits
7. Confidentiality issues

III. ELIGIBILITY

Per requirements of Eligibility under the Universal Standards section, however, potential Part A eligible clients may be provided notarial services in order to facilitate eligibility for Part A services. This is an exception to the requirements of a completed CERV for accessing Part A services.

IV. SECTIONS

In the following sections, you will find:

- → Personnel
- → Referral to Legal

→ Assessment
→ Case Disposition/Discharge
→ Coordination and referral

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	All Attorneys will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are: a. A license to practice law in the State of Louisiana; b. Being in good standing with the Louisiana State Bar Association; c. The absence of pending disciplinary proceedings brought against the attorney by the Louisiana State Bar Association.	Personnel files/resumes/applications for employment reflect requisite qualifications.
1.2	**Orientation**	
1.21	Staff Orientation Orientation of at least eight (8) hours must be provided to all staff within ten (10) working days of employment, including, at a minimum: a. Confidentiality & Limits b. Documentation in case records c. Consumer rights protection and reporting of violations d. Professional ethics e. Emergency and safety procedures f. Data management and record keeping g. Infection control and universal precautions h. Eligibility i. Review of job description	Personnel files reflect completion of orientation and signed job description, along with a checklist of topics covered, date, and orientation was completed with a signature of the supervisor and employee.
1.22	Attorney Orientation- A minimum of sixteen (16) hours of orientation:	Personnel files reflect completion of

#	Standard	Measure
	a. Other legal service providers and referral procedures b. Ryan White Part A Standards of Care	orientation and signed job description, along with a checklist of topics covered, date, and orientation was completed with a signature of the supervisor and employee.
1.3	**Training**	
1.31	Continuing legal education. Attorneys must annually satisfactorily complete all continuing legal education requirements as mandated by Louisiana State Bar Association.	Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training and signature of employee.
1.4	**Supervision**	
1.41	Agency must have and implement a written plan for supervision of all attorney staff	A. Written plan for supervision. B. Documentation of supervision.
1.42	All staff must be evaluated at least annually by their supervisor according to written agency policies on performance appraisal.	A. Written plan for an annual evaluation. B. Personnel files will include an annual plan.
2.0	**REFERRAL TO LEGAL SERVICE**	
2.1	Referral into Legal services shall be accessed by a referral from a Ryan White Part A case manager, with the exception of notarial services to facilitate eligibility for Part A services.	Documentation of eligibility verification provided by referring agency is maintained in clients' file.
3.0	**ASSESSMENT**	

#	Standard	Measure
3.1	An assessment of the presenting problems/needs of the client with HIV-related legal issue, including but not limited to: a) Documents relating to personal and estate planning, such as Wills, Living Wills or Powers of Attorney; b) Simple succession matters; c) Matters of discrimination, including housing and employment; d) Provision of notarial services; e) Assistance with debtor problems; f) Public benefits, as well as insurance and employee benefits; g) Confidentiality issues.	Documented in client file
4.0	**CASE DISPOSITION/DISCHARGE**	
4.1	Client file will document disposition of client's legal issue(s), and notification to client of disposition.	Documented in client file
5.0	**COORDINATION AND REFERRAL**	
5.1	Due to the attorney-client privilege, legal services will be initiated when the client contacts legal staff. However, there are situations where staff from other service providers can provide information concerning the legal needs of clients.	Not applicable.

LOCAL PHARMACY ASSISTANCE PROGRAM (LPAP)

(Approved by Planning Council 1/25/16)

I. DEFINITION/OVERVIEW

Local Pharmacy Assistance Program (LPAP) is the ongoing local program to pay for Ryan White Part A formulary approved medications/medical items for persons with no other payment source.

Local Pharmacy Assistance Program (LPAP) is a program established, operated, and funded locally by Ryan White Part A New Orleans Eligible Metropolitan Area (EMA) to expand the number of covered medications available to financially eligible patients and/or to broaden eligibility beyond that established by the State-operated Louisiana Health Access Program (LA HAP). Determinations regarding the appropriate service category for medication assistance should be assessed as follows:

A. All individuals eligible for LA HAP should access the State Ryan White Part B programs;
B. Uninsured individuals who are not eligible for LA HAP, who need ongoing assistance should be served through LPAP;
C. Insured individuals who are not eligible for LA HAP should be served through Ryan White Part A Health Insurance Assistance (HIA);
D. Uninsured individuals who are eligible for LA HAP but require medications/items not on the Part B formulary that are on the Part A formulary may access LPAP after exhausting all other resources.

II. SERVICES

Cost for prescribed medications to treat eligible individuals. Coverage includes items listed on the Part A formulary. Expenditures are not to exceed the Monthly Medication Cap of $3,000 per client per month. Items not listed on the Part A formulary are not covered.

III. ELIGIBILITY

Per requirements of Eligibility in the Universal Standards of Care for All Ryan White Part A Services section. See also above sections related to eligibility.

Individuals who require one-time or short term medication assistance while an application is pending with LA HAP should be served through

Ryan White Part A Emergency Financial Assistance (EFA).

IV. SECTIONS

In the following sections, you will find:

- → Personnel
- → Referral
- → General Standards

V. SERVICE STANDARDS AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Bachelor degree preferred.	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.2	**Orientation – See Universal Standards for Tier X Staff**	
1.3	**Training – See Universal Standards for Tier X Staff**	
2.0	**REFERRAL INTO LPAP**	
2.1	Program shall be accessed by referral from Ryan White Part A provider.	Documentation of eligibility verification provided by referrer is maintained in client's chart.
3.0	**GENERAL STANDARDS**	
		Client chart contains documentation

#	Standard	Measure
3.1	Service provider will implement a client enrollment and eligibility determination process that includes screening for LDAP, LPAP, and all other potential payment/assistance sources every six months. Service provider will promote access to drug company-sponsored patient assistance programs by screening clients for eligibility, make appropriate referrals, and follow-up.	of screening for third party payer sources; such sources are utilized prior to utilization of Ryan White funds. A. Completed application in client's file. B. An updated log of resources of patient's assistant program.
3.2	Monthly prices for medications do not exceed standard limitations of $3,000. Monthly client medication costs exceeding the standard limitation must be approved by Office of Health Policy (OHP) via the Monthly Medication Allowance procedure.	Documentation in client's chart.
3.3	Service provider will have USPHS prices established by the government for all medications dispensed under this program. Service provider not currently approved for USPHS prices must apply for approval within the first grant year of funding. When USPHS prices do not apply, prices charged for brand name medications under this program cannot exceed the Average Wholesale Price (AWP). Prices for generics cannot exceed the Maximum Allowable Cost (MAC).	Application for USPHS prices will be maintained on site. AWP guidelines and/or MAC guidelines as compared to the actual price charged.
3.4	Written communication related to medications (e.g., referral paperwork, patient profile, dispensing history, etc.) as appropriate with case manager and other treatment team members will be maintained in client's file.	Documentation in client's file.
#	**Other Standards**	**Measure**
4.0	**PHARMACIES/DISPENSING OF MEDICATIONS**	
4.1	Service providers will be responsible for monitoring sub-recipient standards (i.e. pharmacy). These standards will be reflected in either the contract or a	Documentation of requirements in

#	Standard	Measure
	Memorandum of Agreement. Service providers dispensing medications shall adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Louisiana. In addition to licensing requirements, pharmacist and pharmacy will adhere to the following provisions: - Each prescription is dispensed/delivered within two (2) working days (including mail orders). -Label and instructions in other languages upon request. (refer to CLAS standards) -A procedure to voice complaints or grievances with service. -Confidentiality statement signed by pharmacy employees.	Memorandum of Agreement.

MEDICAL CASE MANAGEMENT

(Approved by Planning Council 7/27/15)

I. DEFINITION/ OVERVIEW

Medical Case Management provides a range of client–centered services linking clients with health care, psychosocial, and other services that improve overall health. An essential component of Medical Case Management includes the coordination and follow-up of medical treatment, as well as treatment adherence counseling. The primary goal of Medical Case Management is to work with the primary care provider to assist a client to maintain and improve health status, which is reflected in a client's health indicators (CD4, viral load, acuity). Client empowerment and monitoring of service utilization (including medical appointment adherence) and health indicators are crucial elements of the service.

Enrollment in Medical Case Management may not be permanent; a client's level of need may change over time and require a different level of service to fit their present circumstances. Ongoing and frequent assessment by a medical case manager and a medical case management supervisor should occur to ensure clients receive the appropriate level of care. Routine assessment tools and acuity scales must be used consistently by all Medical Case Management providers, as mandated by the Office of Health Policy (OHP). [Copies of tools can be obtained from OHP.]

Case management providers should implement a consistent method of assigning caseloads based on the unique composition of PLWHA within the EMA. A caseload of 1:35 clients is considered optimal but other factors may impede this goal. Limiting caseloads below 60 is encouraged.

II. SERVICES

Key activities include: (1) completion of comprehensive assessment of service needs, (2) development of a comprehensive, individualized care plan, (3) coordination of services required to implement the plan (service linkage), (4) client monitoring to assess the efficacy of the plan, and (5) periodic re–evaluation and adaptation of the plan as necessary over the duration of the client's case (reassessment), (6) case closure or transfer as appropriate. Activities should also include multi-disciplinary care coordination and client-specific advocacy. Medical case managers are expected to review health status indicators, service utilization, and treatment adherence.

Medical case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the Medical Case Management service provider.

III. ELIGIBILITY

Eligibility for medical case management services is explained under the Universal Standards for All Ryan White Part A Services Eligibility section.

Criteria for case assignment to Medical Case Management is based on a variety of factors (including but not limited to: acuity scores, poor health status as demonstrated by high viral load or low CD4 counts, acute opportunistic infection, or multiple needs). Assignment to Medical Case Management is determined by the criteria established by the Office of Health Policy (OHP). [A copy of the policy can be obtained from OHP.]

IV. SECTIONS

Note: Universal Standards apply to all service categories. This additional service specific standard contains the following sections:

→ Personnel	→ Assessment/Reassessment	→ Ongoing Assessments	→ Discharge/Transition
→ Enrollment in Part A Services	→ Individual Care Plan	→ General Standards	

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualifications**	
1.11	**Minimum qualifications**. All medical case managers will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are: • A currently licensed social worker (RSW, CSW, LMSW, LCSW) from a program accredited by the Council on Social Work Education; OR • A currently licensed nurse (RN or LPN) in Louisiana; OR • A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation; AND one (1) year of post-degree experience in direct service to HIV target population; OR • A bachelor's in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in item C of this part; AND one (1) year of post-degree experience in direct service to HIV target population.	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.12	**Minimum supervisory qualifications**: A medical case management supervisor must meet the *minimum* qualifications for education and experience listed below: A. A currently licensed social worker (RSW, CSW, LMSW, LCSW) from a program accredited by	Personnel files/resumes/applications for employment reflect requisite experience and education.

#	Standard	Measure
	the Council on Social Work Education and two years of paid post degree experience in providing case management services; OR B. A currently licensed nurse (RN or LPN) in Louisiana and two (2) years of paid post degree experience in providing case management services; OR C. A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two (2) years of paid post degree experience in providing case management services; OR D. A bachelor's in liberal arts or general studies with concentration of at least 16 hours in one of the fields listed above and two (2) years of paid post degree experience in providing case management services.	
1.2	**Supervision**	
1.21	**Minimum components of medical case management supervision**. A. Each Medical Case Management service provider must have and implement a written plan for supervision of all medical case management staff. B. Supervisors must review a 10 percent sample of each medical case manager's case records each quarter for compliance with these standards, and quality and timeliness of service delivery with special attention to Comprehensive assessments, Reassessments, Care Plans, tracking of appointments and health outcomes, transition planning and timely referral completion. Areas for improvement should be notated and shared with the medical case manager. C. Medical case managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	A. Service provider has written plan for supervision of all medical case management staff. B. Service provider will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews; the file contains medical case manager signature indicating notification of areas for improvement. C. Personnel files contain annual performance evaluations.
1.22	Each supervisor must maintain a file on each medical case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the medical case manager must include, at a minimum:	a. Documentation of supervision provided b. Supervisors' files on each medical case manager reflect ongoing supervision,

#	Standard	Measure
	• Date, and content of the supervisory sessions • Results of the supervisory case review addressing, at a minimum, completeness and accuracy of records, compliance with standards and effectiveness of service.	supervisory sessions and case review as described above.
1.23	Service provider must maintain linkage with a medical provider (nurse, nurse equivalent, or higher) to provide consultation for medically complex client cases. Agencies are preferred to employ or contract with a nurse.	Service provider must maintain a written consultation plan indicating the method by which routine consultation by a medical provider (nurse, nurse equivalent, or higher) takes place. The written plan should specify the purpose of consultation, the required frequency of consultation, and the minimum essential components of consultation. All consultative sessions should be documented in the client record. Evidence of job description and/or contract with a Louisiana registered nurse with a bachelor's degree in nursing, with experience in HIV and one year of paid experience as a registered nurse in a public health or human service field. Also, a written consultation plan shall be kept on file outlining how nurse will help develop comprehensive care plans for medically complex individuals, as well as offer trainings for medical case managers and general staff.
1.3	**Orientation – See Universal Standards for Tier X Staff**	
1.4	**Training – See Universal Standards for Tier X Staff**	
2.0	**ENROLLMENT IN PART A SERVICES**	
2.1	**The objectives of the enrollment process are to:** ➢ Inform the client of: • all Ryan White Part A funded services available AND	N/A

#	Standard	Measure
	• all Ryan White Part A funded medical case management agencies in the New Orleans EMA AND • what client can expect if s/he enrolls in medical case management services; ➢ Establish and/or verify client eligibility for services; ➢ Collect required state/federal client data for reporting purposes; and ➢ Complete a full Client Eligibility Review and Verification Form (CERV).	
2.2	All funded Medical Case Management agencies must be able to: ➢ Provide enrollment on a walk-in basis; ➢ Schedule an appointment at the client's convenience; ➢ Refer the client to another agency in the event of a waiting list or any capacity constraints prohibiting an agency from serving a client immediately.	Service Provider policy and procedures reflect the availability of walk-in services. Documented referral kept on file at the agency.
2.3	The presentation to the client of information regarding the Ryan White Part A service delivery system will include: A. Confidentiality, release of information, and HIPAA privacy notification as appropriate B. Statement of Consumer Rights and Responsibilities C. Service Provider grievance/complaint procedures	Documented in client's file.
2.4	Financial resources and insurance status shall be documented for all clients and payment shall be sought from any and all third party payers before using Ryan White Part A funds. Documentation of a discussion with each client regarding various options for payment shall be noted in client charts.	A. Documented CERV on file with client signature verifying discussion regarding application for Medicaid/SSI or other benefits resources and will document the dates of these activities. B. A supervisory review will assure that medical case managers are discussing options for alternative payment with each client on a quarterly basis.
3.0	**ASSESSMENT/REASSESSMENT**	
3.1	**The objectives of the assessment/reassessment process are to:** ➢ Establish whether client demonstrates need to enroll in medical case management services	N/A

#	Standard	Measure
	offered by the provider agency; ➢ Gather, on an on-going basis, appropriate client information in order to determine client needs; and ➢ Reassess eligibility verification at least every six (6) months or as required by change in client status, utilizing assessment tools as mandated by OHP. ➢ Conduct a comprehensive reassessment at least annually and to re-inform the client of: • all Ryan White Part A funded services available, AND • all Ryan White Part A funded medical case management agencies in the New Orleans EMA. • Client Rights and Responsibilities and Agency Grievance Policy	
3.2	**Initial Assessment** Within three (3) working days of enrollment, a comprehensive assessment of needs shall be completed to evaluate the client's needs, including, but not limited to the following: • Medical history and current health/primary care status • Available support systems • Substance abuse history and status • Emotional/mental health history and status • Available financial resources (including insurance status) with emphasis on securing 3rd-party insurance coverage, public benefits, and other resources. • Availability of food, shelter, and transportation • Need for legal assistance	Documented in client's file.
3.3	After completion of an initial comprehensive assessment of the client, results shall be reviewed and analyzed by a medical case management supervisor and/or multi-disciplinary team to determine appropriate level of case management services. Clients who are newly diagnosed or new to HIV care should be assigned to medical case management, unless justifiable documented circumstances dictate otherwise.	Client chart contains documentation of review by supervisor or multi-disciplinary team.
3.4	A medical case manager will be assigned within ten (10) working days of completion of enrollment. Immediate needs of eligible clients will be addressed appropriately with the available resources, within one business day of enrollment into services.	All contacts and attempted contacts must be documented in client's file.
3.5	Providers must demonstrate adequate linkages with Ryan White and non-Ryan White agencies to ensure timely coordination and referral to services to meet the client's needs.	Documented by memorandum of understanding and provider policies

#	Standard	Measure
4.0	**INDIVIDUAL CARE PLAN**	
4.1	**The objectives of the Individual Care Plan (ICP) process are to:** ➢ Create an action plan to support improved client health and wellbeing made up of goals and measurable objectives prepared with the participation of the client. ➢ Utilize information gathered during comprehensive assessments of clients in order to develop goals and objectives supporting client empowerment, self-efficacy and improvement in health outcomes. ➢ Utilize assessment tools to monitor and reevaluate the individual care plan. ➢ Review and revise the care plan in a way that supports the client's progress in achieving health-related goals.	N/A
4.2	An individual care plan, and any other assessment tools as required by OHP, will be completed within thirty (30) days following assignment to a medical case manager.	Documented in client's file.
4.3	The Individual Care Plan (ICP) will be a written, comprehensive plan consisting of goals and measurable objectives. The ICP must be prepared with client participation with the primary objective to achieve HIV treatment adherence. The ICP should be holistic in nature, identify barriers to overall wellbeing and stabilization and seek to resolve identified barriers (i.e., housing, substance abuse, self-efficacy etc.) Plans should include: A. Description of identified barriers • Resources available to meet each need • Nature and level of service need • Time frames within which services are to be provided • Who will provide the services • Short and long term goals for resolving each barrier • Documentation of outcomes for each goal	➢ Documentation shall include client's medically focused wellness needs and attempts to address identified barriers (including timeframe and names of providers involved). ➢ Implementation of the individual care plan will be documented through: i. Periodic follow-up and progress notes on each need identified ii. Periodic follow-up with each provider iii. Contact with client every 30-60 days depending on client's level of need, and in connection with monitoring client's progress, including revising of care plan iv. Re-evaluate and develop, as needed, new care plan every 6 months, which will be signed and dated by medical case manager.

#	Standard	Measure
5.0	**ONGOING ASSESSMENTS**	
5.1	**The objectives of ongoing assessments are to:** ➢ Assist case managers in tracking client health outcomes and medical treatment adherence by utilizing tools to both inform development of and monitor progress of individual care plans. ➢ Determine the client's acuity level as needed. ➢ Track client health outcomes and medical appointment attendance.	N/A
5.2	Medical case managers will utilize tools as mandated by OHP to track client status. When appropriate, information collected from ongoing assessments should be reflected in updates to individual care plans.	Documented in client's file.
6.0	**GENERAL STANDARDS**	
6.1	Each service provider providing medical case management services shall have an outreach program and/or working linkages in place designed to reach the population eligible for services and to target individuals with HIV/AIDS requiring multiple interventions, such as disproportionately affected and emerging populations.	• Written outreach plan and publicity/educational materials with evidence/record of distribution in targeted areas such as points of entry into the continuum of care (i.e., substance abuse services, homeless shelters); or • Linkage agreements and documented referrals from linked Service Providers.
6.2	Face to face contact will be made and repeated at least quarterly; home visits are preferable, if client permits.	Documented in client's file.
6.3	Contact with client attempted every 30-60 days depending on level of need.	Documented in client's file.
6.4	Medical Case Managers will refer clients for necessary services within 10 business days. Medical Case Managers will follow-up on the outcomes of referrals made.	Documented in client's file.
6.5	Medical Case Manager will review documentation of monitoring client's current immunological parameters (for example, CD4 count, and HIV viral load) and appointment adherence at least	Documentation of review of current

#	Standard	Measure
	quarterly.	immunological data in client's file
6.6	A **full-time Medical Case Manager** may manage a maximum caseload of 60 clients.	Job descriptions reflect maximum caseloads as described above.
6.7	A **Medical Case Management Supervisor** may supervise eight (8) full-time medical case managers or a combination of full-time medical case managers and other professional-level human services staff.	Caseloads are monitored to ensure that the maximum allowable standard is not exceeded.
6.8	In the event a funded agency is unable to adequately communicate in the client's preferred language, it is then the agency's responsibility to refer the client to an agency with the appropriate language capacity. If no such agency exists, interpretative services will be provided at no cost to the client.	Service Provider maintains updated documentation of staff's language capabilities, including the names and job titles of the specific staff with those skills. A list will be provided to OHP and updated as needed.
7.0	**DISCHARGE/TRANSITION**	
7.1	**The objectives of discharge/transition are to:** ➢ Ensure a smooth transition for a client no longer needing Medical Case Management services at the provider agency; ➢ Accurately track and document clients receiving case management services; and ➢ Assist service providers to appropriately monitor caseload.	N/A
7.2	A client may be discharged from medical case management services through a systematic process that includes a discharge/case closure summary in the client's record. Discharge/case closure summary will include a reason for the discharge and a transition plan to other services or other service provider. If client does not agree with the reason for discharge, s/he should be informed of the service provider's grievance procedure. A client may be discharged from case management services for the following reasons: a. if client no longer meets Ryan White eligibility standards; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency personnel or other clients at risk; d. if client moves out of the service area; if possible an attempt should be made to connect client to services in the new service area; e. if after repeated and documented attempts, a medical case manager is unable to reach a client for a minimum of three (3) months and maximum of six (6) months. Ideally case	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)

#	Standard	Measure
	managers should check in with their clients every 30-60 days depending on need. After a maximum of six (6) months, the program should discharge client from medical case management services or transfer a client as appropriate; f. death	
7.3	In all cases, medical case managers shall ensure that, to the greatest extent possible, clients who leave Medical Case Management are linked with appropriate services to meet their needs and are prepared for the transition. In the case a client changes agencies based on a recommendation in the best interest of their health, a medical case manager should inform the client of any changes in medication delivery/access and insurance coverage they may expect.	Documentation in client's record indicating referrals or transition plan to Non-medical Case Management or other service provider(s).

MEDICAL NUTRITION THERAPY

(Approved by Planning Council 12/17/07)

I. DEFINITION/OVERVIEW

Medical Nutrition Therapy (MNT) for Part A is the provision of nutrition education and/or counseling provided by a licensed/registered dietician/nutritionist. These services should adequately assess the nutritional status of clients and provide nutritional education.

II. SERVICES

Medical Nutrition Therapy (MNT) will include education/counseling for nutrition needs, development and provision of individual nutritional care plans and provide counseling in health promotion, disease progression and disease prevention as it relates to nutrition.

Other services may include referral for BMI (Body Mass Index), bioelectrical impedance analysis (BIA) or other appropriate measures of nutritional status, review of lab results to gauge nutritional status, nutritional supplement needs and medical nutritional therapy. Services may include the provision of nutritional supplements.

III. ELIGIBILITY

Eligibility requirements are outlined in the Universal Standards of Care for All Ryan White Part A services section. An order by a physician, nurse practitioner or physician's assistant is also required for client to receive Medical Nutrition Therapy (MNT).

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Part A services
- → General Standards
- → Coordination and Referral
- → Discharge/Transition

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	Staff and contracted workers have minimum qualifications, including licenses, certifications, and/or training expected and other experience related to the position.	Resume and documentation of training and orientations will be in personnel file.
1.2	Any person who represents him/herself as a licensed dietitian/nutritionist shall conform to the requirements of the Louisiana State Board of Examiners in Dietetics and Nutrition.	Record in personnel file.
1.3	Staff and supervisors will know the requirements of their job description and service elements of the program.	Written job description provided to and signed by staff and kept in personnel file.
1.4	Staff will possess one year experience (preferred) in the nutrition assessment, counseling, evaluation and care plans of people living with HIV/AIDS.	Employee personnel file shall reflect appropriate education, expertise and experience appropriate to their area of practice as well as in the area of HIV/AIDS practice.
1.5	Registered Dietitians/Licensed Nutritionists will maintain membership in the HIV/AIDS Dietetic Practice Group of the American Dietetic Association (ADA).	Record of membership in employee file
1.6	Registered Dietitians/Licensed Nutritionists will meet all standards for Medical Nutrition Therapy (MNT) as described in the ADA standards for MNT.	ADA standards kept on file and agency policies will reflect adherence to these guidelines.
1.7	Registered Dietitians/Licensed Nutritionists will maintain current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission of Dietetic Registration.	Training record in employee file.
1.8	All MNT staff members shall receive training to enhance their basic knowledge about HIV and AIDS and the continuum of care for people living with HIV/AIDS.	Staff will attend at least one training session in which information regarding HIV disease and needs of the population serviced is provided. Maintain copies of training verification in personnel file.

#	Standard	Measure
2.0	**REFERRAL TO MEDICAL NUTRITION THERAPY (MNT)**	
2.1	An order by a physician, nurse practitioner or physician's assistant is required for client to receive MNT.	Copy of physician, nurse practitioner or physician's assistant's order in client file.
2.2	Referral for MNT should include justification. At a minimum, justification *must* include: ▪ Relevant laboratory data ▪ Diagnosis and medical history ▪ Medications Additional justification *may* include but is not limited to: ▪ Nutrition prescription and desired outcome ▪ Alternative and complementary therapies ▪ Karnofsky score ▪ Living situation ▪ Other relevant information that impacts client's ability to care for self.	Copy of referral including required information in client file.
2.3	Dietician/nutritionist will have access to all client medical records.	Fully detailed MOU with primary care provider to ensure access to client's information. When client has a private provider, alternate agreements should be made as appropriate.
3.0	**GENERAL STANDARDS**	
3.1	An initial MNT assessment will be conducted by or under the supervision of a registered dietitian/nutritionist to ensure appropriateness of service.	Signed, dated nutrition assessment on file in client chart which includes all MNT protocol assessment information.
3.2	After the nutrition assessment is completed, a nutrition care plan will be developed, shared and mutually agreed upon with the client.	Signed, dated care plan including measurable goal oriented strategies on file in client records including: ▪ Relevant laboratory data ▪ Diagnosis and medical history ▪ Medications

#	Standard	Measure
		▪ Nutrition prescription and desired outcome ▪ Alternative and complementary therapies ▪ Living situation ▪ Illicit drug use ▪ Other relevant information that impacts client's ability to care for self.
3.3	Clients will be reassessed at least annually.	Signed, dated nutrition assessment on file in client chart which includes all MNT protocol assessment information.
3.4	Nutrition care plan will be updated as necessary and, with a signed and dated HIPAA compliance release, be shared with client's primary care provider and/or other personnel involved in client's care.	Update, signed plan on file in clients record. Signed, dated HIPAA compliance release of information and record of date that care plans were shared with primary care provider also in client record.
3.5	Nutrition intervention is based on the nutrition assessment and care plan.	Progress notes to detail content of ongoing nutrition counseling sessions and detailed intervention that will include self-management training and appropriate referrals. These progress notes will be shared with client's primary care provider.
3.6	Registered Dietitian/Licensed Nutritionist is able to provide 'Nutrition and HIV' training to clients and their providers in local HIV organizations and facilities.	Documentation of training and curricula on file at agency.
3.7	Registered Dietitian/Licensed Nutritionist will provide nutrition education material to referred clients.	Material that promotes proper nutrition and food safety will be on file at agency and available to the

#	Standard	Measure
		clients.
4.0	**COORDINATION AND REFERRAL**	
4.1	Providers must establish formal referral relationships and linkages to HIV primary medical care or medical case management.	MOU and other formal documentation of linkages between primary care, case management and other services in the community will be kept on file with appropriate updates and signatures.
5.0	**DISCHARGE/TRANSITION**	
5.1	Agency will have a written policy for discharge and transition for MNT.	Documentation in the client's record: ▪ That client received discharge policy indicating the reason the client was discharged. ▪ Discharge notification sent to client.

MEDICAL TRANSPORTATION SERVICES

(Approved by Planning Council 9/24/07)

I. DEFINITION/OVERVIEW

Medical Transportation Services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. Services may be provided routinely or on an emergency basis.

II. SERVICES

This category offers transportation services to HIV/AIDS infected individuals and accompanying essential caregiver and/or child(ren) others to access health care services, including routine and emergency rides and destinations as supported by client need. Services may include the following modes of transportation: distribution of vouchers, such as public transit tokens and/or passes, gasoline vouchers, van and taxi services.

III. ELIGIBILITY

Eligibility is established per the requirements of the Universal Standards of Care for all Ryan White Part A services section. Ryan White Part A funds are funds of last resort. Contractors are responsible for doing routine screening for third party payer.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Intake/Referral into Medical Transportation Services
- → Independent Requests for Service
- → General Provisions
- → Services
- → Coordination and Referral

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	

#	Standard	Measure
1.1	**Staff Qualification**	
1.11	Driver Qualifications and Driver's license: All paid and volunteer drivers must hold all licensing required by the State of Louisiana pertaining to the provision of transportation services as described herein.	Agency maintains documentation of all required licenses, driving records, and proof of insurance for every transportation provider.
1.12	Funded agency must contract with licensed vendor or and keep on file driving record check for each driver and proof of insurance for each vehicle providing transportation. Proof of current automobile liability insurance is required for at least the minimum required by the State of Louisiana.	Copy of current insurance certification and driving record check.
1.2	**Orientation**	
1.21	**Orientation**. Service providers shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to clients within ten (10) working days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum: a. HIV Basic Science and Psychosocial issues b. Basic overview of Ryan White Part A services and providers c. Client rights and responsibilities d. Confidentiality (with signed confidentiality agreement) e. Client relations f. Cultural competency/sensitivity g. Professional ethics h. Programmatic requirements including applicable Standards of Care and protocol for assessment treatment adherence	Orientation program educates staff on above described required subject matter. Personnel file reflects completion of orientation and signed job description
1.3	**Training**	
1.31	Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services annually, as determined by Agency personnel policy. Staff salaries that encompass 25% of Ryan White Part	Personnel files of sub-contractors staff reflect eight (8) hours of training annually.

#	Standard	Measure
	A funds must complete eight (8) hours. Appropriate and professional-training priorities for training should include but not be limited to: current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, etc.), and cultural sensitivity	
2.0	**INTAKE/REFERRAL INTO MEDICAL TRANSPORTATION SERVICES**	
2.1	Referral into medical transportation services shall be accessed by referral from a Ryan White Part A case manager	Documentation of eligibility verification provided by referring agency is maintained in client's file.
2.2	Referring agency shall provide a complete CERV and justification form for taxi as well as van services.	Client justification form.
3.0	**INDEPENDENT REQUESTS FOR SERVICE**	
3.1	Clients independently requesting or inquiring about transportation services, who have not yet been referred for same, shall be referred by the transportation coordinating provider to a case management agency and who will refer eligible clients back to the coordinating agency in a timely manner.	Provider written plan for redirecting client.
3.3	Clients who discontinue the program will be required to reestablish eligibility before resuming service.	Provider written policy.
3.4	If transportation cannot be provided by transportation providers, the coordinating agency will notify the case management agency that other arrangements need to be made.	Provider written policy.
4.0	**GENERAL PROVISIONS**	
4.1	Transportation agency shall provide information to clients and to referring agencies on the specific programs offered, (e.g.: van/car service, taxi vouchers, gas vouchers, bus passes and tokens, and other options available to meet client needs.)	Documentation exists to show how referring agencies are informed of transportation services.

#	Standard	Measure
4.2	In accordance with HRSA guidelines and the Universal Standards, essential caregiver and/or child(ren) others will be allowed to accompany HIV infected person, as necessary for the benefit and support of the infected individual.	Client's relation to individual is documented.
4.3	**Vehicle Safety**	
4.31	All vehicles used to transport clients shall be in good repair, equipped for adverse weather conditions, and carry evidence of periodic inspection as required by law.	All vehicles used to transport clients carry evidence of current inspection ("brake tag.").
4.32	Agency shall have written protocols for employees and subcontractors to follow in case of emergencies.	Written emergency protocols are distributed and available to staff, volunteers and subcontractors.
4.33	Agency's procedures shall include use of seatbelts/restraint systems as required by law, including use of child safety seats as applicable.	Appropriate safety systems are installed in vehicles.
5.0	**SERVICES**	
5.1	Providers shall specify criteria, policies, and procedures utilized to determine voucher allotments for clients, taking into account degrees of need for the service.	Criteria, policies, and procedures to determine allotments are maintained and available to referring agencies.
5.2	Provider must have the ability to provide round trip transportation to all appointments.	Written policy regarding services available to clients.
5.3	Provider must maintain detailed legible records of UIN of individuals provided with transportation, and origin and destination for all taxi, van and gas voucher trips. The UINs of	Records are maintained showing, clients served, origin and

#	Standard	Measure
	individual receiving bus tokens will also be recorded.	destination for all trips.
5.4	Transportation service shall be prompt and dependable.	Documented in agency's written policy
5.5	Agency shall assure transportation coverage throughout the EMA either directly or through collaboration with other transportation providers.	As monitored by OHP.
5.6	Agency shall assure accommodation of transportation needs of disabled individuals in accordance with the Americans with Disabilities Act.	Agency will maintain records of monitoring compliance with safety standards, driver qualifications, and adequacy of equipment for safety of disabled individuals.
5.7	Agency subcontracting for services shall go through an objective bid process prior to awarding contracts.	Records are maintained documenting bid process for any subcontractors.
5.8	Providers may reimburse clients for mileage up to the approved IRS reimbursement rate.	Written policy regarding reimbursement rate
6.0	**COORDINATION AND REFERRAL**	
6.1	Providers shall show on-going collaboration/linkages with HIV/AIDS service organizations and other community service organizations within the New Orleans EMA.	Documentation reflects collaboration and referral system.
6.2	Providers shall have a documented referral system in place.	Provider's written referral plan

MENTAL HEALTH

(Approved by Planning Council 6/24/13)

I. DEFINITION/OVERVIEW

Mental health services are the provision of psychological and psychiatric treatment and counseling services, for individuals with a diagnosed mental illness, conducted individually and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed mental health professionals.

II. SERVICES

Mental health counseling services include intensive mental health therapy and counseling provided solely by state-qualified mental health professionals.

III. ELIGIBILITY

Eligibility is established per requirements of Eligibility in the Universal Standards of Care for All Ryan White Part A Services section. Ryan White Part A funds are funds of last resort. Contractors are responsible for doing routine screening for third party payer.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Mental Health
- → Intake into Mental Health
- → Assessment/Service Planning
- → Collaboration and Referral
- → Discharge and Transition
- → Quality Assurance

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	

#	Standard	Measure
1.11	**Minimum qualifications:** All staff providing direct mental health services to clients must be qualified within the laws of the State of Louisiana to provide mental health services in one of the following professions: a. Clinical social worker b. Marriage and family therapist c. License professional counselor d. Psychologist e. Psychiatrist f. Psychiatric nurse g. Psychotherapist	A. Personnel files/resumes/applications for employment reflect requisite experience/education B. Current License will also be maintained.
1.12	**Minimum Supervisory qualifications:** A mental health supervisor must be a licensed clinical mental health professional.	A. Personnel files/resumes/applications for employment reflect requisite experience/education B. Current License will also be maintained.
1.2	**Orientation**	
	Orientation: shall be provided to all staff within ten (10) working days of employment including at minimum: a. Crisis intervention procedures b. Louisiana Mental Health Code c. Confidentiality d. Documentation in case records e. Consumer rights and responsibilities f. Consumer abuse and neglect reporting policies and procedures g. Professional ethics h. Emergency and safety procedures	Personnel file reflects completion of orientation and signed job description.

#	Standard	Measure
	i. Data management and record keeping j. Infection control and universal precautions k. Review of job description l. Programmatic requirements including applicable Standards of Care	
1.3	**Training**	
1.31	Additional training required during the first ninety (90) days of employment. In addition to the required initial orientation, during the first ninety (90) calendar days of employment all new employees must receive additional training related to the target group to be served and specific knowledge, skills and techniques necessary to provide services to the target group. This training must be provided by an individual with demonstrated knowledge of both the training topics and the target group and must include at minimum: A. HIV basic science B. Insurance, disability and financial access issues C. Psychosocial issues of the HIV-infected client D. Resource identification E. Cultural competency	Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training and signature of employee.
1.32	Continuing education/in-service training: Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-service annually, as determined by agency personnel policy	Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training and signature of employee.
1.4	**Supervision**	
	Minimum components of mental health care supervision: A. Each mental health service provider must have and implement a written plan for regular supervision of all unlicensed staff. B. Notes of weekly supervisory conferences shall be maintained for such staff.	1. Agency has written plan of supervision. 2. Supervisors' files reflect notes of weekly supervisory conferences. 3. Personnel files contain annual

#	Standard	Measure
	C. Staff subject to formal supervision must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	performance evaluations.
2.0	**REFERRAL TO MENTAL HEALTH**	
2.1	Referral into Mental Health shall be accessed by referral from a Ryan White Part A case manager.	Documentation of eligibility verification provided by referring agency is maintained in client's file.
3.0	**INTAKE INTO MENTAL HEALTH**	
3.1	Presentation to the client of information regarding the HIV service delivery system, including: a. Confidentiality and release of information b. Statement of Consumer Rights and Responsibilities c. Agency grievance/complaint procedures d. Alternative service providers e. After-hours emergency/crisis intervention contact procedures	Client's central file contains the appropriate intake documentation required of the agency.
3.2	An appointment will be scheduled within three (3) working days of a client's request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a more timely manner.	Client chart contains documentation of each item listed above
3.3	Financial resources, insurance and/or Medicaid/Medicare status of all clients shall be documented and payment shall be sought from any and all third party payers before using Ryan White Part A funds.	Documentation in client's file.
4.0	**ASSESSMENT/SERVICE PLANNING**	
4.1	Initial assessment protocols shall provide screening of individuals to determine needs and appropriate service plan.	Documentation individual client service plan.

#	Standard	Measure
4.2	The Agency shall arrange **24-hour crisis response** by qualified crisis intervention staff for active clients who may experience emotional emergencies. The protocol will require documentation in client's file.	Agency written protocol for crisis intervention.
4.3	A **service plan** shall be completed within 30 days that is specific to individual client needs. The service plan shall be prepared and documented for each client. Individual, and family case records will include documentation of the following: a. Eligibility b. Psychosocial assessment c. Treatment plans, including goals and objectives d. Progress notes e. Referrals f. Discharge summary	Documentation in client's file.
4.4	Client and family participation in service planning shall be maximized.	Client's service plan.
4.5	Agency shall not exceed caseload set forth for licensing guideline for mental health by the Office of Mental Health.	The Agency maintains records of staff caseloads and staffing provided for each case and licensing.
5.0	**COORDINATION AND REFERRAL**	
5.1	Providers shall show ongoing collaboration/linkages with HIV/AIDS service organizations within the Greater New Orleans EMA.	Documentation reflects collaboration and referral system.
5.2	Providers shall have a documented referral system in place.	Referral list and policy.
5.3	Case conferences with members of the client's multi-disciplinary care team shall be held with client's consent and as appropriate.	Client records include documentation of multi-disciplinary

#	Standard	Measure
		case conferences.
5.4	In the event that a funded agency is unable to adequately communicate in the client's preferred language, it is then the agency's responsibility to refer the client to an agency with the appropriate language capacity. If no such agency exists, interpretative services will be provided at no cost to the client.	Agency maintains updated documentation of staff's language capabilities, including the names and job titles of the specific staff with those skills. A list will be provided to OHP and updated as needed.
6.0	**DISCHARGE/TRANSITION**	
6.1	The objective of discharge/transition planning is to ensure a smooth transition for a client no longer needing services at the provider agency.	Not Applicable
6.2	A client may be discharged from mental health services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the provider agency's grievance procedure. A client may be discharged from HIV mental health services for the following reasons: a. death; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency, case manager, or other clients at risk; d. if client moves out of the service area; if possible an attempt should be made to connect client to services in the new service area; or; e. if after repeated and documented attempts, a mental health worker is unable to reach a client for a period of twelve (12) months. This criterion recognized that some clients require only minimal services, such as information and referral; thus, may be having only periodic contact with the mental health worker. Ideally a mental health worker	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)

#	Standard	Measure
	should check in with their clients monthly as determined by client need, but at a minimum of every six (6) months. If after a maximum of twelve (12) months, the mental health worker has made repeated attempts to reach a client and is unsuccessful, the client should be discharged from mental health services at the agency.	

VI. QUALITY ASSURANCE

#	Standard	Measure
7.0	Professional standards of practice and ethics shall be followed by all mental health professionals in accordance with licensing for the individual discipline represented.	The Agency has a written quality assurance/performance improvement (QA/PI) plan. Staff personnel files reflect training in QA/PI as appropriate.
7.1	Agency shall maintain a quality assurance/improvement program designed to monitor the quality of services delivered to the client.	Written QA/QI plan and documentation of implementation.

NON-MEDICAL CASE MANAGEMENT

(Approved by Planning Council 7/27/15)

I. DEFINITION/ OVERVIEW

Non-Medical Case Management provides advice and assistance to empower clients to access a variety of necessary services (including medical, social, community, legal and financial) to support medically related outcome measurements.

Clients will have varying levels of need throughout their enrollment in services. Clients who demonstrate a low level of need may benefit from *Non-medical Case Management*. Distinct case management categories are described under separate sections (See description for Medical Case Management).

Enrollment in either medical case management (active) or non-medical case management (direct services only) is not permanent; a client may move from one type of case management to the other depending on current circumstances. Ongoing and frequent assessment by a non-medical case manager and a medical case management supervisor should occur to ensure clients receive the appropriate level of care. Routine assessment tools and acuity scales must be used consistently by all Medical Case Management providers, as mandated by the Office of Health Policy (OHP). [Copies of tools can be obtained from OHP.]

II. SERVICES

Key activities include: (1) completion of comprehensive assessment of service needs conducted by a non-medical case manager meeting the same qualifications as a medical case manager, (2) coordination of services required to support health outcomes, and (3) periodic reevaluation of client needs. Non-medical case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the Non-Medical Case Management service provider.

Clients with a lower level of need, requiring only the direct services offered or referred by the service provider would benefit from *Non-Medical Case Management*. Assignment to either Medical or Non-Medical Case Management is based on criteria as established by the Office of Health Policy.

III. ELIGIBILITY

Eligibility for non-medical case management services is explained under the Universal Standards for All Ryan White Part A Services Eligibility section.

IV. SECTIONS

Note: Universal Standards apply to all service categories. This additional service specific standard contains the following sections:

→ Personnel	→ Assessment/Reassessment	→ Discharge/Transition
→ Enrollment into Part A system	→ General Standards	→ Coordination and Referral

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualifications**	
1.11	**Minimum qualifications**: All case managers will meet the qualifications for the position as outlined in the service provider's job description. The minimum requirements are: a. A bachelor's degree (preferred) in any field; OR b. Three (3) years of experience regarding HIV services AND a minimum of a high school diploma/GED (required).	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.12	**Minimum supervisory qualifications**: A Non-Medical case management supervisor must meet the *minimum* qualifications for education and experience listed below: E. A currently licensed social worker (RSW, CSW, LMSW, LCSW) from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing case management services; OR F. A currently licensed nurse (RN or LPN) in Louisiana and two (2) years of paid post degree experience in providing case management services; OR G. A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two (2) years of paid post degree experience in providing case management services; OR H. A bachelor's in liberal arts or general studies with concentration of at least 16 hours in one	Personnel files/resumes/applications for employment reflect requisite experience and education.

#	Standard	Measure
	of the fields listed in item C of this part and two (2) years of paid post degree experience in providing case management services.	
1.2	**Supervision**	
1.21	**Minimum components of case management supervision**. A. Each case management service provider must have and implement a written plan for supervision of all case management staff. B. Supervisors must review a 10 percent sample of each case manager's case records each quarter for completeness, compliance with these standards, and quality and timeliness of service delivery. C. Case managers must be evaluated at least annually by their supervisor according to written service provider policy on performance appraisals.	• Service provider has written plan for supervision of all case management staff. • Service provider will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews • Personnel files contain annual performance evaluations.
1.22	Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	• Documentation of supervision provided • Supervisors' files on each case manager reflect ongoing supervision, supervisory sessions and case review as described above.
1.3	**Orientation – See Universal Standards for Tier X Staff**	
1.4	**Training – See Universal Standards for Tier X Staff**	
2.0	**ENROLLMENT INTO PART A SERVICES**	
2.1	**The objectives of the enrollment process are to:** ➢ Inform the client of: • all Ryan White Part A funded services available AND • all Ryan White Part A funded case management agencies in NO EMA AND • what client can expect if s/he enrolls in case management services; ➢ Establish and/or verify client eligibility for services; ➢ Collect required state/federal client data for reporting purposes; and	N/A

#	Standard	Measure
	➢ Completion of a full Client Eligibility Review and Verification Form (CERV).	
2.2	Funded Non-Medical Case Management service providers must be able to: ➢ Provide enrollment on a walk-in basis; ➢ Schedule an appointment at the client's convenience; ➢ Refer client to another service provider in the event of a waiting list or any capacity constraints prohibiting a provider from serving a client immediately.	Service provider policy and procedures reflect the availability of walk-in services. Documented referral kept on file at the agency.
2.3	The presentation to the client of information regarding the Ryan White Part A service delivery system will include: • Confidentiality and release of information, and HIPAA privacy notification as appropriate • Statement of Consumer Rights and Responsibilities • Service provider grievance/complaint procedures	Documented in client's file.
2.4	Financial resources and insurance status for all clients shall be documented and payment shall be sought from any and all third party payers before using Ryan White Part A funds. Documentation of a discussion with each client regarding various options for payment shall be noted in client charts.	• Documented CERV on file with client signature verifying discussion regarding application for Medicaid/SSI or other benefits resources and will document the dates of these activities. • A supervisory review will assure that case managers are discussing options for alternative payment with each client on a quarterly basis.
3.0	**ASSESSMENT/REASSESSMENT**	
3.1	**The objectives of the assessment/reassessment process are to:** ➢ Establish whether client demonstrates a need or continued need to enroll in non-medical case management services offered by the service provider; ➢ Gather on an on-going basis appropriate client information in order to determine client needs; ➢ Reassess at least every six months or as required to respond to a change in client status, utilizing assessment tools as mandated by OHP.	N/A

#	Standard	Measure
3.2	**Initial Assessment** Within three (3) working days of enrollment, a comprehensive needs assessment shall be completed to evaluate the client's needs, including, but not limited to the following: • Medical history and current health/primary care status • Available financial resources (including insurance status) with emphasis on securing 3rd-party insurance coverage, public benefits, and other resources. • Availability of food, shelter, and transportation • Available support system • Need for legal assistance • Substance abuse history and status • Emotional/mental health history and status	Client chart contains documentation of each client's need for (or problems with) food, substance abuse treatment, childcare, transportation, obtaining and storing medications, etc. Such information should be general and all-inclusive.
3.3	After completion of initial comprehensive needs assessment, results shall be reviewed and analyzed by a supervisor and/or multi-disciplinary team to determine appropriate level of case management services. Clients who are newly diagnosed or new to HIV care should be assigned to medical case management, unless justifiable documented circumstances dictate otherwise.	Client chart contains documentation of review and case assignment by supervisor or multi-disciplinary team.
3.4	Complete comprehensive reassessment should occur annually.	Client chart contains documentation.
3.5	In order to maintain appropriate provision of services to clients, providers are expected to ensure the availability of both Medical and Non-Medical Case Management. OHP will monitor to verify clients are assigned based on the documented client need as related to established criteria.	Client file appropriately scored per acuity scales with cases assigned to categories based on need levels as documented.
3.6	Upon reassessment and review of client record by supervisor or multi-disciplinary team, a client may be assigned to medical case management.	Documentation in client file.
3.7	Providers must demonstrate adequate linkages with Ryan White and non-Ryan White agencies to ensure timely coordination and referral to services to meet the client's needs.	Documented by memorandum of understanding and provider policies
4.0	**GENERAL STANDARDS**	
4.1	Each service provider providing case management services shall have an outreach program and/or working linkages in place designed to reach the population eligible for services and to target individuals with HIV/AIDS requiring multiple interventions, such as disproportionately	• Written outreach plan and publicity/educational materials with evidence/record of distribution in targeted areas; or

#	Standard	Measure
	affected and emerging populations.	• Linkage agreements and documented referrals from linked service providers.
4.2	Does not require service plan	Documentation of reason client is under non-medical case management (acuity scale score)
4.3	At minimum, a semi-annual face-to-face contact will occur with each client and will include an assessment/reassessment of eligibility.	All contacts and attempted contacts must be documented
4.4	If client presents with increased need, a reassessment should occur and client should be referred into Medical Case Management.	Documented in the program's policy.
4.5	In the event a funded service provider is unable to adequately communicate in the client's preferred language, it is then the service provider's responsibility to refer the client to service provider with the appropriate language capacity. If no such service provider exists, interpreter services will be provided at no cost to the client.	Service provider maintains updated documentation of staff's language capabilities, including the names and job titles of specific staff. A list will be provided to OHP and updated as needed.
4.6	Non-Medical Case Manager will review documentation of monitoring client's current immunological parameters (for example, CD4 count, and HIV viral load) and appointment adherence at least semi-annually.	Documentation of review of current immunological data in client's file
4.7	A **full-time Non-Medical Case Manager** may manage a maximum active caseload of 100 clients.	Job descriptions reflect maximum caseloads as described above.
4.8	A **Case Management Supervisor** may supervise eight (8) full-time case managers or a combination of full-time case managers and other professional-level human services staff.	Caseloads are monitored to ensure the maximum allowable standard is not exceeded.
5.0	**DISCHARGE/TRANSITION**	

#	Standard	Measure
5.1	**The objective of discharge/transition planning are to:** ➢ Ensure a smooth transition for a client no longer needing services at the service provider or moving to medical case management; ➢ Accurately track and document clients receiving non-medical case management services; and assist service providers to more easily monitor caseload.	
5.2	A client may be discharged from case management services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the service provider's grievance procedure. A client may be discharged from HIV case management services for the following reasons: • if client no longer meets Ryan White eligibility standards; • at the request of the client (client no longer needs or desires services); • if a client's actions put the service provider personnel or other clients at risk; • if client moves out of the service area; if possible an attempt should be made to connect client to services in the new service area; • if after repeated and documented attempts, a case manager is unable to reach a client for a period of twelve (12) months. Ideally case managers should check in with their clients as determined by client need, but at a minimum of every six (6) months. If after twelve (12) months, the case manager has made repeated attempts to reach a client and is unsuccessful, the client should be discharged from case management services at the service provider; • death.	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)
5.3	In all cases, case managers shall ensure that, to the greatest extent possible, clients who leave Non-medical Case Management are linked with appropriate services to meet their needs and are prepared for the transition. For example, if a client were moving to another area, the case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to Medical Case Management or other provider(s).

ORAL HEALTH CARE

(Approved by Planning Council 05/22/2017)

I. DEFINITION/OVERVIEW

Oral health care is the provision of diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists, and auxiliaries.

The Oral Health Care Service Standard refers to service providers operating under contract with the Office of Health Policy and AIDS Funding as well as those entities subcontracted to provide services by a Ryan White Part A funded agency. In addition, **all Part A service providers who subcontract services with non-Part A providers should refer to Section 6 of the Universal Service Standards**, which detail requirements and recommendations for all Ryan White Part A subcontractors.

II. SERVICES

- → Services available will include routine dental examinations, prophylaxis, x-rays, fillings, replacements, endodontistry, treatment of gum disease and lesions, and oral surgery.
- → Emergency procedures will be treated on a walk-in basis as availability and provisions allow at clinics. If clinics cannot provide adequate services for emergency care, the client will be referred to the emergency room.
- → Services will not include cosmetic, non-medically required, dental care.

III. SECTIONS

In this document, you will find:

- → Personnel
- → Intake into Oral Health
- → General Standards
- → Coordination and referral
- → Discharge/Transition

IV. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Licensing/Accreditation: Dentists Dentists must have documentation as specified by the State of Louisiana, including dental school degree, malpractice insurance, drug license and Louisiana State Board of Dentistry license.	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.3	**Supervision**	
1.31	Dental hygienists and assistants must perform all services to clients under supervision of a licensed dentist.	Copy of supervising dentist license on file.
2.0	**INTAKE INTO ORAL HEALTH**	
2.1	Proper referral form from case management	Documentation in client's file.
2.2	Staff informs client of HIV delivery service issues: d. Confidentiality and release of information e. Statement of Consumer Rights and Responsibilities f. Agency grievance/complaint procedures	D. Agencies will maintain documentation of the above for each patient. E. Patient Satisfaction Surveys will be conducted periodically. Providers will retain client sign in lists with dates, check-in and checkout times noted.
3.0	**GENERAL STANDARDS**	
3.1	Eligible clients shall receive services within 45 days for routine diagnostic care. Emergencies may be addressed on a walk-in basis or within 72 hours. If clinics cannot provide adequate services for emergency care, the client will be referred to hospital care at nearest Emergency Department.	Providers shall submit updated lists of all services provided. The lists will include: written justification by dentist of HIV-relation to services

#	Standard	Measure
		needed, follow-up treatment expected, and any diagnostic and preventive care administered.
3.2	Providers are required to demonstrate that they will adhere to the clinical standards of care accepted for the dental treatment of HIV-specific illnesses and for oral health care techniques.	Personnel files/resumes/applications for employment reflect requisite experience/education.
3.3	Case manager or physician may issue referrals for oral surgery, endodontistry, treatment of lesions, or other specialized care.	Referral documentation in client's file.
3.4	Provider's physical plant will comply with appropriate building, zoning, health and safety codes and be clean, well-ventilated, properly lighted, heated, air conditioned, maintained and handicapped accessible.	Appropriate certificates of compliance.
4.0	**COORDINATION AND REFERRAL**	
4.1	Providers must demonstrate adequate linkages with HIV services organizations and community based organizations providing HIV services.	A. Agencies will provide documentation of previous or current contracts or MOUs with the HIV community OR B. Supervisory staff will provide certification of completion of training on HIV issues in oral and dental care, related diseases, and maintenance.
5.0	**DISCHARGE/TRANSITION**	
5.1	Provider will have written policy for discharge, transition, and referrals for specialty care.	Provider written policy for discharge, transition, and referrals for specialty care.

OUTREACH SERVICES

(Approved by Planning Council 8/27/07)

I. DEFINITION/OVERVIEW

Outreach services are intended to identify individuals who know their status or those of unknown status so that they may become aware of the availability of Part A services and access care and treatment.

Activities must be planned and delivered in coordination with State and local HIV prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes.

Individual outreach is defined as activities aimed at locating individuals who are aware of their HIV status so that they may be successfully linked into Primary Medical Care. Individuals who are not aware of their HIV status should be linked to Early Intervention Services (EIS) or a collaborative prevention program. Activities should be conducted in such a manner as to reach those known to have delayed seeking care.

II. SERVICES

Outreach services may include both case finding and consumer recruitment through street outreach. Street outreach activities should be designed to find individuals who are at high risk of HIV and to refer those individuals into care and treatment services (such as Early Intervention Services (EIS), Primary Medical Care (PMC) and Medical Case Management (MCM). Case finding activities should also be targeted to reach populations known to be at disproportionate risk for HIV infection, as demonstrated through local epidemiologic data.

Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who know their HIV status but are not actively in treatment. Quantified program reporting is required to assist local planning and evaluation efforts. Broad activities that market the availability of health-care services for PLWH are not considered appropriate Part A outreach services. HIV prevention education, counseling and testing are not allowable activities under this service category. Outreach providers are required to collaborate with State and local prevention programs.

III. ELIGIBILITY

Outreach services pertain to linking HIV positive individuals or non-HIV positive individuals into care. This shall only require that the individual being served is a resident of the EMA. (See Universal Standards, Verification of Eligibility sections 1.1 and 1.3) Financial eligibility verification shall not apply.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Part A services
- → Coordination and Referral
- → Discharge/Transition

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Service providers will employ staff who are knowledgeable and experienced regarding HIV outreach and the HIV continuum of care (i.e. care and clinical resources).	Documentation in employee's file.
1.2	**Orientation**	
1.21	Service providers shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to clients within ten (10) working days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum: A. HIV Basic Science and Psychological Issues B. HIV Outreach techniques and procedures C. Infection Control D. Client rights and responsibilities E. Confidentiality F. Client relations G. Cultural competency/sensitivity H. Safety in the workplace I. Professional ethics J. Employee rights and responsibilities	1. Presence of an orientation program that educates staff on above described required subject matter. 2. Personnel file reflects completion of orientation and signed job description. 3. OHP will monitor compliance with training and continuing education requirements. 4. Failure to comply with training components may result in suspension and could result in subsequent loss of

#	Standard	Measure
	K. Programmatic requirements including applicable Standards of Care L. General understanding of available resources M. List of current resources. N. Centers for Disease Control and Prevention (CDC) and United States Public Health Service (USPHS) guidelines	funding. 5. A signed confidentiality agreement is in all staff files. 6. Presence of CDC and USPHS regulations and guidelines on HIV counseling, testing and referral will be kept on file at site
1.22	Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related education programs/in-services annually, as determined by the agency personnel policy.	Personnel files reflect eight (8) hours of training annually.
1.3	**Training**	
1.31	Training in HIV outreach and counseling is required for all staff funded under this initiative. Training services are offered through Louisiana Office of Public Health HIV/STD Program.	Documentation in personnel file or training log
1.32	Ongoing training for staff must be provided to appropriate staff to maintain current knowledge about outreach.	Documentation in personnel file or training log
2.0	**REFERRAL TO PART A SERVICES**	
2.1	Identified HIV positive individuals will be referred to a Part A Early Intervention Services or Medical Case Management provider or directly to a Primary Medical Care provider to facilitate transition to Primary Medical Care. Outreach providers shall follow-up with agencies to which clients were referred.	A written referral process (such as a referral log or client specific documentation) and documentation of follow-up to agencies to which clients were referred, as well as follow-up with clients. Written client consent must be obtained and kept on file

#	Standard	Measure
		in order to follow-up with referral. A good faith effort to obtain such consent must be documented.
3.0	**COORDINATION AND REFERRAL**	
3.1	Providers must establish formal referral relationships and linkages to HIV primary care, case management, and other services in the HIV continuum of care as appropriate. Outreach should work to expand the provider network to include relationships with local points of entry, both short and long term. Outreach providers will partner with community based access points to identify and refer HIV positive clients not in care into the health care system.	MOU and other formal documentation of linkages between primary care, case management and Outreach sites will be kept on file with appropriate updates and signatures.
4.0	**DISCHARGE/TRANSITION**	
4.1	Client will be considered discharged upon successful referral to EIS or case management provider or primary care provider	1. With client consent, documentation of client contact with EIS or case management or primary medical care. OR 2. Written note indicating that client expressly refused referral services OR 3. Documented attempts at multiple follow-up attempts through data management system

PSYCHOSOCIAL SUPPORT SERVICES

(Approved by Planning Council 6/24/13)

I. DEFINITION/OVERVIEW

Psychosocial support services are the provision of support and counseling activities such as child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Nutritional counseling under this category should be provided by a non-registered dietitian and excludes nutritional supplements.

This can include individual and group counseling as well as counseling for affected individuals and families.

II. SERVICES

Support counseling includes such services as HIV support groups, caregiver support, and bereavement counseling.

III. ELIGIBILITY

Eligibility is established per the requirements of the Universal Standards of Care for all Ryan White Part A services section. Ryan White Part A funds are funds of last resort. Contractors are responsible for doing routine screening for third party payer. These services may be accessed by affected individuals and families.

Funds awarded under the Ryan White HIV/AIDS Program may be used for services to individuals not infected with HIV only in the circumstances described below.

a. The service has as its primary purpose enabling the non-infected individual to participate in the care of someone with HIV disease or AIDS.

b. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care.

c. The service promotes family stability for coping with the unique challenges posed by HIV/AIDS.

d. Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral into Psychosocial Support Services
- → Intake into Psychosocial Support Services
- → Assessment/Reassessment
- → Coordination and Referral
- → Discharge/Transition
- → Quality Assurance

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	**Minimum qualifications:** All staff providing Psychosocial Support Services must meet the minimum training expectations outlined in 1.2 and 1.3 and as determined by the agency.	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.12	**Minimum Supervisory qualifications:** A psychosocial support services supervisor must be a licensed clinical mental health professional with a minimum of a master's degree.	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.2	**Orientation**	
1.21	Orientation shall be provided to all staff, within ten (10) working days of employment including at minimum: a. Louisiana statutes pertinent to the services provided b. Documentation in case records c. Consumer rights and responsibilities	Orientation program educates staff on these subject areas. Personnel file reflects completion of orientation and a signed job description.

#	Standard	Measure
	d. Consumer abuse and neglect reporting policies and procedures e. Emergency and safety procedures f. Data management and record keeping requirements g. Programmatic requirements including applicable Standards of Care h. HIV basic science i. Psychosocial issues of the HIV infected client/affected family j. Communication and listening skills k. Ethics and accountability l. Confidentiality/HIPAA m. Review of job description n. Rules and policies of the program o. Basic infection control and universal precautions p. Recognizing an individual in crisis q. Crisis intervention procedures r. Empowerment and self-efficacy s. Consumer roles and responsibilities on HIV/AIDS planning bodies t. Ryan White Part A Services and other services available in the community	
1.3	**Additional Training**	
1.31	In addition to the required initial orientation, during the first ninety (90) calendar days of employment all new employees must receive additional training related to the target group to be served and specific knowledge, skills and techniques necessary to provide services to the target group. This training must be provided by an individual with demonstrated knowledge of both the training topics and the target group and must include at minimum: a. HIV basic science b. Access issues related to insurance, disability and finances c. Psychosocial issues of the HIV-infected client/affected family d. Resource identification	Personnel files reflect training log with documentation of subject matter and attendance at sixteen (16) hour comprehensive educational program during first ninety (90) days of employment.

#	Standard	Measure
	e. Cultural and linguistic appropriateness	
1.32	Continuing education/in-service training: Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-service annually, as determined by agency personnel policy.	Documented in personnel file or training log.
1.4	**Supervision**	
1.41	**Minimum components of psychosocial support services supervision:** Each psychosocial support services provider must have and implement a written plan for regular supervision of all non-licensed staff.	Agency has written plan of supervision.
1.42	Notes of supervisory conferences shall be maintained for such staff.	Supervisors' files reflect notes of supervisory conferences.
1.43	Agency shall maintain a relationship with a mental health professional for consultation as needed by peers and agency staff on issues pertaining to client counseling and for consultation in the event of a potential mental health crisis.	Documentation of agency agreement with mental health professional
1.44	Peers will consult with clients' Case Manager to address, as needed, consistent and relevant care for each client. Peers will advocate for clients in navigating the continuum of care when necessary.	Documentation of peer's consultation with client's Case Manager
1.45	Staff subject to formal supervision must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Personnel files contain annual performance evaluations.
2.0	**REFERRAL INTO PSYCHOSOCIAL SUPPORT SERVICES**	

#	Standard	Measure
2.1	Entry into psychosocial support services shall be accessed by a referral from a Ryan White Part A case manager.	Documentation of eligibility verification provided by referring agency is maintained in clients' file.
3.0	**INTAKE INTO PSYCHOSOCIAL SUPPORT SERVICES**	
3.1	An appointment will be scheduled within three (3) working days of a client's request for psychosocial support services. In emergency circumstances, an appointment will be scheduled within one work day. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timely manner.	Client chart contains documentation.
3.2	The intake process will include: a. Verification of eligibility for services b. Presentation to the client of information regarding the HIV service delivery system, including: a. Confidentiality and release of information b. Statement of Consumer Rights and Responsibilities c. Agency grievance/complaint procedures d. Alternative service providers e. After-hours emergency/crisis intervention contact procedures	Client chart contains documentation of each item listed.
3.3	Financial resources, insurance and/or Medicaid/Medicare status of all clients shall be documented and payment shall be sought from any and all third party payers before using Ryan White Part A funds.	Client chart contains documentation.
4.0	**ASSESSMENT/REASSESSMENT**	
4.1	Initial assessment protocols shall provide for screening of individuals to distinguish level of need and appropriate service plan.	Client chart contains documentation.
4.2	Agency shall have a written protocol in regard to managing 24 hour crisis situations.	Documentation of agency

#	Standard	Measure
		regarding crisis protocol.
4.4	A service plan shall be completed within 30 days that is specific to individual client needs. The service plan shall be prepared and documented for each client. Individual, family and group case records will include documentation of the following: a. Eligibility b. Psychosocial assessment c. Treatment plans, including goals and objectives d. Progress notes e. Referrals f. Discharge summary	A. Client chart contains documentation. B. Client files are reviewed for goals and outcomes periodically.
4.5	Attendance records and monthly progress summary shall be kept for group therapy sessions.	Group attendance log.
4.6	Client and family participation in service planning shall be maximized.	Client chart contains documentation.
5.0	**COORDINATION AND REFERRAL**	
5.1	Providers shall show ongoing collaboration/linkages with HIV/AIDS service organizations within the Greater New Orleans EMA.	Documentation reflects collaboration and referral system.
5.2	Providers shall have a documented referral system in place.	Agency's written referral procedure.
5.3	Case conferences with members of the client's multi-disciplinary care team shall be held as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.

#	Standard	Measure
6.0	**DISCHARGE/TRANSITION**	
6.1	A client may be discharged from psychosocial support services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the provider agency's grievance procedure. A client may be discharged from HIV support counseling services for the following reasons: a. death; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency, agency staff, or other clients at risk; d. if a client's behavior is disruptive to the provision of services; e. if the client becomes ineligible for Ryan White services.	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)

VI. QUALITY ASSURANCE

#	Standard	Measure
7.0	Professional standards of practice and ethics shall be followed by all Psychosocial Support Services staff in accordance with licensing for the individual discipline represented.	Written standards and code of ethics.
7.1	The Agency shall monitor staff caseload to ensure that they are manageable for clinicians so that high quality services can be uniformly provided.	The Agency maintains records of staff caseloads and staffing provided for each case

REFERRAL FOR HEALTH CARE/SUPPORTIVE SERVICES

(Approved by Planning Council 10/28/13)

I. DEFINITION/OVERVIEW

Referral for Health Care/Supportive Services directs a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of Ambulatory/Outpatient Medical Care or Case Management Services.

This can include individual and group counseling.

II. SERVICES

Services may include benefits/entitlement counseling and referral or assistance to determine client eligibility for other public and private programs, e.g., Medicaid, Medicare Part D, the health insurance Marketplace.

III. ELIGIBILITY

Eligibility is established per the requirements of the Universal Standards of Care for all Ryan White Part A services section. Ryan White Part A funds are funds of last resort. Contractors are responsible for routine screening for third party payers.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral into Referral for Health Care/Supportive Services
- → Intake into Referral for Health Care/Supportive Services
- → Assessment/Reassessment
- → Coordination and Referral
- → Discharge/Transition

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	**Minimum qualifications:** All staff providing Referral for Health Care/Supportive Services must meet the minimum training expectations outlined in 1.2 and 1.3 and as determined by the agency. Staff must hold a minimum of a Bachelor's degree or evidence of certification or proficiency in the areas outlined in 1.2 and 1.3.	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.12	**Minimum supervisory qualifications:** A Referral for Health Care/Supportive Services supervisor must hold a master's degree in a human service related field which includes: psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation.	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.2	**Orientation**	
1.21	Orientation shall be provided to all staff, within ten (10) working days of employment including at minimum: a. Documentation in case records b. Consumer rights and responsibilities c. Consumer abuse and neglect reporting policies and procedures d. Emergency and safety procedures e. Data management and record keeping requirements f. Programmatic requirements including applicable Standards of Care g. HIV basic science h. Psychosocial issues of the HIV infected client/affected family i. Communication and listening skills j. Ethics and accountability k. Confidentiality/HIPAA	Orientation program educates staff on these subject areas. Personnel file reflects completion of orientation and a signed job description.

#	Standard	Measure
	l. Review of job description m. Rules and policies of the program n. Basic infection control and universal precautions o. Recognizing an individual in crisis p. Crisis intervention procedures q. Empowerment and self-efficacy r. Consumer roles and responsibilities on HIV/AIDS planning bodies s. Ryan White Part A Services and other services available in the community t. Access issues related to insurance, disability and finances u. Entitlement and benefit programs other than Part A services	
1.3	**Additional Training**	
1.31	In addition to the required initial orientation, during the first ninety (90) calendar days of employment all new employees must receive additional training related to the target group to be served and specific knowledge, skills and techniques necessary to provide services to the target group. This training must be provided by an individual with demonstrated knowledge of both the training topics and the target group and must include at minimum: a. Resource identification b. Education on applications for eligibility under entitlement and benefit programs other than Part A services will be included and periodically updated as changes occur c. Multi-disciplinary team communications a. Cultural and linguistic appropriateness	Personnel files reflect training log with documentation of subject matter and attendance at sixteen (16) hour comprehensive educational program during first ninety (90) days of employment.
1.32	Continuing education/in-service training: Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-service annually, as determined by agency personnel policy.	Documented in personnel file or training log.
1.4	**Supervision**	

#	Standard	Measure
1.41	**Minimum components of Referral for Health Care/Supportive Services supervision:** A. Each Referral for Health Care/Supportive Services provider must have and implement a written plan for regular supervision of all non-licensed staff. B. Supervisors must review a 10 percent sample of case records each month for completeness, compliance with standards, and quality and timeliness of service delivery with special attention to status of benefits, service plans, tracking of health outcomes, transition planning and timely referral completion. Areas for improvement should be noted and shared with staff. C. Referral for Health Care/Supportive Services staff must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	A. Agency has written plan for supervision. B. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews; the file contains staff signature indicating notification of areas for improvement. C. Personnel files contain annual performance evaluations.
2.0	**REFERRAL INTO REFERRAL FOR HEALTH CARE/SUPPORTIVE SERVICES**	
2.1	Entry into Referral for Health Care/Supportive Services shall be accessed by a referral from a clinician, primary care provider or Ryan White Part A case manager.	Documentation of eligibility verification provided by referring agency is maintained in clients' file.
3.0	**INTAKE INTO REFERRAL FOR HEALTH CARE/SUPPORTIVE SERVICES**	
3.1	An appointment will be scheduled within three (3) working days of a client's request for Referral for Health Care/Supportive Services. In emergency circumstances, an appointment will be scheduled within one work day. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timely manner.	Client chart contains documentation.
3.2	The intake process will include: a. Verification of eligibility for services	Client chart contains documentation of each item listed.

#	Standard	Measure
	b. Presentation to the client of information regarding the HIV service delivery system, including: i. Confidentiality and release of information ii. Statement of Consumer Rights and Responsibilities iii. Agency grievance/complaint procedures iv. Alternative service providers v. After-hours emergency/crisis intervention contact procedures	
4.0	**ASSESSMENT/REASSESSMENT**	
4.1	Initial assessment protocols shall provide for screening of individuals to distinguish level of need and appropriate action plan related to obtaining and managing benefits. The documented action plan should address status of benefits, needs, resource gaps, and specific goals specific to obtaining and utilizing appropriate benefits. Assessments should be coordinated with client's Case Manager as appropriate.	Client chart contains documentation.
4.2	Review of action plan should occur at least every six months and should include status of benefits and utilization.	Client chart contains documentation.
4.3	Reassessment, if not completed by client's Case Manager, should occur at least every six months and should include screening of eligibility, benefits, health status information.	Client chart contains documentation.
5.0	**COORDINATION AND REFERRAL**	
5.1	Providers shall show ongoing collaboration/linkages with HIV/AIDS service organizations within the Greater New Orleans EMA as well as insurance vendors.	Documentation reflects collaboration and referral system.
5.2	Providers shall have a documented referral system in place.	Agency's written referral procedure.

#	Standard	Measure
5.3	Case conferences and/or care coordination with members of the client's multi-disciplinary care team shall be held as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.
5.4	Provider shall demonstrate previous experience working with insurance providers, health care providers, and clients in efforts to maximize health insurance benefits.	Documentation of linkage agreement with insurance provider.
5.5	Providers shall establish adequate linkages with insurance providers as appropriate for the reimbursement of co-payments in order that clients receive needed medical care in a timely manner.	Documentation of linkage agreement with insurance provider.
6.0	**DISCHARGE/TRANSITION**	
6.1	A client may be discharged from Referral for Health Care/Supportive Services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the provider agency's grievance procedure. A client may be discharged from HIV support counseling services for the following reasons: a. death; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency, agency staff or other clients at risk; d. if the client's behavior is disruptive to the provision of services; e. if the client becomes ineligible for Ryan White services; f. if after repeated and documented attempts, the staff person is unable to reach a client for a minimum of three (3) months. This criterion recognized that some clients require only minimal services, such as information and referral; thus, may be having only periodic contact with the Referral staff person.	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)

SUBSTANCE ABUSE TREATMENT SERVICES - OUTPATIENT

(Approved by Planning Council 4/30/12)

I. DEFINITION/OVERVIEW

Substance abuse treatment services - Outpatient is the provision of medical treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal or illegal drugs) provided in an outpatient setting by qualified personnel.

Provision of treatment and/or counseling addresses substance abuse, addiction, and dependency for alcohol and other drugs. A goal of the continuum of substance abuse treatment is to encourage individuals to access primary care services and adhere to HAART as well as other treatments indicated. All treatment providers will be in compliance with standards as stipulated by the State of Louisiana Department of Health and Hospitals. Additionally, providers will have specific knowledge, experience, and services regarding the needs of persons with HIV/AIDS.

II. SERVICES

Examples of services include regular, ongoing substance abuse treatment and counseling offered on an individual and/or group basis by a state-licensed provider. Services must include provision of or links to the following: recovery readiness; harm reduction; 12-step model; rational recovery approach model; aftercare; mental health counseling to reduce depression; anxiety; and other disorders associated with substance abuse; medical treatment for addiction; and drug-free treatment and counseling. The needs of women with children and persons with disabilities will be considered.

Interdisciplinary collaboration is required across the various groups that work with the substance abusing population and those at risk. Collaborators should share general best practices to overcome philosophical barriers and client specific care plans to coordinate medical treatment.

III. ELIGIBILITY

Eligibility for substance abuse treatment services is explained under the Universal Standards of Care for All Ryan White Part A Services Eligibility section.

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral into Substance Abuse Treatment Services
- → Intake into Substance Abuse Treatment Services
- → General Standards
- → Assessment/Reassessment and Service Planning
- → Coordination and Referral

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.11	**Staff Qualification**	
	Minimum qualifications: All staff providing direct substance abuse counseling or treatment services to clients will meet the qualifications for the position as outlined in the agency's job description. a. Graduate degree in substance abuse counseling or MSW with at least 1 year experience in substance abuse, *OR* b. Licensed Addiction Counselor (LAC) or equivalent training, *OR* c. Counselor In Training (CIT) supervised by appropriate licensed/certified professional, *OR* d. Counselor Intern supervised by appropriate licensed/certified professional, AND e. Medical care will be overseen by a physician when addiction medications are administered. f. Staff qualified within the laws of the state of Louisiana to provide mental health service in one of the following professions: clinical social workers, marriage and family therapists, professional counselors, psychologists, psychiatrists, psychiatric nurses, and psychotherapists.	A. Proof of licenses and certifications indicated in "minimum qualifications." B. Documentation of supervision during client interaction with CITs or Interns. C. Documentation of all addiction medications are administered and signature of a physician overseeing procedure.
1.12	**Minimum supervisory qualifications.** A substance abuse treatment supervisor must be	Proof of licenses and

#	Standard	Measure
	licensed and credentialed in accordance with all applicable State laws and regulations (RS 37:3387.5).	certifications indicated in "minimum qualifications."
1.2	**Orientation**	
	Orientation. Orientation shall be provided to all staff within ten (10) working days of employment, including at a minimum: a. Crisis intervention procedures b. Louisiana Mental Health Code c. Standards of Care d. Confidentiality e. Documentation in case records f. Consumer Rights and Responsibilities g. Consumer abuse and neglect reporting policies and procedures h. Professional Ethics i. Emergency and safety procedures j. Data Management and record keeping k. Infection Control and universal precautions l. Review of job description m. Programmatic requirements, including applicable Standards of Care	Personnel file reflects completion of orientation and signed job description.
1.3	**Training**	
1.31	**Additional training required during the first ninety (90) days of employment:** In addition to the required initial orientation, during the first ninety (90) calendar days of employment, all new employees must receive additional training related to the target group to be served and specific knowledge, skills, and techniques necessary to provide services to the target group. This training must be provided by an individual with demonstrated knowledge of both the training topics and the target group and must include a minimum of: a. HIV basic science b. Coinfection treatment education c. Treatment adherence, including medications resistance	Documentation included in the employee file reflects the date of training, contents, name of trainer, topic, and length of training and signature of employee.

#	Standard	Measure
	d. Interactions/complications of concurrent substance use with HIV treatments e. Cultural competency f. Insurance, disability and financial access issues g. Resource identification h. Psychosocial issues of the HIV infected client/affected family	
1.32	Continuing education/in-service training. In accordance with the State Department of Health and Hospitals and other state licensing and credentialing boards all direct care staff must satisfactorily complete the required hours in continuing education training. A minimum of eight (8) hours of professional developmental training must be in substance abuse treatment and HIV/AIDS related education.	Documentation included in the employee file that reflects date of training, contents, name of trainer, topic, length of training, and signature of employee.
1.4	**Supervision**	
1.41	Minimum components of substance abuse treatment supervision:	
1.42	Each substance abuse treatment provider must have and implement a written plan for regular supervision of all staff by a licensed supervisor with a minimum of a Master's degree in accordance with all applicable laws and regulations.	Agency has written plan for supervision of all staff.
1.43	Notes of weekly supervisory conferences shall be maintained for such staff.	Supervisor's files reflect notes of weekly supervisory conferences.
1.44	Staff must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Personnel files contain annual performance evaluations.
2.0	**REFERRAL INTO SUBSTANCE ABUSE TREATMENT SERVICES**	
2.1	Referral into substance abuse treatment services shall be accessed by a referral from a Ryan White Part A case manager. In the event that a client self refers the provider will contact a Part A case manager to coordinate a referral into substance abuse treatment services.	Documentation of eligibility verification provided by referring agency is maintained in clients' file.

#	Standard	Measure
2.2	Justification for referral must be documented by referring provider.	Documented in the client's file.
3.0	**INTAKE INTO SUBSTANCE ABUSE TREATMENT SERVICES**	
3.1	An appointment will be scheduled within three (3) working days of a client requesting substance abuse treatment services. In emergency circumstances, appointments will be scheduled within one (1) working day. If services cannot be provided within these time frames, the agency will offer to refer the client to another organization to provide the requested services in a timelier manner.	Client chart contains documentation of each item listed above
3.21	The intake process will include: a. Professional diagnosis of substance abuse and/or dependency for alcohol and/or other drugs b. Verification of Medicaid/Medicare eligibility	Client chart contains documentation.
3.22	Presentation to the client of information regarding the HIV service delivery system, including: a. Confidentiality and release of information forms b. Statement of consumer rights and responsibilities c. Agency grievance/complaint procedures d. Alternative service providers e. After hours emergency/crisis intervention contact procedures	Client chart contains documentation.
3.3	Financial resources, insurance and/or Medicaid/Medicaid status of all clients shall be documented and payment shall be sought from any and all third party payers before using Ryan White Part A funds.	Client chart contains documentation.
3.4	In the event that a funded agency is unable to adequately communicate in the client's preferred language, it is then the agency's responsibility to refer the client to an agency	Agency maintains updated documentation of staff's language

#	Standard	Measure
	with the appropriate language capacity. If no such agency exists, interpretative services will be provided at no cost to the client.	capabilities, including the names and job titles of the specific staff with those skills. A list will be provided to OHP and updated as needed.
4.0	**GENERAL STANDARDS**	
4.1	Provider's physical plant will comply with appropriate building, zoning, health, and safety codes. Facilities will be clean, well ventilated, properly lighted, heated, air-conditioned, and maintained.	Evidence of current unconditional license and /or certification is on file for each provider and for organization as a whole, where applicable.
4.2	Agency must be in compliance with the Americans with Disabilities Act (ADA) to indicate full accessibility by all clients. If not in compliance at the time of funding, agency must demonstrate a plan, including timeline, to become compliant within the funding time period.	Evidence of current unconditional license and /or certification is on file for each provider and for organization as a whole, where applicable.
4.3	Services must follow State guidelines of the Department of Health and Hospitals, RS 40:1058.1 – RS 40:1058.10.	Evidence of current unconditional license and /or certification is on file for each provider and for organization as a whole, where applicable.
5.0	**ASSESSMENT/REASSESSMENT AND SERVICE PLANNING**	
5.1	Assessment protocols shall provide for screening of individuals to determine level of need and appropriate service plan. The assessment shall include: 1. The presenting problem	Client chart contains documentation of each item

#	Standard	Measure
	2. Substance abuse history 3. Medical and psychiatric history 4. Treatment history	listed.
5.2	The client will be given a clear explanation of the facility's philosophy and treatment practices as well as treatment options and information about, and referral to, other agencies as appropriate.	Client chart contains documentation.
5.21	The provider will attempt to determine what other services are being received by the client, and agencies providing services will maintain active interdisciplinary collaboration with each other in order to optimize care and avoid duplication of services.	Client chart contains documentation.
5.23	Informed consent shall be obtained prior to initiation of any and all treatment. Clients shall be informed of all treatments, medications, and protocols that are considered experimental, and written informed consent to participate in any experimental treatment will be expressly obtained.	Client chart contains documentation.
5.24	The agency will have protocols for crisis intervention and referral to the appropriate level of service.	Documentation on site.
5.25	A comprehensive treatment plan specific to individual client needs shall be established. A. An initial treatment plan shall be established within thirty (30) days and will include the following documentation: a. Medical and psychosocial assessment b. Treatment plans, including goals and objectives with designated target dates B. The treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to	Client chart contains documentation.

#	Standard	Measure
	therapy.	
5.26	Client records will include the following: a. Eligibility b. Medical and psychosocial assessment c. Treatment plans, including goals and objectives with designated target dates d. Progress Notes e. Referrals f. Discharge Summary	Client chart contains documentation.
5.27	Attendance records shall be kept for group sessions.	Attendance log on site.
5.28	Client and family participation in service planning should be maximized.	Documentation on site.
6.0	**COORDINATION AND REFERRAL**	
6.1	Providers shall demonstrate on-going collaboration/linkages with HIV/AIDS service organizations and other community service organizations within the New Orleans EMA.	Documentation reflects collaboration and referral system on site.
6.2	Providers shall have a documented referral system in place.	Documentation of referral system on site.
6.3	Case conferences with members of the client's multi-disciplinary team shall be held, as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.
6.0	**Discharge/Transition**	
6.1	A client may be discharged from substance abuse services through a systematic process	Documentation of case closure in

#	Standard	Measure
	that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the provider agency's grievance procedure. A client may be discharged from the program for the following reasons: a. death; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency, case manager, or other clients at risk; d. if client moves out of the service area; if possible an attempt should be made to connect client to services in the new service area; or e. if after repeated and documented attempts, and a substance abuse provider is unable to reach a client for a period of twelve (12) months.	client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)
6.2	In all cases, the provider shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the provider would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the provider may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to other providers/agencies

TREATMENT ADHERENCE COUNSELING

(Approved by Planning Council 12/17/12)

I. DEFINITION/OVERVIEW

Treatment Adherence Counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS Treatments by non-medical personnel outside of the medical case management and clinical setting.

II. SERVICES

Education and counseling interventions may include: individual one-on-one antiretroviral therapy (ART) education; one-on-one adherence supports through one or more modalities; group education; group counseling; multidisciplinary education and counseling interventions; and peer support. Education and counseling services should use specific adherence tools such as reminder devices and interactive communication technologies. These services are intended to be available to clients of all Ryan White Part A funded agencies.

Note: Standards of Care for Treatment Adherence Counseling specifically apply to services delivered by treatment adherence specialist outside of clinical settings. Clinical personnel may also provide adherence-related services to patients in clinical settings. Services delivered by Medical Case Managers and/or clinicians should be recorded as activities of Medical Case Management and/or Ambulatory/Outpatient Medical Care. Treatment adherence specialist delivered services are intended to supplement, not supplant, clinical encounters and must be coordinated across the multidisciplinary care team.

III. ELIGIBILITY

Per requirements of Eligibility in the Universal Standards of Care for All Ryan White Part A Services section. Ryan White Part A funds are funds of last resort.

Provision of these services should be targeted to the following case scenarios: treatment failure or change in treatment regime, including starting a new treatment regime.

IV. SECTIONS

In this document you will find:

→ Personnel
→ Referral to Treatment Adherence Counseling
→ Intake into Treatment Adherence Counseling
→ General Standards
→ Coordination and referral
→ Discharge/Transition

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	*Minimum Qualifications:* ▪ 18 years of age or older ▪ High School diploma or GED ▪ Completion of HIV related education training course from a grantee approved training program ▪ Basic knowledge of and service delivery skills related to the following: o Communication skills o Cultural sensitivity *Preferred:* ▪ Basic computer skills (particularly Microsoft Word and Excel) ▪ Person Living with HIV/AIDS (PLWHA) ▪ Bilingual Spanish/English capacity ▪ Basic knowledge of and service delivery skills related to the following: o Clinical science of HIV/AIDS o Current HIV treatment therapies o Mental health and substance use/abuse o Client confidentiality ▪ Knowledge of available health and social services	Personnel files/resumes/applications for employment reflect requisite experience/education.
1.2	**Orientation**	
1.21	The objectives of staff orientation are: ➢ To educate staff on general policies, procedures and expectations for the position. ➢ To ensure health educators are knowledgeable about available medical and support services.	N/A

#	Standard	Measure
	➢ To ensure staff know and understand programmatic requirements, including the Standards of Care.	
1.22	**General Staff Orientation**: Orientation of at least eight (8) hours must be provided to all staff within ten (10) working days of employment, including, at a minimum: a. Confidentiality with signed confidentiality agreement b. Documentation in case records c. Consumer rights protection and reporting of violations d. Consumer abuse and neglect reporting policies and procedures e. Professional ethics f. Client rights and responsibilities g. Employee rights and responsibilities h. Emergency and safety procedures i. Data management and record keeping j. Infection control and universal precautions k. Eligibility verification procedures l. Review of job description	Personnel file reflects completion of orientation and signed job description.
1.23	Additional orientation of sixteen (16) hours is required during the first thirty (30) days of employment. Topics covered must include orientation to the target population, the HIV service delivery system in the New Orleans Eligible Metropolitan Area (EMA), and information about treatment adherence including but not limited to: a. List of current resources and sources for updated information b. Programmatic requirements, including Ryan White Part A Standards of Care c. Treatment adherence concepts d. Interviewing, counseling and interpersonal skills e. HIV and STI Basic Science and Psychological Issues	Personnel file reflects completion of additional orientation.
1.3	**Training**	
1.31	The objective of staff training is to ensure a standard level of knowledge and skills among treatment adherence specialists to support the provision of quality care to PLWHA.	N/A
1.32	To ensure provision of quality services, staff (including supervisors) must be knowledgeable	Documented in personnel file.

#	Standard	Measure
	and skilled in the topic areas listed below. Basic training in the following areas is required during the first ninety (90) days of employment. Training provided to new staff by the agency must be provided by an individual with demonstrated knowledge of both the training topics and the target group: a. Motivational interviewing b. Treatment adherence c. Medications resistance d. Treatment as Prevention (TasP) strategies e. Health outcome measures f. Health literacy g. Psychosocial issues of the client/affected family h. Cultural sensitivity i. Multi-disciplinary team communications j. National HIV/AIDS Strategy (NHAS)	
1.33	Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services annually, as determined by agency personnel policy. Appropriate and professional training priorities should include, but are not limited to: current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, etc.), and cultural sensitivity.	Personnel files reflect eight (8) hours of training annually.
1.4	**Supervision**	
1.41	*Minimum Supervisory Qualifications:* An appropriate supervisor must meet the *minimum* qualifications for education and experience listed below: ▪ A bachelor's (required) or master's degree (preferred) in a human service field which includes: psychology, education, counseling, public health, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two (2) years of paid post degree experience in providing health education/risk reduction and/or HIV-related services. ▪ OR a registered nurse. AND	Personnel files/resumes/applications for employment reflect requisite experience and education.

#	Standard	Measure
	▪ Demonstrated knowledge about health education and risk reduction interventions (required). *Thirty (30) hours of graduate level course credit in the human services-related field may be substituted for the two (2) years of required paid experience. All experience must be obtained after completion of the degree or licensure and must be professional level experience.*	
1.42	Each supervisor must maintain a file on each treatment adherence specialist supervised and hold supervisory sessions on at least a weekly basis. The file on the treatment adherence specialist must include, at a minimum: Date, time, and content of the supervisory sessions, and results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	Documentation of supervision provided Supervisors' files on each treatment adherence specialist reflect ongoing supervision, supervisory sessions and case review as described above.
2.0	**REFERRAL TO SERVICE**	
2.1	Any member of the multidisciplinary care team (including, but not limited to physician, nurse, prescriber, case manager, clinician, and patient) can recommend referral into services. Referral to this service requires a current CERV.	Client's file reflects referral
3.0	**INTAKE INTO SERVICE**	
3.1	Proper referral form from case management	Documentation in client's file.
3.2	An appointment will be scheduled within five (5) working days of a client referral to treatment adherence counseling services.	Client chart contains documentation
3.3	Staff informs client of HIV service delivery related policies and procedures: a. Confidentiality and release of information b. Statement of Consumer Rights and Responsibilities c. Agency grievance/complaint procedures	F. Agencies will maintain documentation of the above for each patient. G. Patient Satisfaction Surveys will be conducted periodically. H. Providers will retain client sign in lists with dates, check-in and check-out times noted.

#	Standard	Measure
3.4	To promote a multidisciplinary approach, all relevant forms and assessments should be forwarded from the referring entity to the treatment adherence specialist upon client consent to release information. Information to be shared should include copies of the CERV and comprehensive assessment form. Copies of lab reports, listing of medication regime, information on pharmacy fills, etc., should also be shared as applicable. The reason for the referral should be documented.	Client chart contains documentation
4.0	**ASSESSMENT/REASSESSMENT/ADHERENCE SERVICES**	
4.1	An adherence plan should be developed collaboratively between the client and treatment adherence specialist. The plan will document the mutual intention and expectations of the provider and client and should include goals, objectives, interventions, modalities, and any other aspects of the counseling services.	The written adherence plan documented in the client chart should, at a minimum, include treatment education with the following components: ▪ Factual information about the medications, including side effects ▪ Known drug interactions ▪ The importance of adherence ▪ Known consequences of 'drug holidays' ▪ The potential for drug resistance ▪ Importance of successful regimen ▪ Patient and provider tasks ▪ Projected goals and proposed timelines
4.2	Services should be responsive to the client's current situation. Reassessment should occur every three (3) months at a minimum.	Client chart contains documentation of semi-annual reassessment

#	Standard	Measure
4.3	Treatment adherence specialist will provide one-on-one patient education to make available information about HIV disease and treatments. All education contacts will be documented.	Progress notes on file in patient chart at a minimum will include: ▪ Date, duration, type of contact ▪ What occurred during the contact ▪ Signature and title of the person providing the contact ▪ Referrals provided and interventions made ▪ Results of referrals, interventions, and progress made toward goals in the adherence plan
4.4	Treatment adherence specialist may provide one-on-one patient contact to support patients as they seek and receive services. Support can include: ▪ Accompanying patients to medical visits, including clinical trials visits ▪ Helping patients understand HIV disease and treatment options ▪ Helping patients understand and address any barriers to adherence ▪ Providing emotional support	Progress notes on file in patient chart at a minimum will include: ▪ Date, duration, type of contact ▪ What occurred during the contact ▪ Signature and title of the person providing the contact ▪ Referrals provided and interventions made ▪ Results of referrals, interventions, and progress made toward goals in the adherence plan
4.5	Treatment adherence specialist may provide group sessions to support patients as they seek and receive services.	Progress notes on file in patient chart at a minimum will include: ▪ Date, duration, type of contact ▪ What occurred during the

#	Standard	Measure
		contact ▪ Signature and title of the person providing the contact
5.0	**GENERAL STANDARDS**	
5.1	Policies and procedures shall exist to ensure compliance with program requirements including all client eligibility requirements communicated by the Mayor's Office of Health Policy and the Universal Standards of Care.	Provider maintains policies and procedures designed to ensure compliance with client eligibility requirements. Client files contain required eligibility data.
5.2	Agency shall monitor for programmatic compliance on a periodic basis.	Provider has documentation of self-monitoring for programmatic compliance.
5.3	Services shall be accessible by public transportation or through arrangement with transportation service providers. Services should be delivered in a confidential setting in accordance with client needs, including delivery in a community-based setting.	Provider is located in an area accessible by public transportation, or by documented special arrangement with transportation providers.
5.4	All services will be provided in such a way as to overcome barriers to access and utilization, including efforts to accommodate linguistic and cultural diversity.	Provider maintains a list of interpreters. There is documentation of staff training to explain information in plain language and with cultural sensitivity.
6.0	**COORDINATION AND REFERRAL**	
6.1	A copy of the adherence plan, as well as updates related to progress towards achieving plan goals, should be communicated to the referring providers.	Client chart contains documentation that the plan and progress reports are shared with referring providers.
6.2	Routine communication, such as case conferences, between treatment adherence	Client chart contains

#	Standard	Measure
	specialist, case manager, physician, and other key treatment team members (e.g. pharmacist, behavioral health providers, housing provider, etc.) should occur as needed to ensure a multidisciplinary approach and to avoid any potential duplication.	documentation that routine multidisciplinary coordination case conferences occur.
6.3	Providers must demonstrate adequate linkages with AIDS service organizations and Community based organizations providing HIV services.	Agencies will provide documentation of previous or current contracts or Memorandums of Understanding.
7.0	**DISCHARGE/TRANSITION**	
7.1	Provider will have written policy for discharge, transition and referrals for other services.	Provider written policy for discharge, transition and referrals for specialty care.
7.2	Achievement of the goals outlined in the adherence plan and/or demonstrated improvement of health indicators may indicate the client no long needs the service. A mutually agreed upon transition plan should be developed and implemented as appropriate. The transition plan should include plans for ongoing support and communication across the multi-disciplinary team, including notification to the referring entity.	Client chart will indicate achievement of goals/health indicators and reflect a signed and dated transition/discharge plan as mutually developed and agreed upon by the client and provider.
7.3	Clients should not be terminated from services until it is clear that a mutually agreed upon discharge/transition plan is appropriate. If the client falls out of service, then the provider will follow-up for 30 days. A case closure summary will be completed for each client upon cessation of services.	Documentation of attempts to contact client will be in client chart. Client chart will include signed and dated case closure summary which will include summaries of adherence success or remaining challenges, any referrals, reason for termination, as well as a relapse prevention plan.

STATEMENT OF CONSUMER RESPONSIBILITIES

1. RESPECT, COURTESY, AND CONFIDENTIALITY – YOU HAVE THE RESPONSIBILITY

To treat health and social service providers and staff with respect and courtesy at all times.

2. GIVING CORRECT AND COMPLETE INFORMATION – YOU HAVE THE RESPONSIBILITY

To give your provider accurate and complete information about your health condition and social situation, medication use, past and current treatment and the names and addresses of other providers you are using or have used. You must give this information to the best of your ability. You are responsible for coming to appointments with your providers prepared to ask questions if needed and be able to tell them about things that concern you. This makes it easier for the providers to give you the best information about your care.

3. SEEKING FACTS ABOUT YOUR CARE – YOU HAVE THE RESPONSIBILITY

To ask questions about the care you are receiving if you do not completely understand it. This means that you should know about the risks, benefits and financial aspects of your care. You also have the right to have advocate/s ask about this information.

4. FOLLOWING THE TREATMENT PLAN – YOU HAVE THE RESPONSIBILITY

To follow a treatment plans that you and your provider/s have agreed upon. You have the responsibility to tell your provider right away if you decide to stop treatment or go against your provider's advice. You are responsible for what happens to you.

5. SCHEDULED APPOINTMENTS – YOU HAVE THE RESPONSIBILITY

To keep appointments that you and your providers have scheduled. If you have to cancel, you are responsible for telling your provider that you will not be there.

6. COMMUNICATING YOUR FINANCIAL NEEDS – YOU HAVE THE RESPONSIBILITY

To give accurate and complete information about third-party payers, (like insurance companies, Medicaid, Medicare, etc.) to your providers and their facilities. You should make sure that you give them any forms that they may ask for, or to send in any forms that are required of you as soon as you possibly can. You also have the responsibility to talk to your providers about your financial situation, regarding your financial needs and tell them of you need help in figuring out what your financial needs are before you start receiving services from your provider.

7. RULES AND REGULATIONS OF SERVICE PROVIDER ORGANIZATIONS – YOU HAVE THE RESPONSIBILITY

To follow the rules and regulations of your providers and their agencies/facilities**.**

8. VOICING COMPLAINTS AND GRIEVANCES – YOU HAVE THE RESPONSIBILITY

To voice complaints and presenting grievances in an appropriate and timely manner. You should do this by following the providers' grievance policies and procedures and you may ask for help in doing this if you need it.

9. CONTINUING CARE – YOU HAVE THE RESPONSIBILITY

To ask when and where to go for more treatment and follow-up services whenever you leave a providers' facility or care.

10. AN ADVANCES DIRECTIVE FOR CARE - YOU HAVE THE RESPONSIBILITY

To make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RESPONSIBILITY

To look and ask questions about all health care bills. To get referrals and help with any payment problems.

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RESPONSIBILITY

To voice complaints, to suggest changes and to be informed about how to file a grievance (a formal written complaint.) To do this without harassment, interference and pressure.

13. CONFIDENTIALITY AND ACCESS TO RECORDS – YOU HAVE THE RESPONSIBILITY

To have all of your records kept strictly confidential and not to be released without your written permission. To access all of your records and to have copies of these at a fair copying cost.

14. FREEDOM FROM CONSTRAINTS – YOU HAVE THE RESPONSIBILITY

To be free from all types of constraints when you deal with health or social service providers and treatment plans.

15. TRANSFERS AND CONTINUITY OF CARE – YOU HAVE THE RESPONSIBILITY

To uninterrupted treatment. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred TO another provider or facility without an explanation for the transfer. You must be informed of the options that are available.

STATEMENT OF CONSUMER RIGHTS

1. RESPECT, COURTESY, AND PRIVACY – YOU HAVE THE RIGHT

To be treated at all times with respect and courtesy within a setting, this provides you with the highest degree of privacy possible.

2. FREEDOM FROM DISCRIMINATION – YOU HAVE THE RIGHT

To freedom from discrimination because of age, ethnicity, gender, religion, sexual orientation, values and beliefs, marital status, medical condition, or any other arbitrary criteria.

3. ACCESS TO HIV/AIDS SERVICE INFORMATION – YOU HAVE THE RIGHT

To be informed by your healthcare and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services.

To be advised of the risks and to discuss benefits of any proposed treatments. You have the right to give your informed consent to any treatments or services before they are provided.

4. IDENTITY AND PROVIDER CREDENTIALS – YOU HAVE THE RIGHT

To know the names, titles, specialties, and affiliation of all health and social service providers and anyone else involved in your care. To know about the health or social service organization's policies and procedures.

5. CULTURALLY SENSITIVE SHARING OF INFORMATION – YOU HAVE THE RIGHT

To have information shared with you in a respectful manner and in a way that is easy to understand, which takes into account the differences in each person's background, culture, and preferences.

6. CONSENT AND THE CARE PLAN – YOU HAVE THE RIGHT

To be informed involved in and make individualized plane of care prior to the start of and during the course of treatment. To disagree, change your mind, or request a medical second opinion without affecting the ongoing availability of treatment services. The second opinion provider must notify you of any change they have made to your care plan before it happens.

7. CHOICE AND ACCESS TO SERVICE – YOU HAVE THE RIGHT

To be informed of all available services upon intake. To choose and access all treatment/services for which you qualify.

8. DECLINING SERVICE – YOU HAVE THE RIGHT

To decline treatment/services without pressure from your health care or social service provider. To refuse to participate in any research studies or experiments that the provider may recommend. To change your mind after refusing OR consenting to treatment, trial, counseling, or any other service without affecting ongoing care. To make these decisions without pressure from your services**.**

9. NAMING AN ADVOCATE – YOU HAVE THE RIGHT

To choose an advocate (such as a family member of another person) to give you support and to represent your rights. This person (the Advocate) makes sure that your rights are not forgotten due to your HIV status, and also make sure that you are getting the correct kind of HIV services and care.

10. AN ADVANCES DIRECTIVE FOR CARE - YOU HAVE THE RIGHT

To make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RIGHT

To look and ask questions about all health care bills. To get referrals and help with any payment problems.

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RIGHT

To voice complaints, to suggest changes and to be informed about how to file a grievance (a formal written complaint.) To do this without harassment, interference and pressure.

13. CONFIDENTIALITY AND ACCESS TO RECORDS – YOU HAVE THE RIGHT

To have all of your records kept strictly confidential and not to be released without your written permission. To access all of your records and to have copies of these at a fair copying cost.

14. FREEDOM FROM CONSTRAINTS – YOU HAVE THE RIGHT

To be free from all types of constraints when you deal with health or social service providers and treatment plans.

15. TRANSFERS AND CONTINUITY OF CARE – YOU HAVE THE RIGHT

To uninterrupted treatment. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred TO another provider or facility without an explanation for the transfer. You must be informed of their options that are available.