MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment Committee Service Definitions Development
November 8, 2023

Purpose

At their September 2023 meeting, the Care and Treatment Committee (Committee) approved five new support service categories for consideration for the next Ryan White Program Part A/MAI Request for Proposals cycle. This document is intended to assist the Committee in the development of service descriptions for the new service categories.

The Health Resources and Services Administration (HRSA) service definitions and samples from other Ryan White-funded jurisdictions are included in this document.

Considerations

- Of the five services approved, only one is currently funded.
- Will there be a request for a waiver of the "75% core/25% support" funding restrictions to account for funding of the additional support services?
- What other funding streams support the service?
- Is the service intended for a specific population?
- Are there any restrictions for the service?

1. Emergency Financial Assistance

Status: Currently funded support service

Other Funders (based on 2023 Needs Assessment): General Revenue $147,358; Part B $520,191

HRSA 16-02 Definition (pg. 17)

Description:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. EFA must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

EFA funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the EFA category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Other Sample Services:

- Washington, DC EMA
- Los Angeles County, CA EMA
- Texas, Part B

DC | HEALTH
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HIV/AIDS,
Hepatitis, STD and TB Administration

Emergency Financial Assistance (EFA)

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Emergency Financial Assistance (EFA) provides limited, one-time or short-term payments to assist Ryan White HIV/AIDS Program customers with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, and medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance or another HRSA RWHAP allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

EFA activities are composed of the following eligible services:

1. Emergency rental assistance (first month's rent, past due rent)
2. Emergency utility payments (gas, electric, oil and water)
3. Emergency telephone services payments
4. Emergency food vouchers
5. Emergency moving assistance
6. Emergency medication

II. INTAKE AND ELIGIBILITY

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load. .

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

   - Current lease or mortgage statement
   - Deed settlement agreement
   - Current driver's license
   - Current voter registration card
   - Current notice of decision from Medicaid
   - Fuel/utility bill (past 90 days)
   - Property tax bill or statement (past 60 days)
   - Rent receipt (past 90 days)
   - Pay stubs or bank statement with the name and address of the customer (past 30 days)
   - Letter from another government agency addressed to customer
   - Active (unexpired) homeowner's or renter's insurance policy
   - DC Healthcare Alliance Proof of DC Residency form
   - If homeless, a written statement from case manager or facility

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.
   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)

7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. IMPLEMENTATION GUIDELINES

Emergency Financial Assistance (EFA) programs are intended to address emergency needs that could result in eviction for non-payment of rent, disconnection of utilities or telephone service, or lack of sufficient food.

Direct cash payments to customers are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a customer should not be funded through emergency financial assistance.

Provision of EFA should be part of a larger plan to address barriers to HIV care and treatment. Therefore, EFA is a collaborative effort between case managers and EFA provider staff and all applications must be submitted by the customer's case manager. Case management and EFA provider staff must ensure that they are familiar with these Service Standards and all other EFA related policies and procedures to ensure the effective implementation of EFA services. If a customer (potential EFA customer) does not have a case manager, the EFA provider staff will refer the customer to an agency that provides access to case management services.

1. Application Tracking System: EFA provider agencies must develop, implement and maintain a comprehensive tracking system that documents a customer's EFA application status from start to finish; i.e., incomplete draft, complete, submitted, pending, approved, denied, error, requested service provided, etc.

2. EFA provider agencies must establish frequent communication guidelines for staff to communicate application status at each stage with the case manager who submitted the application.

3. EFA provider agencies must also maintain effective methods of communication with other HIV providers in the jurisdiction to ensure that there is widespread knowledge and understanding of the EFA benefits available for customers.

4. Incomplete Applications: EFA provider staff must contact the case manager who submitted the application within 24 hours of receipt to convey the incomplete status. EFA provider staff and case managers must work together to ensure that the application is completed. If the application is incomplete over seven business days, the EFA provider agency can deny the application and the case manager must re-submit.

5. EFA provider agencies must develop policies, procedures and forms that reflect all requirements of the EFA Service Standards.

6. Supervisor(s) must conduct quarterly audits of EFA customer records to ensure that EFA applications are processed in accordance with agency policies and procedures, particularly the policies regarding eligibility, documentation, and timeliness of application processing.

7. Timeline for Processing EFA Application and Providing EFA: The emergency nature of this benefit requires that the application processing and the subsequent provision of the benefit be done in a timely manner, to avoid any harmful consequences brought on by the initial need. In jurisdictions where EFA is provided directly by case managers, completed EFA applications must be processed within three business days of receipt. In jurisdictions where EFA is provided centrally, completed EFA applications must be processed within five business days of receipt.

8. Customers that require receipt of a specific voucher must be notified of the availability of their approved voucher within 24 hours of its approval and arrangements for the expeditious provision of that voucher to the customer must be made. If case managers are picking up vouchers on the customer's behalf, it must be done within 24 hours of its approval.

IV. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	**Measure**
A application for EFA needs to be completed prior to the provision of assistance	Signed and dated application for EFA in the customer's record
A brief needs assessment for case management services is to be completed prior to the provision of assistance	Documentation of needs assessment for case management services in customer's record signed and dated
For those customers determined to need case management services, develop an emergency assistance plan within 24 hours of providing emergency assistance	For customers in need of case management services, signed and dated documentation of emergency assistance plan
Review the emergency assistance plan and reassess needs every 30 days for 3 months	Signed and dated emergency assistance plans reassessed every 30 days in customer's record
Provide Emergency Financial Assistance (EFA) for essential services including: ● Utilities ● Housing (Emergency Housing 1-14 days and Short-term Housing 15-30 days) ● Transportation ● Food (including groceries, food vouchers, and food stamps) ● Non-ADAP formulary medications *Note: Brand name formulations may be paid for with Ryan White funds only if generic formulation is not available*	Signed and dated documentation of assistance provided for essential services with frequency and duration outlined in customer's record
EMERGENCY RENTAL ASSISTANCE (FIRST MONTH'S/PAST DUE RENT)	
Scope of Service: Provides emergency rental payments for customers with critical delinquency, or first month's rent for new dwelling, made by the EFA provider directly to landlord	
Standard	**Measure**
Additional Eligibility Criteria ● Customers must be at least one month past due to submit an application for delinquent rent unless a summons or writ of eviction has been received	● Approval letter with monthly rent amount for first month's rent ● Delinquency notice or itemized statement for emergency rent from landlord

● Customers whose past due balance exceeds the maximum benefit, must pay down to the benefit amount before a check can be issued to provide assistance **Maximum Benefit** ● Annual cap for rental assistance is based on Fair Market Rents (FMR) established by HUD ● For customers renting rooms, the annual cap for rental assistance will be based on an $800.00 FMR ● Customers can receive assistance on multiple occasions in a 12-month period, as long as the total amount of assistance in the 12-month period does not exceed the equivalent of three times one month's rent at the fair market rate.	● A copy of a current lease agreement ● W-9 Form with the landlord's Tax Identification Number. The EFA provider is required to report all rental payments to the IRS each year. ● Documentation that cap has been exceeded for the year
EMERGENCY UTILITY PAYMENTS	
Scope of Service: Provides payment of electricity, water, oil, or gas bills, made by the EFA provider directly to utility company	
Standard	**Measure**
Additional Eligibility Criteria ● Customers must have a disconnection notice to be eligible to apply ● Customers whose past due balance exceeds the maximum benefit, must pay down to the benefit amount before a check can be issued to provide assistance **Maximum Benefit** ● Maximum benefit for a 12-month period is $1,500.00 ● Customers can receive assistance on multiple occasions in a 12-month period, as long as the total amount of assistance in the 12-month period does not exceed $1,500.00 **Exclusions** ● Customers living in subsidized housing are not eligible for utilities assistance	● A copy of a bill that includes a disconnection notice dated within 30 days of the application date to ensure current billing information ● Documentation that cap has been exceeded for the year
EMERGENCY TELEPHONE SERVICES PAYMENT	
Scope of Service: Provides for the payment of telephone bills made by the EFA provider directly to the telephone company	
Standard	**Measure**
Additional Eligibility Criteria ● Customers must have a disconnection notice to be eligible to apply ● Customers whose past due balance exceeds the maximum benefit, must pay down to the benefit amount before a check can be issued to provide assistance **Maximum Benefit** ● Maximum benefit for a 12-month period is $300.00	● A copy of a bill that includes a disconnection notice dated within 30 days of the application date to ensure current billing information ● Documentation that cap has been exceeded for the year

● Customers can receive assistance on multiple occasions in a 12-month period, as long as the total amount of assistance in the 12-month period does not exceed $300.00 **Exclusions** ● If telephone service is provided as part of a bundled package with other services such as cable TV or internet service, application and billing document must clearly identify the telephone charges for which payment is requested	
EMERGENCY FOOD VOUCHERS	
Scope of Service: Provides food vouchers in the form of supermarket gift cards given by the EFA provider directly to case managers, who thereafter distribute the vouchers to customers	
Standard	**Measure**
Additional Eligibility Criteria ● Customers must document effort to seek food resources elsewhere before accessing food vouchers **Maximum Benefit (Individual)** ● The maximum benefit for a single application for an individual is $300.00 ● Customers may access this service three times in each 12-month period, at intervals of at least three (3) months. ● Total 12-month cap for individual customers is $900.00 **Maximum Benefit (Family)** The maximum benefit for a single application for families is $700 ● Family cap of $700 is computed as follows: $300.00 for the PLWH, plus $100.00 per dependent for a maximum of four dependents ● Customers may access this service three times in each 12-month period, at intervals of at least three (3) months ● Total 12-month cap for families is $2,100.00 **Exclusions** ● Dependents can only be included in a food voucher application if they are 18 or younger ● Vouchers are intended for food purchases only and shall not be used to purchase alcohol, tobacco products, or lottery tickets	● Documentation of effort to seek food from other resources is provided through a referral certification form, ● (For customers seeking food vouchers for dependents) proof of dependency through birth certificates, tax returns, or court documentation of guardianship ● Signed voucher policy reflecting agreement to comply with voucher use restrictions ● Documentation that cap has been exceeded for the year
EMERGENCY MEDICATION	
Scope of Service: Provides HIV medications that are not included in the ADAP formulary; medications when the ADAP financial eligibility is restrictive; and medications if there is a protracted State ADAP eligibility process (such as a wait list) and/or other means of accessing medications are not available (i.e., pharmaceutical company assistance programs) Purchase of pharmaceuticals must be directly linked to the management of HIV disease that is consistent with the most current HIV/AIDS Treatment Guidelines; coordinated with the State's Part B AIDS Drug Assistance	

Program (ADAP); and implemented in accordance with requirements of the 340B Drug Pricing Vendor Program and/or Alternative Methods Project.

Standard	Measure
Additional Eligibility Criteria ● Customers with insurance and other third-party payer sources are not eligible for EFA assistance unless there is documentation on file that the medication is not covered by their prescription benefits **Maximum Benefit** ● The maximum benefit is $4,000.00 ● Service may be accessed no more than twice in a 12-month period. Any extenuating circumstances require recipient/administrative agent approval **Program Rules** ● EFA can be used during the ADAP eligibility determination period. Initial medications purchased for this use is not subject to the $4,000.00/customer/year cap. ● EFA can be used to reimburse dispensing fees associated with purchased medications ● Dispensing fees are not subject to the $4,000.00/customer/year cap ● Agency may reimburse the pharmacy a minimal dispensing fee per prescriptions as outlined in a MOU *Purchasing Medications during ADAP application period:* ● No more than a 30-day supply of medication on the ADAP formulary can be purchased at a time for each customer. If more than 30 days is needed, the medication can be refilled for another 30 days ● If the ADAP denied the coverage, the agency staff should work with the customer and the customer's attending physician to find alternate funding sources which may include manufacturer's compassionate/patient assistance programs, religious groups, or other community resources	● Evidence of enrollment in insurance or other third-party payer source ● Evidence that medication is not covered by existing prescription benefits ● Documentation that cap has been exceeded for the year

EMERGENCY MOVING ASSISTANCE

Scope of Service: Provides payment of moving services for applicants that are moving to a new dwelling. The EFA provider may obtain a contract with a moving company for no more than one year, or obtain quotes from various companies per job to obtain the most cost-effective service

Standard	Measure
Required Documentation	• Inventory of items to be moved • Addresses of pick-up and delivery location • Customer name and contact information
Maximum Benefit	• Maximum benefit is $2000 • Service may be accessed once in a 12 month period

Exclusions	• Service cannot be used to move applicant outside of the Eligible Metropolitan Area (EMA)

CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan	Documentation of case closure in customer's record with clear rationale for closure

Emergency Financial Assistance (EFA) for Ryan White Program Clients

ELIGIBILITY:

- Los Angeles County Resident
- HIV-positive
- Current income ≤ 500% FPL
- Not currently receiving any other form of emergency financial assistance

SERVICES:

Assistance with paying:

- Rent*
- Utilities** (including Cell Phone and Wi-Fi)
- Food

You can apply for $5,000 (maximum) over a 12-month period

TO LEARN MORE OR APPLY:

Please contact your HIV Medical Care Coordination (MCC) Team **OR** an HIV Benefits Specialist (BSS) **OR** your LAFAN Case Manager for an application. Please refer to the list of contacts on back.

*Must provide a rental agreement in your name.

**Must provide a utility bill in your name.

All financial assistance payments are made on the client's behalf while maintaining confidentiality and protecting personal health information. No direct payments are made to clients.

Emergency Financial Assistance Service Standard

Health Resources & Service Administration (HRSA) Description:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a HRSA Ryan White HIV/AIDS Program (RWHAP) client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance Program (LPAP), or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency financial assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

It is expected that all other sources of funding in the community for EFA will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer-of-last-resort, and for limited amounts, uses, and periods of time. EFA funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the EFA category.

Limitations:

Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through EFA.

Services:

RWHAP Part B/State Services funds may be used to provide services in the following categories:

1. ADAP eligibility determination period; and
2. Emergency Financial Assistance (EFA).

EFA can be used during the ADAP eligibility determination period. Initial medications purchased for this use are not subject to the $800/client/calendar year cap.

EFA can be used to reimburse dispensing fees associated with purchased medications. Dispensing fees are not subject to the $800/client/calendar year cap.

EFA is an allowable support service with an $800/client/calendar year cap.

- The agency must set priorities, delineate, and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary.

- Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer-of-last-resort, and for limited amounts, limited use, and limited periods of time.

EFA provides funding through:

- Short-term payments to agencies
- Establishment of voucher programs

EFA to individual clients is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used.

EFA funds used to pay for otherwise allowable RWHAP services must be accounted for under the EFA category.

EFA funds may be used on the following essential items or services:

- Utilities (may include household utilities such as gas, electricity, propane, water, and all required fees)

- Housing (may include as rent or temporary shelter. EFA can only be used if HOPWA assistance is not available or if client is not eligible for HOPWA services)
- Food (groceries or food vouchers)
- Transportation
- Prescription medication assistance such as short-term, one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit (not to exceed a 30-day supply)
- Other RWHAP allowable costs needed to improve health outcomes.

Universal Standards:

Service providers for Emergency Financial Assistance must follow HRSA/DSHS Universal Standards 1-46 and 137-139.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Assisting Clients during ADAP Eligibility Determination Period: RWHAP-eligible clients with documentation of an emergency need for HIV medications are able to receive short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (two months or less). **Assisting Clients with Short-Term Medications:** RWHAP-eligible clients with documentation of pending health insurance medication plan approval are able to receive short-term HIV medication assistance through EFA.	1. Percentage of clients with documentation of short-term HIV medication assistance provided during the ADAP application period. 2. Percentage of clients with documentation of short-term HIV medication assistance provided during the health insurance application period.
Client Determination for Emergency Financial Assistance: Applicants must demonstrate an urgent need resulting in their inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, need may be demonstrated by, but not limited to, the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • They are unable to provide for basic needs and/or shelter • A failure to provide EFA will result in danger to the physical health of the client or dependent children • Other emergency needs as deemed appropriate by	3. Percentage of clients with documentation of determination of EFA needs. 4. Percentage of clients with documentation of a service plan for EFA that indicates the emergent need, other resources pursued, and outcome of EFA provided. 5. Percentage of clients with documentation of resolution of the emergency status and referrals made (as applicable) with outcome results.

the agency Agency staff will conduct an assessment of the presenting problems/needs of the client with the emergency financial issue. A service plan will be developed documenting the client's emergent need resulting in their inability to pay bills/prescriptions without assistance, and other resources pursued noted prior to using EFA funding for assistance.	

2. Health Education/Risk Reduction

Status: Currently unfunded support service

Other Funders (based on 2023 Needs Assessment): Health Education-Part C $357,706; Part D $23,982; Risk Reduction-Part D $48,001

HRSA 16-02 Definition (pg. 18)

Description:

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre- exposure prophylaxis (PrEP) for clients' partners and treatment as prevention.
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage).
- Health literacy.
- Treatment adherence education.

Program Guidance:

Health Education/Risk Reduction services cannot be delivered anonymously.

Other Sample Services:

- Santa Clara, CA TGA
- Washington, DC EMA
- Texas, Part B

Health Education & Risk Reduction

Service Definition

Health Education and Risk Reduction Services is the provision of services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status. (San Jose, CA TGA Definitions for Eligible Services *Ryan White HIV/AIDS Treatment Extension Act 2009*, Page 6).

Goals: The Standards of Care serve as guides to gauge the quality of HIV services in Santa Clara County.

Health Education and Risk Reduction Service providers are expected to comply with the Universal Standards of Care, as well as these additional standards:

Standards of Care

1.0 Standard of Care: Licensure or Assurance

- No additional standards.

2.0 Standard of Care: Knowledge, Skill, and Experience

- No additional standards

3.0 Standard of Care: Client Rights, Responsibilities, Confidentiality

- No additional standards

4.0 Standard of Care: Access to Services

- No additional standards

5.0 Standard of Care: Care and Treatment

- No additional standards

6.0 Standard of Care: Outreach and Provider Continuity

- No additional standards

7.0 Standard of Care: Continuous Quality Improvement

- No additional standards

8.0 Standard of Care: Staff Training

- No additional standards

References and Published Guidelines:

1. For a comprehensive overview of references, guidelines and resources please see the official WEB site for Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) at http://hab.hrsa.gov
2. **San Jose, CA TGA –** Definitions for Eligible Services *Ryan White HIV/AIDS Treatment Extension Act of 2009*, July 1, 2011, Definition of "**Health Education and Risk Reduction**" Page 6.

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HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Health Education/Risk Reduction

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Health Education/Risk Reduction is the provision of education and risk reduction counseling to customers living with HIV. It includes 1) sharing information with customers about medical and psychosocial support services, 2) educating customers on HIV transmission and secondary prevention, 3) counseling them to improve their health status and reduce the risk of transmission to others. Topics covered may include:

- Education on risk reduction strategies to reduce transmission, such as pre-exposure prophylaxis (PrEP), non-occupational post-exposure prophylaxis (nPEP) for customers' partners, and treatment as prevention (TasP)
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White clients to maintain proof of eligibility annually, with recertification every six months. Supporting documentation is required to demonstrate client eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting CD4 count and viral load. Laboratory results should be within 6 months of the date of certification.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the applicant (past 30 days)
- Letter from another government agency addressed to applicant
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

3. **Income:** Client income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A notarized letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A notarized statement from the applicant projecting current annual income must be included
   - Copy of the tenant's lease showing client as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. RECERTIFICATION (6 months) REQUIREMENTS

To maintain eligibility for Ryan White services, the customer must complete the six-month recertification process. Providers may elect to have clients sign a self-attestation of no change in eligibility at the six-month recertification.

III. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	**Measure**
An initial health education/risk reduction assessment is completed prior to the initiation of the HE/RR plan	Documentation of assessment in customer's record signed and dated by health educator
Within 30 days of initial assessment, an HE/RR plan is developed for each eligible customer and signed by the health educator. The plan should include: ● Goals ● Expected outcomes ● Actions taken to achieve each goal ● Person responsible for completing each action ● Target date for completion of each action	HE/RR plan, documented in customer record, signed and dated by the customer and health educator
HE/RR plan is reassessed every 90 days to assess customer progress and identify emerging needs	Documentation of review and update of HE/RR plan as appropriate signed and dated by customer and health educator
Refer customer to other services as appropriate, e.g. mental health, treatment for substance use disorder, patient navigation services, etc.	Documentation of referrals in customer's record
HEALTH EDUCATION / LITERACY	
Standard	**Measure**

Customers living with HIV are educated about HIV transmission and how to reduce the risk of HIV transmission, including (PrEP/nPEP, TasP, and STI screening and treatment) ~~Customers living with HIV are provided information about~~ available medical and psychosocial support services Customer are provided information to purchase health insurance from the market place. Customers living with HIV are provided health literacy individually or in group format to increase knowledge to help ~~navigate the health system~~	Documentation that customers served under this category are educated about HIV transmission and how to reduce the risk of HIV transmission to others. Includes description of the types of information, education, and counseling provided to customers Documentation that customers served under this category receive information about health literacy and purchase of health insurance. Includes description of the types of health information, education, health insurances and counseling provided to customers.
RISK REDUCTION COUNSELING/TREAMENT ADHERENCE	
Standard	**Measure**
Customers living with HIV receive counseling on how to improve their health status and reduce the risk of HIV transmission to others, including (PrEP/nPEP, TasP, and STI screening and treatment) Treatment adherence counseling is provided to customers who are positive on benefits of viral suppression	Documentation that customers served under this category receive counseling on how to improve their health status and reduce the risk of transmission to others. Includes description of the types of information, education,on antiretroviral medications and counseling provided to customers.
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when HE/RR services are no longer needed, goals have been met, upon death or due to safety issues. Prior to discharge: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider. Transfer: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. Documentation: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge ● Referrals made at time of discharge, if applicable

may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program ● Is deceased	Documentation of case closure in customer's record with clear rationale for closure

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. Agencies are also responsible for maintaining documentation of the appropriate education, qualifications, training, and experience in personnel files.

Health Education/Risk Reduction
Service Standard
Minority AIDS Initiative

HRSA Definition: Health Education/Risk Reduction (HE/RR) is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as preexposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:

HE/RR services cannot be delivered anonymously.

MAI HE/RR Services:

HE/RR with MAI can vary greatly from client status (incarceration vs recently released), client knowledge concerning HIV, and time allowed with client. HE/RR models will vary by MAI provider and will focus on education that is most relevant to the client at the encounter. Each provider shall create a curriculum for service workers to follow during their encounter with the client. Topics may include (but are not limited to):

- Information regarding medical and psychosocial support services (ex. services available in the client's community and how to access services such as clinic, pharmacy, substance use treatment, family counseling, dentist, mental health)
- How to improve/maintain health status (ex. how to continue medication regimen after release, nutrition and self-care, medical treatment adherence for HIV and co-infections, dental treatment information)
- Available resources to meet needs for recently released (services outside medical and psychosocial such as public transportation, homeless shelters, food banks, social service organizations, employment/vocational development agencies)
- Treatment adherence education (ex. how to continue medication regimen after release, how to fill a prescription, availability of PrEP and PEP for partners, healthy relationship options)
- Methods of HIV transmission and risk reduction
- Health literacy (ex. how to communicate needs and concerns to medical providers, how to read lab reports, medication side effects)
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage, AIDS Drug Assistance Program)

HE/RR shall be provided to people living with HIV and cannot be provided anonymously.

Unit Definition: 1 unit= 15 minutes of service

Service Standard and Performance Measure:

Standard:	Measure:
MAI provider will use agency HE/RR curriculum to provide HE/RR to incarcerated and recently released clients. Topics addressed should be prioritized by the client needs, the incarceration status, the environment services are provided, and the amount of time the provider has to spend with the client.	Percentage of clients with documentation of specific health and risk reduction topics discussed during HE/RR session. Percentage of clients with documentation of specific social service topics discussed during HE/RR session.

3. Housing

Status: Currently unfunded support service

HRSA 16-02 Definition (pg.18-19)

Description:

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.
HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,6 although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Other Sample Services:

- Atlanta, GA EMA
- Texas, Part B
- Florida, Part B
- Maricopa, AZ EMA

POLICY AND PROCEDURE NOTICE: PPPN-072
HOUSING

Summary and Purpose of PPN: To guide the administration of the Ryan White Part A Program to provide a standard Priority Service definition and requirements.

Authority:

- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
  https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf

- HAB PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
  https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

- Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions
  https://hab.hrsa.gov/sites/default/files/hab/Global/faq_service_definitions_pcn_final.pdf

- Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Housing Services, Frequently Asked Questions
  https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/Housing_FAQs_Final.pdf

- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs & Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements)
  http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf

Background:

Atlanta EMA Quality Management Standards

The purpose of the Ryan White Part A quality management standards and measures is to ensure that a uniformity of service exists in the Atlanta Eligible Metropolitan Area (EMA) such that the consumers of a service receive the same quality of service regardless of where the service is rendered. These standards set forth the minimal acceptable levels of quality in

service delivery and to provide measurement of the effectiveness of services. EMA Standards of Care may be found on the Ryan White Part A website at **www.ryanwhiteatl.org**.
Also see PPPN-038 Compliance with Standards.

Service Definition

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Allowable activities include:

- Emergency Lodging *(hotel/motel vouchers)*
- Short-term Housing Rental Assistance *(3-6 months of rental subsidy)*
- Medium-term Housing Rental Assistance *(6-12 months of rental subsidy)*

Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Policy and Procedure:

1. Subrecipient must have mechanisms in place to assess and document housing stating and housing service needs of new clients, and at least annually for existing clients.

2. Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits[1] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

3. Subrecipient must be able to provide documentation and assurance that no Ryan White funds are used to provide direct payments to clients for rent or mortgages.

4. Subrecipient must maintain documentation and client records that include;
   - Services provided including number of clients served, duration of housing services, types of housing provided, and housing referral services
   - client eligibility determination
   - Individualized housing plans for all clients that receive short-term, transitional, and emergency housing services

5. Subrecipient must ensure staff providing housing services are case managers or other professionals who possess a comprehensive knowledge of local, state, and federal housing programs and how to access those programs.

6. Subrecipient must develop and maintain housing policies and procedures that are consistent with this Housing Policy. Subrecipient must ensure assistance provided help clients obtain stable long-term housing.

Unit of Service Definition

Housing Services			
Subservice Name	**Definition**	**Unit**	**Funding Sources**
Housing Assistance	Rental assistance for longer than one-time or episodic emergency need, not to exceed cumulative period of 24 months. Cannot include mortgage payments.	Payment	EHE, B, Other
Residential Housing	Housing facility for homeless or people at risk for homeless living with HIV/AIDS. Not to exceed cumulative period of 24 months.	Payment	EHE, B, Other
Emergency Lodging	Housing facility for homeless or people at risk for homeless living with HIV/AIDS in emergency situations. May include hotel/motel voucher. Not to exceed cumulative period of 3 months.	Payment	EHE

Approved: April 2021

Housing Services Service Standard

Health Resources & Services Administration (HRSA) Description:

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent experiencing homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA Ryan White HIV/AIDS Program (RWHAP) recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HIV/AIDS Bureau (HAB) recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development (HUD), which currently uses 24 months for transitional housing.

Housing referral activities performed by Ryan White-funded medical or non-medical case managers are reported under the respective case management service category. Referral services provided by Ryan White-funded housing specialists are reported under the Housing service category.

Limitations:

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits. These may be allowable costs under HUD Housing Opportunities for Persons with AIDS (HOPWA) grant awards.

Services:

Eligible housing may include housing that:

- Provides some type of core medical or support services (such as mental health services, residential substance use disorder services, residential foster care, or assisted living residential services).
- Does not provide direct core medical or support services but is essential for a client or family to gain or maintain access to and adherence to HIV-related medical care and treatment.

Funds received under this category may be used for the following housing-related expenditures:

- Housing referral services provided by a housing case manager or other professional who possesses a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed. These services may include assessment, search, placement, and advocacy services.
- Emergency housing, defined as housing services provided in response to an unforeseen event that jeopardizes a household's ability to pay housing costs. Assistance is limited to 1 month of rental/utility assistance within a contract year.
- Transitional housing, defined as housing support for a person experiencing homelessness that helps the client to gain or maintain access to medical care. Funds may be used for rental and/or application fees; however, funds cannot be used for rental deposits. Funds may also be used for transitional residential housing that provides some type of core medical or support services. Transitional housing assistance is based on need and available resources and is limited to no more than 6 continuous months of funding within a contract year.
- Short-term assistance, defined as support for a person currently in housing but needing financial support for rent and/or utilities to gain or maintain medical care.

The maximum amounts of emergency housing assistance, transitional housing assistance, and short-term housing assistance shall be uniform throughout each HIV Service Delivery Area (HSDA) and be determined by 1) planning councils (PCs) in areas where the PC determines recommended allocations for Ryan White Part B (RW/B) and State Services funds; or 2) by the Administrative Agency (AA) based on consumer input/planning processes in RW/B-only HSDAs.

Universal Standards:

Service providers for Housing Services must follow HRSA/DSHS Universal Standards 1-46 and 153-158.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Emergency Housing Assistance: Agency staff will initiate an intake within 3 business days of the onset of the emergency housing need. Assessment of client housing status and housing service needs must be documented. Reason(s) for emergency assistance may include but are not limited to: • Client is unable to pay rent due to a recent job loss • Client is on an unpaid medical leave of absence or has exhausted all leave balances • Client is unable to work due to recent hospitalization • Client had to purchase unexpected costly HIV medications or pay for unexpected HIV-related medical expenses out-of-pocket The housing assessment must document the following: • The actual costs to avoid eviction • Other resources are not reasonably available to address the unmet housing need • Client will maintain and/or achieve stable housing as a result of housing assistance Staff will contact the client at the end of the month to determine if the housing emergency has been resolved. If the emergency is not resolved and the client needs additional assistance, the client may be assessed for short-	1. Percentage of client charts with documentation of an intake that occurred within 3 business days of emergency need. 2. Percentage of client charts with an emergency housing needs assessment. 3. Percentage of client charts with documentation of follow-up conducted after 1 month to determine if the client is stably housed. (Pilot Measure) 4. Percentage of clients experiencing housing instability or homelessness in the 12-month measurement period. *(HRSA HAB measure)*

term housing assistance.	
Housing Plan for Transitional and Short-Term Housing: All clients receiving assistance for transitional and/or short-term housing must have a housing plan that includes: • Housing status • Reason for housing service need • Other resources screened for housing assistance Plans must detail the on-going housing stability goal with a focus on access to medical treatment and supportive services. The plan must include: • Sustainable short-term and long-term goals for alleviating risks of a lack of housing, establishing affordable permanent housing stability, and improving access to health care and supportive services • Identification of barriers to sustainable housing • Steps to address housing needs • Referral(s) to available housing support services • Budget and money management skills building, if indicated The housing plan must be reviewed at least monthly and updated with progress toward housing goals.	5. Percentage of client charts with a housing plan. 6. Percentage of client charts with housing plans updated at least monthly.
Housing Referral Services: Housing-related referrals provided by housing assistance/referral providers should include a housing assessment, housing search, placement, and advocacy services to seek housing. This may include applications to other funding sources or housing-related visits to court systems.	7. Percentage of client charts with documentation of all elements of housing referral services provided. 8. Percentage of clients with documentation of the outcome of referral services. (Pilot Measure)

Staff will document in the client's primary record all activity to assist the client in securing housing and the outcome of the assistance, including whether the client has obtained secure and stable housing.	

Housing Support Service Guidance for Funding Sources Ryan White Part B and State of Florida General Revenue

The Florida Department of Health, HIV/AIDS Section, has added housing as an allowable support service under the following funding sources: Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue.

Purpose

- To expand upon housing services as described in the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), *Policy Clarification Notice #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds.*
- To provide guidance on allowable costs for housing services funded by Ryan White Part B and State of Florida General Revenue.

Please Note

The Ryan White Part B housing support service should only be used as a last resort if a client is not qualified for the Florida State Housing Opportunities for Persons With AIDS (HOPWA) Program, and should not supplant HOPWA. Also, transferring the client from one funding source (such as HOPWA) to another (such as Ryan White Part B) is not a substitute for assisting the client towards financial independence and self-sufficiency. Local areas may develop and implement requirements that are stricter based on local needs.

Neither Ryan White HIV/AIDS Program (RWHAP) funds nor RWHAP matching funds may be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source [Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act]. This means that a client may not access Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue when the client is receiving or is eligible to receive the housing services in another local, state, or federal program. This requirement does not preclude an individual from receiving allowable housing services not provided by other local, state, or federal programs, or pending a determination of eligibility from these other programs. The housing services provided by Ryan White Part B may be used for

	HIV-related services only when no other source of payment exists.
Overview/Description	Housing services provide short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain medical care. The allowable housing services include housing referral services and transitional, short-term, or emergency housing assistance. Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness, and to gain or maintain access and compliance with HIV-related medical care and treatment. Housing services must also include the development of an individualized **Housing Plan of Care (Attachment 1)** that must be updated monthly to guide the client's linkage to permanent housing.
Program Guidance	Lead agencies and subcontractors utilizing the housing support service line item must develop mechanisms to allow newly identified clients access to housing services (including clients that are already homeless). These lead agencies and subcontractors must assess every client's housing needs at least monthly to determine the need for new or additional services. In addition, lead agencies and subcontractors must develop an individualized Housing Plan of Care for each client receiving housing services and update it monthly. Lead agencies and subcontractors must provide the HIV/AIDS Section with a copy of the individualized, written Housing Plan of Care (consistent with this Housing Policy) upon request. Short-term or emergency assistance is understood as transitional in nature, and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Thus, such assistance cannot be permanent; and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation. Lead agencies, subcontractors, and local decision making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months, and HRSA/HAB recommends that lead agencies and subcontractors consider using HUD's definition as their standard. However, the HIV/AIDS Section has set a cap of 12 months of housing assistance within a 24-month period, which can be for consecutive months, where one month of assistance includes

rent and/or utility assistance (and is based on funding availability). Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue funds can be used to pay for bills before they are due. However, they do not have to pay the full amount for bills, and can provide partial subsidy especially if funds are limited.

Allowable Housing Expenditures

Funds received under Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue **may** be used for the following housing expenditures:

- **Housing-related referral services** (and fees associated with these services) including housing assessment, search, placement, and advocacy services must be provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs (can fund a FTE staff position to perform the above tasks to get clients into permanent, stable housing); or
- **Short-term or emergency housing** defined as necessary to gain or maintain access to medical care and must be related to either:
  - Housing services that include some type of core medical or supportive service including, but not limited to, residential substance use disorder services/treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or
  - Housing services that do not provide direct core medical or supportive services, but are essential for a client or family to gain or maintain access to and compliance with HIV-related medical care (outpatient/ambulatory health services) and treatment (necessity of housing services for purposes of medical care must be certified or documented by, for example, a note from the case manager).

Non-Allowable Housing Expenditures

Funds received under Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue **may not** be used for the following housing expenditures:

- Direct cash payments to clients.
- Mortgage payments.

- Rental/security deposits. Because rental/security deposits are typically returned to clients as cash, this would violate the prohibition on providing cash payments to clients. In some instances, deposits may be retained as payment (e.g., damage to the property). As such costs would additionally be unallowable, RWHAP lead agencies and subcontractors cannot pay for a rental/security deposit using federal funds, program income generated from federal funds, or pharmaceutical rebates generated from federal funds.
- If funding a FTE staff position for housing-related referral services, staff cannot perform medical or non-medical case management services. However, if multiple responsibilities are performed by a single FTE, then there must be a differentiation between staff roles and funding source (e.g., dual timekeeping should be done by staff with blended responsibilities for more than one program).

Using the "Housing" Support Service Category vs. the "Emergency Financial Assistance" Support Service Category

The **"Housing"** support service category should be used to cover transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that extends beyond a one-time payment and there is a need for additional housing services. Clients receiving housing services must have their housing needs assessed annually and an individualized written Housing Plan of Care developed monthly to determine if there is a need for new or additional housing services. The housing service category can be used for clients that are on a waitlist for HOPWA Tenant-Based Rental Assistance (TBRA) as funding allows.

"Emergency Financial Assistance (EFA)" provides limited one-time or short-term payments to assist a client with an emergent need for paying expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), transportation, and medication when other resources are not available to help. EFA can occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for EFA will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through EFA, and should be reported in the applicable service category.

Therefore, the **EFA** support service category should be used for a housing service that consists of a one-time payment for a client's utility or housing bill. This one-time payment can be every three months. A housing assessment and individualized Housing Plan of Care would **NOT** be required for a one-time housing payment provided under EFA.

Documentation

The following must be documented when using the "Housing" line item funds:

- Total housing services provided, including the number of clients served, duration of housing services, types of housing provided, and housing-related referral services. **This must be included in the monthly invoice.**
- Staff providing housing services (case managers or other professionals who possess a comprehensive knowledge of local, state, and federal housing programs and how to access those programs). **This must be included in the monthly invoice.**
- Client-specific records that document (available upon request):
    - Client eligibility.
    - Housing services, including referral services provided.
    - Mechanisms that are in place to allow newly identified clients access to housing services.
    - Monthly individualized, written Housing Plans of Care (consistent with this Housing Policy) covering each client receiving short-term, transitional, and emergency housing services.
    - Type of housing assistance (e.g., rent, utility, hotel, housing-related referral services) provided to clients to help them obtain long-term, stable housing.
    - Housing assistance using the **Client Housing Support Service Payment Assistance Worksheet (Attachment 2)**.
- Funds have been used only for allowable purposes; assurance that no Ryan White funds were used to provide direct cash payments to clients, for mortgage payments, or rental/security deposits. This will be reviewed during fiscal monitoring.

Please Note: The **Housing Support Service File Review Worksheet (Attachment 3)** will be used in conjunction with the "Patient Care Universal and Programmatic Monitoring Tool" to verify the required documentation.

Development of the Housing Plan of Care

Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue funded providers must document the appropriateness of providing housing assistance for each assisted household. In providing this housing assistance, the lead agency's/subcontractor's qualified staff should assess the client's housing needs and related resources, along with the reasons or causes of the housing need. The assessment should help determine how to best use the housing assistance in connecting the on-going permanent housing arrangements, including forms of supportive housing or more independent living arrangements reasonably associated with the assessment of the client's needs. Ongoing assessment of the housing assistance and supportive services is required by PCN 16-02. These requirements should be met through a housing needs assessment and the development of an individual Housing Plan of Care for each assisted household.

The **Client Needs Assessment for Assistance (Attachment 4)** is intended to provide information to help achieve housing stability, and is an opportunity to collect as much information as possible about the household's needs, preferences, and challenges. This information helps inform the development of a Housing Plan of Care and the services that are subsequently provided.

Within 15 days of the start of housing assistance, the client (with the help of the Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Manager) will develop and commit to an individualized Housing Plan of Care. The primary goal of the Housing Plan of Care is to assist the client in maintaining independence from the housing assistance at the end of the time-limited assistance. The Housing Plan of Care will address the following financial aspects:

- Budget and money management issues (e.g., if the cause for housing debt is related to the household's poor money management practices, such as the use of credit cards or cash for non-essential items, or entertainment activities).
- Assisting the client to plan and budget their finances. In assisting the client to plan his/her finances, the client and the Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Manager should continue to review all items on the **Client Budget Worksheet (Attachment 5)**, including the goals and the progress to achieving these goals.
- Accessing additional income sources and social services.
- Time frames for completing various disability applications, participating in the telephone interview, gathering all

medical records, and a contingency plan in the event the disability application is denied.
- Coaching session on how to go to the source of debt and establish a workable payment plan.
- Referring the client to credit or financial counseling company.

Please Note: Although the regulations and guidelines do not specifically include criteria that would preclude assistance based on a client's assets, assets should be considered when determining the client's ability to pay for and maintain permanent, affordable housing beyond Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded housing assistance.

In addition to the financial aspects addressed during the development of the Housing Plan of Care, alternatives to RWHAP housing services should be explored and include, but are not limited to, the following:

- Exploring lower cost housing options.
- Exploring housing options with family members.
- Exploring locations close to family members for increased family support.
- Seeking public housing or other public assistance housing programs.
- Moving to a community where the client has a support network, and/or access to affordable and available housing.

The Housing Plan of Care should document a household's goals for housing, identify resources and services needed to achieve those goals, outline what assistance will be delivered and who will deliver it, and include an estimated timeline for achieving goals. The Housing Plan of Care should identify the household's on-going housing stability needs and likely options for providing related assistance (including the use of other housing programs and mainstream health and human welfare programs) in connection with their need to access medical treatment and supportive services associated with HIV/AIDS issues. All Housing Plans of Care should be developed collaboratively between a household and Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Manager or other appropriate staff person.

Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Managers (as authorized by contract, and these policies and procedures) are responsible

for making sure clients meet the housing assistance qualifications and requirements; for assisting with the Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue housing assistance application process; for documenting and verifying that all requirements for the assistance are met; for developing a Housing Plan of Care; and for maintaining accurate and updated files on clients.

The Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Manager will help the client develop their individualized Housing Plan of Care, which is a written assessment with the primary goal of assisting the client to achieve independence from Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded housing assistance and live within their financial means. The Housing Plan of Care is developed by the Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Manager together with the client to determine the need for housing assistance, the type of housing assistance, and what will happen at the end of the time-limited housing assistance being provided. Housing assistance must be provided in a manner that has a sufficient or clear beneficial effect on addressing the client's assessed immediate or short-term housing needs, and only be provided in connection with the client's demonstrated compliance with the Housing Plan of Care.

The Housing Plan of Care should be simple and clear statements that include the goals of the client in securing stable and permanent housing independent of continued Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded housing assistance. The Housing Plan of Care should include **SMART** (**S**pecific, **M**easurable, **A**ttainable/**A**chievable, **R**elevant, and **T**ime bound) goals with target dates, should document progress towards achieving these goals and dates, and should document the accomplished goals and completion dates.

The Housing Plan of Care should be updated monthly. Each month the Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Manager should review the client's need for continued housing and financial assistance. The financial status of the client is reviewed and modified as necessary, and documented in the Housing Plan of Care. If there have been any financial changes, then the client should provide appropriate documentation of all income and expenses.

Documentation of efforts to secure permanent housing, help the client to achieve independence, and help the client to maintain affordable housing must be maintained in the client's file. The Ryan White Part B, Patient Care Networks General Revenue, and 4B000 General Revenue funded providers reserve the right to refuse further assistance if the client does not demonstrate an effort to implement all or portions of his/her Housing Plan of Care.

CAREWare Instructions

- The following documents must be scanned and attached under the "Unique IDs" tab, "Attachments" hyperlink:
  - Housing Plan of Care **(Attachment 1)**.
  - Client Housing Support Service Payment Assistance Worksheet **(Attachment 2)**.
  - Client Needs Assessment for Assistance **(Attachment 4)**.
  - Client Budget Worksheet **(Attachment 5)**.
- Documents must have an identifying name; use drop down box to select "Housing."
- The comment box is not required, but is encouraged if needed.
- The four housing documents should be updated and scanned into CAREWare as needed.

Reporting Requirements (please consult each of these reporting requirements' respective manuals and/or guidance for more specific details and due dates)

<u>Ryan White HIV/AIDS Program Services Report (RSR)</u>

As per the *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual*, the housing support service is a required client-level data element for RWHAP services. **Therefore, this information must be captured in the RSR.**

The **"client's housing status"** is required for clients with service visits in the housing services category (the below is excerpted from the *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual*).

XML Variable Name: HousingStatusID

This data element is the client's housing status at the end of the reporting period. There are three response categories for this data element:

- Stable Permanent Housing.

- Temporary Housing.
- Unstable Housing.

Stable Permanent Housing includes the following:

- Renting and living in an unsubsidized room, house, or apartment.
- Owning and living in an unsubsidized house or apartment.
- Unsubsidized permanent placement with families or other self-sufficient arrangements.
- HOPWA-funded housing assistance, including TBRA or Facility-Based Housing Assistance, but not including the Short-Term Rent, Mortgage, and Utility (STRMU) Assistance Program.
- Subsidized, non-HOPWA, house or apartment, including Section 8, the HOME Investment Partnerships Program, and Public Housing.
- Permanent housing for formerly homeless persons, including Shelter Plus Care, the Supportive Housing Program (SHP), and the Moderate Rehabilitation Program for SRO Dwellings (SRO Mod Rehab).
- Institutional setting with greater support and continued residence expected (psychiatric hospital or other psychiatric facility, foster care home or foster care group home, or other residence or long-term care facility).

Temporary Housing includes the following:

- Transitional housing for homeless people.
- Temporary arrangement to stay or live with family or friends.
- Other temporary arrangement, such as a Ryan White Program housing subsidy.
- Temporary placement in an institution (e.g., hospital, psychiatric hospital or other psychiatric facility, substance abuse treatment facility, or detoxification center).
- Hotel or motel paid for without emergency shelter voucher.

Unstable Housing Arrangements include the following:

- Emergency shelter, a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside.
- Jail, prison, or a juvenile detention facility.
- Hotel or motel paid for with emergency shelter voucher.

These definitions are based on:

- HOPWA Program, Annual Progress Report (APR), Measuring Performance Outcomes, form HUD-40110-C.
- McKinney-Vento Act, Title 42 US Code, Sec. 11302, General definition of homeless individual.

"Core medical and support services delivered" must be reported if eligible clients received housing support services during the reporting period (the below is excerpted from the *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual*).

XML Variable Name: ClientReportServiceDelivered

- Service Delivered.
- ServiceID (see table in the manual).
- DeliveredID (2—Yes).

Planned Leveraged Non-HOPWA Funds

RWHAP housing support services MUST also be reported to the Florida State HOPWA Program as leveraged funds.

Florida State HOPWA Program project sponsors are required to complete the Planned Leveraged Non-HOPWA Funds table in the *Florida State HOPWA Program Policies and Procedures* (Attachment 26). This table is used to list other federal, state, local, and private funds planned to be used and actually used in conjunction with HOPWA funds. The state must illustrate plans to obtain and use other public and private resources to be used for the purpose of providing HOPWA housing activities to and addressing the critical housing needs of persons living with HIV/AIDS. Therefore, the information requested for this form must be provided in order for the state to continue to receive a HOPWA grant award from HUD.

Other resources (non-HOPWA leveraged resources) to be used in conjunction with HOPWA funds refers to cash resources separate from the HOPWA contract award; and may include cash and in-kind contributions, such as the value of services or materials provided by volunteers, or by other individuals or organizations. The organizations may include, but are not limited to: Housing Choice Vouchers (Section 8), Public Housing Authority units, Supportive Housing for Persons with Disabilities/Elderly, **Ryan White HIV/AIDS Treatment Modernization Act programs**, and other federal programs, state funds, local government funds, and private philanthropy.

	The Planned Leveraged Non-HOPWA Funds table information is included in the HOPWA Annual Progress Report (APR) and then incorporated into the Consolidated Annual Progress and Evaluation Report (CAPER), which is the report submitted by the State HOPWA Program to the Florida Department of Economic Opportunity who then submits the final CAPER (including three other housing partners' data) to HUD.
Coordination Between Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Managers and HOPWA Program/HOPWA Housing Coordinators	Coordination should be done between Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue funded Case Managers and HOPWA Housing Coordinators regarding clients, which will not only provide benefit from their experience, resources, and processes/systems, but also ensure there is not duplication of housing services. In addition, this coordination ensures that clients are not being transferred from one program (HOPWA) to another (Ryan White Part B, Patient Care Networks General Revenue, or 4B000 General Revenue) and possibly back again, delaying addressing the client achieving financial independence and self-sufficiency. Finally, the client will be best served by his/her medical and housing care team working together to ensure improved health outcomes and housing stability.

Maricopa County
Ryan White Part A Program Policies and Procedures

Housing

PURPOSE:

To guide the administration of Ryan White Part A (RWPA) Program's **Housing Services** (a support service under the Ryan White HIV/AIDS Treatment Extension Act of 2009). The administration of funds must be consistent with RWPA client eligibility criteria and the service category definitions established by the Phoenix EMA RWPA Planning Council.

DEFINITIONS:

Housing Services is the provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care.

Short-term or emergency housing defines as necessary to gain or maintain access to medical care and must be related to either –

- Housing services that include some type of medical or supportive service, including, but not limited to, residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or
- Housing services that do not provide direct medical or supportive services, but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment; necessity of housing services for purposed of medical care must be certified and documented

POLICIES:

- Housing services must be advertised in the RWPA brochure and shared with all new clients so newly identified clients have access to housing services.
- Upon request, the Housing Service provider should be able to supply an individualized, written housing plan, consistent with the HRSA/HAB Program Monitoring Standards for Housing Services, covering each client receiving short term, transitional and emergency housing services. Written plans may include:
    - Number of clients served
    - Duration of housing services
    - Types of housing provided
    - Housing referral services
    - Client eligibility determination
    - Assistance provided to clients to help them obtain stable long-term housing

- Staff providing housing services must be case managers or other professionals who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs.
- Short term or emergency assistance must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintains, a long-term, stable living situation.
- Housing funds cannot be provided in the form of direct cash payments to recipients and cannot be used for mortgage payments.
- For contracts that fund salaries, the program should document at least 50% of allocated staff time with billed client units. Costs per client and costs per units should be reasonable when compared to EMA annual averages.

CLIENT CHARTING:

All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoken with and a brief summary of what was communicated in adherence with the client charting definition.

All paper chart documents must be original documentation and contain original dates and signatures of contract budgeted staff providing services i.e. assessments, treatment plans, and progress notes. All Electronic Medical Records must include authenticated, dated electronic signatures. The AA will only review documentation which is authenticated original documentation, and will not accept copies of assessments, treatment plans, or progress notes as acceptable documentation of services provided. Any records that do not include authenticated signatures of budgeted contract staff providing services will be considered unallowable units, and will not be reimbursed.

ELIGIBLE COSTS AND SERVICES:

Unit categories may include:

Time Units: Reflect the amount of direct service time.

Service Units: Reflect completion of a particular service related activity such as a case finding.

Product Units: Reflect the provision of a product/widget which has an identified cost.

Line Item Units: Reflect expenses identified in the budget such as salaries and fringe benefits. Must align with agency's approved budget and support documents submitted during billing.

Unit Information			CAREWare Data Entry Components			
Unit Category	**Unit Name**	**Unit Description**	**Client Name**	**Date**	**Unit Measure**	**Price**
Service Unit	Housing Services	Payments made for housing financial assistance	Entered into CAREWare under actual client name.	Date Payment was issued	1 unit = Cost of Client's First Month's Rent	Actual Cost
Time Unit	Housing Services NMCM	Time spent providing housing coordination and first month's payment assistance to eligible clients	Entered into CAREWare under actual client name.	Date service was delivered	1 unit = 15 minutes	$0
Line Item	Housing Services 10% Indirect	Unit for Administrative Costs applied to this contract. May only be billed if line item is in approved budget and support documents confirm identified expense	AAA Administrative, Admin	Last day of the month	1 unit = 1 unit per month	Actual Cost

4. Non-Medical Case Management Services

Status: Currently unfunded support service

Other Funders (based on 2023 Needs Assessment): General Revenue $547,953; Part B $147,961; Part C $120,593; Part D $71,955

HRSA 16-02 Definition (pg. 20-21)

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs.
- Development of a comprehensive, individualized care plan.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Client-specific advocacy and/or review of utilization of services.
- Continuous client monitoring to assess the efficacy of the care plan.
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary.
- Ongoing assessment of the client's and other key family members' needs and personal support systems.

Program Guidance:

NMCM services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Sample Services:

- Washington, DC EMA
- Texas, Part B
- Georgia, Part B

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Non-Medical Case Management

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Non-Medical Case Management Services Description: Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services.

NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services

- Continuous client monitoring to assess the efficacy of the care plan
    - Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems :

SERVICES DESCRIPTION: NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Under this service category, you can provide NMCM services, Benefits and Entitlement Counseling, and/or Re-entry Planning.

Benefits and Entitlement Counseling: Non-Medical Case Management Services may also include benefits counseling that assists eligible customers in obtaining access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and health insurance plans through health insurance Marketplaces/Exchanges.
This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the recipient.
Key activities include:
A. Initial assessment of emergent service needs, and appropriate referrals
B. Development of a comprehensive, individualized care plan
C. Continuous customer monitoring to assess the efficacy of the care plan
D. Re-evaluation of the care plan at least every 6 months with adaptations as necessary
E. Ongoing assessment of the customer's needs and personal support systems

Re-entry Planning: Non-Medical Case Management Services can also provide transitional case management for incarcerated persons as they prepare to exit the correctional system.
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes. This service category does not include the provision of Treatment Adherence Services.
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II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or letter from landlord that customer is resident

1. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
- A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return

- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
- Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENACE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of 'no change' when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

INITIAL ASSESSMENT OF SERVICE NEEDS	
Standard	**Measure**
NEEDS ASSESSMENT To identify customer issues and care needs. Each customer will participate in at least one face-to-face interview with their assigned non-medical case manager within ten (10) business days of determining Ryan White eligibility to complete the Needs Assessment. The following information must be recorded and is required if a customer does not already have a current assessment on file. The Needs Assessment must include an assessment of need in the following areas: 1. Finances/benefits 2. Housing 3. Transportation 4. Substance Use 5. Mental Health 6. Domestic violence 7. Basic needs, such as nutrition, food, and clothing 8. Support system 9. Current medical providers and medical case management providers 10. Identification of Legal Issues, if they exist 11. Any additional information required by the CareWare system not obtained at the intake	Documentation of assessment in customer's record signed and dated by health educator
DEVELOP INDIVIDUALIZED SERVICE PLAN	

Standard	Measure
INDIVIDUALIZED SERVICE PLAN Provider must develop individualized service plan, must document long and short-term goals and objectives to improve access to medical care and social services. Within ten (10) business days of determining Ryan White eligibility, the NMCM must develop an individualized service plan with input from the customer. The Service Plan must contain: 1. Goals and measurable objectives responding to customer needs. 2. Timeframes to achieve objectives 3. Screening for eligibility for entitlements and assistance in completing applications 4. Solutions to address barriers which are customer-specific. 5. Referrals for support services. 6. Documentation of the customer's participation in primary medical care. 7. Customer signature and date, signifying participation with development and agreement with Plan Provider must review the service plan within 90 days and modified accordingly.	Individualized service plan documented in customer record, signed and dated by the customer and non medical case manager
COORDINATION & MONITORING OF INDIVIDUALIZED SERVICE PLAN/REASSESSMENT	
Standard	**Measure**
COORDINATION & MONITORING OF INDIVIDUALIZED SERVICE PLAN	Documentation of review and update of HE/RR plan as appropriate signed and dated by customer and health educator

Provider must document contact with active customers every 90 days or as dictated by customer's needs. The nonmedical case manager must monitor the Service Plan and document the customer's progress on their goals. The goals are expected to be reached within 90 days. **If goals are not met within 90 days, Reassessment must occur.**	The customer record must include: 1. Progress notes detailing each contact with or on behalf of the customer to implement the service plan. 2. Progress of Service Plan 3. Any communication with any provider agency; such as documents, progress notes, etc. 4. Documentation of follow-up for referred services and missed appointments. 5. Documentation of Adjustment to Service Plan if necessary 6. Documentation of case conferencing when necessary 7. Documentation of emergency situations as they arise, such as crisis intervention.
Provider must ensure that at least eighty percent (80%) of all persons initially seeking services will be established into the care system within five (5) working days of initial contact. If this is not possible, the reason must be documented in the customer's file.	Documentation of referrals in customer's record
ONGOING ASSESSMENTS FOR SUPPORT	
Standard	**Measure**
Provider must provide education on HIV transmission and how to reduce the risk of infection to others	Documentation that customers were educated about HIV transmission and how to reduce the risk of HIV transmission to others. Documentation must Include description of the types of information, education, and counseling provided to customers
Provider must provide information on available psychosocial support services to customers	Documentation that customers received information about available medical and psychosocial support services. Includes description of the types of information, education, and counseling provided to customers
RE-ENTRY PLANNING	

Standard	Measure
Providers must provide transitional case management for incarcerated persons as they prepare to exit the correctional system. The PLWH is expected to be eligible for Ryan White services upon their release.	Documentation on customer's record of plan for engagement in services after release
Providers must review ● Discharge planning, ● Continuity of treatment and ● Provide community linkages	Documentation on customer's record
TRANSITION & DISCHARGE/CASE CLOSURE	
Standard	**Measure**
TRANSITION & DISCHARGE/CASE CLOSURE Case Closure/Discharge 1. Reasonable efforts must be made to retain the customer in services by phone, letter and/or any communication method agreed upon by the customer. 2. The provider will make appropriate referrals and provide contacts for follow-up. 3. The provider must document the date and reasons for closure of the case including but not limited to: service provided as planned, no contact, customer request, customer moves out of service area, customer died, customer ineligible for services, etc. 4. A summary of the services received by the customer must be prepared for the customer's record. Case Transfer: 1. If the customer is being transitioned, the provider must facilitate the transfer of customer records/information, when necessary. 2. The customer must sign a consent to release of information form to transfer records which are specific and dated.	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. Documentation must be kept for each customer, which includes: 1. Customer's name and demographic information 2. Name and contact info of customer's Medical Case Manager and Primary Care Provider, if they have one 3. Proof of HIV+ status. 4. Initial intake and needs assessment forms. 5. Signed, initial and updated individualized service plan. 6. Consent for services. 7. Progress notes detailing each contact with or on behalf of the customer. These notes must include the date of contact and names of the person providing the service. 8. Documentation that the customer received rights and responsibilities information.

	9. Signed "Consent to release information" form. This form must be specific and time limited. 10. Discharge and/or case closure information including person completing discharge and/or case closure, date and reason for discharge and/or case closure.

IV. PERSONNEL QUALIFICATIONS

PERSONNEL QUALIFICATIONS: Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

A. NON-MEDICAL CASE MANAGER

1. Associate's/Bachelor's degree in health or human services related field preferred. High School diploma or GED required.
2. A minimum of 2 years of past experience working with persons living with HIV or at high risk of HIV acquisition preferred.
3. Ongoing education/training in HIV related subjects.
4. Agency will provide new hires with training regarding confidentiality, customer rights and the agency's grievance procedure.

B. Non Medical Case Management Supervisor: Licensure as a Physician, Registered Nurse (RN), Nurse Practitioner , or as an advanced level graduate /Clinical Social Worker in the Jurisdiction(s) in which services are rendered.

C. CASE MANAGEMENT ASSISTANT/ COMMUNITY HEALTH WORKER

1. Para-professional with a High School diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
2. Ability to read, write, understand and carry out instructions.
3. Knowledge of community resources.
4. Sensitivity towards persons living with HIV/AIDS.
5. Bi-lingual preferred when appropriate.
6. Ongoing education/training in HIV related subjects.

D. ELIGIBILITY/INTAKE SPECIALIST

1. Para-professional with a High School diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
2. Ability to read, write, understand and carry out instructions.
3. Knowledge of community resources.
4. Sensitivity towards persons living with HIV/AIDS.
5. Bi-lingual preferred when appropriate.
6. Ongoing education/training in HIV related subjects.

All Non-Medical Case Managers, Case Manager Assistants, Community Health Workers and /Eligibility/ Intake Specialists must complete a minimum training regimen within one year of hire date that includes:

Non-Medical Case Management Service Standard

Health Resources & Services Administration (HRSA) Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Program Guidance:

NMCM Services have as their objective providing coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management (MCM) services have as their objective improving health care outcomes.

Referrals for health care and support services provided during a case management visit (medical or nonmedical) should be reported in the appropriate case management service category (i.e., MCM or NMCM). If a client who is enrolled in NMCM receives referral services that are not provided during a case management visit or by the client's medical case manager, these services can be reported under Referral for Health Care and Support Services (RHCS), provided the service

standards for RHCS are met. Recipients should take steps to ensure services are not billed in duplicate across different service categories.

Limitations:

Non-Medical Case Management services do not involve coordination and follow-up of medical treatments.

Non-Medical Case Management is a service based on need and is not appropriate or necessary for every client accessing services. NMCM is designed to only serve individuals who are unable to access or remain in medical or support services on their own. This service should not be used as the only access point for medical care and other agency services. Clients who do not need guidance and assistance in improving or gaining access to needed services should not be enrolled in NMCM services. Clients should be graduated when they are able to maintain needed services independently, or when they have needs that can be adequately addressed under another support category, such as Referral for Health Care and Support Services (RHCS).

Clients can only receive one category of case management service (MCM or NMCM) at one time. However, clients that were previously enrolled in NMCM can be discharged and enrolled in MCM services if they experience an increase in acuity.

Services:

Key activities of NMCM include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six (6) months with adaptations as necessary
- Ongoing assessment of the client's needs and available resources to support those needs

In addition, NMCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be

eligible (e.g., Medicaid, Medicare Part D, state pharmacy assistance programs, pharmaceutical manufacturer's patient assistance programs, other state or local health care and supportive services, or Marketplace insurance plans).

Universal Standards:

Service providers for Non-Medical Case Management must follow HRSA/DSHS Universal Standards 1-46 and 129-132.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Initial Assessment: All clients enrolled in NMCM should receive an initial assessment to determine their need for medical and support services, as well as barriers to accessing services and client strengths and resources. The 30-day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information. The assessment should determine client needs in the following areas: • Access to medical care and medication • Food security and nutritional services • Financial needs and entitlements • Housing security • Transportation • Legal assistance • Linguistic services • Any other applicable medical or support service needs The following should also be included in the initial assessment: • Client strengths and resources • Other agencies that serve client and household • A brief narrative summary of the assessment	1. Percentage of clients with a completed initial assessment within 30 calendar days of the first appointment to access NMCM services.

session(s)	
Care Planning: The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum: • Problem statement based on client need • One to three current goals • Interventions to achieve goals (such as tasks, referrals, or service deliveries) • Individuals responsible for the activity (such as case management staff, the client, other team members, the client's family, or other support person) • Anticipated time for the completion of each intervention The care plan should be updated with outcomes and revised or amended in response to changes in access to care and services. Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed, and not at set intervals. Care plans must be updated at least every 6 months, with documentation that all required elements (problem statement/need, goals, interventions, responsible party, and timeframe) have been reviewed and, if appropriate, revised.	2. Percentage of clients with a care plan that contains all of the following: 2a: Problem statement/need 2b: Goal(s) 2c: Intervention (tasks, referral, service delivery) 2d: Responsible party for the activity 2e: Timeframe for completion 3. Percentage of clients with care plans that have been updated at least every 6 months.
Assistance in Accessing Services and Follow-Up: Case management staff should work with the client to overcome barriers to accessing services and to complete the interventions identified in the care plan. Assistance should be based on the needs identified, collaboratively with the client, during the care planning process. If any assistance is denied by the client, this should be documented.	4. Percentage of clients with documentation of assistance provided, based on the client care plan. 5. Percentage of clients with documentation of any assistance denied by the client. 6. Percentage of clients who received assistance in accessing outside services that have documentation of follow-up.

When clients are aided with services elsewhere (outside of the agency providing NMCM services), case notes include documentation of follow-up and outcome.	
Case Closure/Graduation: Clients who are no longer engaged in active medical case management services should have their cases closed with a case closure summary documented in the client's chart. This should include both a brief narrative progress note and formal case closure/graduation summary. All closed cases should be reviewed and signed by the case management supervisor. Clients must be notified of plans for case closure and provided written documentation explaining the reason for closure/graduation and the process to be followed if the client elects to appeal the case closure/graduation from service. At the time of case closure, clients should also be provided with contact information to reestablish NMCM services and information on the process for reestablishment. A client is considered to be "out of care" if three attempts to contact the client (via phone, e-mail, and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter), as permitted by client authorization when trying to re-engage a client. Case closure proceedings should be initiated by the agency 30 days following the third attempt at contact. Common reasons for case closure include: • Client no longer needs non-medical case management services	7. Percentage of closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary). 8. Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). 9. Percentage of clients with closed cases who were provided with information about the reason for discharge, the process to appeal their discharge, and how to reestablish NMCM services

• Client is referred to another case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client is or will be incarcerated for more than 6 months in a correctional facility. • Provider-initiated termination due to behavioral violations, per agency's policy and/or procedures • Client death Graduation criteria: • Client completed case management goals for increased access to services/care needs • Client is no longer in need of case management services (e.g., client can resolve needs independent of case management assistance or has needs that can be adequately met by RHCS) Note: Staff should not inactivate clients in Take Charge Texas (TCT) at the time of case closure or graduation, unless the case is being closed due to a deceased client.	

Georgia Case Management Definitions

Medical Case Management

Medical Adherence Assessment
-- new to treatment or experienced
-- change in regimen
-- determine willingness to adhere
-- by RN in clinical setting

Individual Medication Adherence Counseling
-- new to treatment or experienced
-- change in regimen
-- ongoing regimen
-- by RN in clinical setting

Initial Enrollment
-- intake, assessment, and initiation of Individual Service Plan
-- coordination and follow-up of medical treatment
-- discussion of treatment adherence

Individual Service Plan (ISP)
-- face-to- face
-- review progress, identify additional needs, establish next steps, and set new goals
-- discuss medical treatment, adherence
-- initial or comprehensive updated
-- determine acuity level

Interim contacts
-- face-to-face or non face-to-face
-- must include coordination and follow-up of medical treatment and adherence
--follow-up on ISP goals and current needs

Discharge linkage
-- coordinate care for clients leaving hospital
-- link to clinic, access services and medication
-- education on enrollment
-- by RN or medical case manager in treatment setting

Georgia (Revised Version) 2018

Non-Medical Case Management

Initial Enrollment – Nonmedical
-- intensive enrollment visit for intake and assessment
--explanation of program, navigating health care system, discussion of needs, and collection of eligibility information (income, etc.)
-- may include assistance in obtaining medical, social, community, legal, financial, emergency assistance to self-managed client (housing, transportation, food, etc.) and other needed services.

Interim Contacts
-- face-to-face or non face-to-face
-- follow-up on ISP goals and current needs
-- including obtaining updates on needs and income.
-- may include assistance in obtaining medical, social, community, legal, financial, emergency assistance to self-managed client (housing, transportation, food, etc.) and other needed services.

Supportive/Self Management
-- face-to-face or non face-to-face
-- reevaluate and update
-- does **not** involve coordination or follow-up of medical treatment

Benefits/Financial Counseling
-- enrolling in ADAP, PAP, HICP and other entitlements
-- determining eligibility for Medicaid, Medicare, other payer
-- regardless of credential of staff performing activity

Peer Encounter
-- face-to-face or non face-to-face
-- by a peer advocate/educator
-- includes follow-up with clients lost to care, other client follow-up, and navigation
-- does not include benefit/financial counseling
-- does not include client education

Source: *Georgia Ryan White Parts A, B, D CAREWare Sub-services and Definitions,* 2018

5. Psychosocial Support Services

Status: Currently unfunded support service

Other Funders (based on 2023 Needs Assessment): Part D $53,204

HRSA 16-02 Definition (pg. 23)

Description:

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

***Program Guidance*:**

Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

Other Sample Services:

- Washington, DC EMA
- Cleveland, OH TGA
- Miami-Dade, FL EMA (former definition to be found)

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Psychosocial Support Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Psychosocial Support Services provides individual and/or group support and counseling services to address customers' continuing behavioral and physical health concerns. Psychosocial support should be delivered by staff, volunteers, and/or peers to help clients access health and benefits information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve quality of life for participants. Key activities include:

- Support and counseling activities
- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services
- Caregiver support

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data

13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	**Measure**
Prior to the initiation of the psychosocial support service plan, customers are assessed for: ● support system and psychosocial support needs ● history of accessing primary care and other services and barriers to access— noting psychosocial support barriers in particular	Documentation of intake and assessment in customer's record signed and dated by psychosocial support staff
The type and level of psychosocial support services to be delivered must be documented in an existing Ryan White service plan or outlined in a new support plan. The plan for psychosocial support services must include identified problem(s), goal(s) to address problem, and target date for completion.	Psychosocial support service plan, documented in customer record, signed, and dated by the customer and psychosocial support staff
Psychosocial support service plan is reassessed every 90 days to review customer's treatment adherence as well as engagement and retention in in primary care and medical case management **Exclusions** Funds under this service category may not be used for social/recreational activities or to pay for a customer's gym membership.	Documentation of reviewed and updated of psychosocial support service plan as appropriate signed and dated by customer and psychosocial support staff. Documentation should indicate topics covered, activities conducted, and goals achieved. Additional activities in the client record, if applicable, must include: ● Progress notes for each contact with client by phone or at face-to-face meetings ● Progress notes recording activities on behalf of the client to implement the Support Plan ● Progress toward goals ● Communications with referring agency (e.g., missed/kept appointments, etc.) ● Contacts with client (by phone or face-to-face), depending on client need ● Documentation of follow-up for referred services ● Documentation of follow-up to missed appointments ● Management of emergency situations as they arise ● Adjustment to support plan, if necessary ● Case conferencing when necessary ● Crisis intervention when necessary
Customers may receive support counseling in either an individual or group format. Counseling must be	Documentation of counseling services provided in customer record, indicating:

conducted by a qualified individual (professional or peer) and should be structured, with a treatment plan or curriculum, to move clients towards attainable goals. Pastoral care/counseling must be available to all eligible customers regardless of religious denominational affiliation and must be provided by: ● An institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider ● A licensed or accredited provider, wherever such licensure or accreditation is either required or available	● Date of session ● Duration of session ● Name and title of the group, if applicable ● General topics discussed ● Summary of activities conducted ● Goals and objectives selected and achieved during the session(s)
Customers may receive nutritional counseling services (e.g., nutrition education, assessment, and counseling) by a non-registered dietitian to assist them in: ● Maintaining treatment regimens ● Remaining in primary medical care ● Using food products in the best way possible to maintain or improve health and maximize health benefits *Note: A nutritional plan cannot be developed by a registered dietitian under this service category.* **Exclusions** ● Funds under this service category may not be used to provide nutritional supplements (*See Food Bank/Home-Delivered Meals).*	Documentation of nutritional service(s) provided in customer record
Customers may receive bereavement counseling	Documentation of bereavement counseling provided in customer record
The provider must ensure that referrals and linkages to other services, such as mental health and substance abuse treatment, are made as appropriate and documented with the status of outcomes	Documentation of referral(s) in customer's record
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when psychosocial support services are no longer needed, goals have been met, upon death or due to safety issues. <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. <u>Documentation</u>: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge

present to sign for the letter, it must be returned to the provider. Transfer: If customer transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	● Referrals made at time of discharge, if applicable
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals	Documentation of case closure in customer's record with clear rationale for closure

● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison, or inpatient program ● Is deceased	

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

At minimum, all psychosocial support service staff and volunteers must have a high school diploma or GED plus one year of social service experience. Qualifying life experience may substitute educational and professional requirements. They must be able to provide linguistically and culturally appropriate services for people living with HIV, and complete documentation as required by their positions. Staff will be sensitive to the needs of persons of diverse life experiences, including customers with substance use disorder, mental illness, with co-occurring disorders and, ideally, will have prior experience working with the target population. Staff and volunteers will also be trained in or have relevant experience in core competencies:

- Active listening and other one-on-one support skills
- Group facilitation, if applicable
- Conflict de-escalation/resolution
- Roles and responsibilities of peer emotional support
- Client assessment skills, including:
    - Conducting an initial needs assessment (as appropriate to job function)
    - Identifying an individual at imminent risk who is in need of a higher level of support
- Awareness of resources for appropriate referral

All newly hired psychosocial support services staff and volunteers must complete the following trainings:

a. HIV 101, including impacted communities, disease process, co-morbidities, and psychosocial effects of the virus
b. HIV counseling and testing
c. HIV care system, resources, and access
d. Motivational interviewing
e. Information and techniques for working with substance use disorder
f. Sexual health and risk

g. Gender competency
h. Names reporting
i. Cultural Awareness, sensitivity, and competency
j. Consent laws, client confidentiality, Health Insurance Portability and Accountability Act (HIPAA), client rights, and agency grievance procedures
k. Entitlement programs, benefits to clients, and community resources/support services

In addition to attending the above, all psychosocial support services staff and volunteers are required to attend ongoing annual training on topics related to their position, including, but not limited to:

a. Sexual health
b. Substance use disorder, sensitivity and cultural approaches and related issues
c. Mental health
d. Domestic violence
e. Sexually transmitted infections (STIs)
f. Partner notification
g. Bereavement
h. Cultural and linguistic competence
i. Nutrition

Pastoral Care Counselor

- All pastoral care counselors must have appropriate and valid licensure as required by their jurisdiction.

Psychosocial Support Services Supervisor

- All non-professional staff delivering psychosocial support services must be supervised by a licensed professional.
- The supervisor of psychosocial support staff must be appropriately trained, knowledgeable and highly competent in the areas of HIV/AIDS, substance use disorder, community referrals, educational services, general computer skills, and the areas of competence and training expected of psychosocial support staff.
- Supervisors will have at least two years of work experience with related populations or issues.
- Supervisors will also complete the trainings required of new psychosocial support service staff, as noted in this section.

V CLINICAL QUALITY MANAGEMENT

A continuous Clinical Quality Management Program for HIV patient care. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

Every agency that provides Ryan White supported Substance Abuse services must develop and implement a Quality Management (QM) Plan. The QM Plan should be actively supported and guided by the formal agency leadership and senior administration, and appropriate resources should be committed to support continuous quality improvement activities. Agencies with multiple funded service categories must integrate the Substance Abuse QM Plan into their broader QM Plan and specifically address HIV-related services. The QM Plan must be in writing. At least once a year, the QM Plan must be reviewed and updated routinely by the QM committee. Staff from all levels of the agency, as well as patients should serve on the QM committee. Each member of the committee should be aware of the QM infrastructure. However, all agency staff regardless of their participation on the committee must understand their role in the agency's/program's quality improvement activities.

Psychosocial Support Services

SERVICE CATEGORY DEFINITION

Psychosocial Support Services:

Psychosocial Support Services provide group or individual support and counseling services to include HIV support groups to assist eligible people living with HIV to address behavioral and physical health concerns.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- ◊ Have an HIV/AIDS diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Psychosocial Support Services

PERSONNEL QUALIFICATIONS

An individual providing psychosocial support services must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of psychosocial support services is to provide group support and therapy for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for psychosocial support services are:

- 80% of psychosocial support clients have received education specifically geared towards the importance of medical adherence.
- 80% of psychosocial support clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Psychosocial Support Services

SERVICE STANDARDS

	Standard	Measure	Goal
1	* Psychosocial Support services are provided by qualified professionals	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2	* Documentation is maintained of all topics discussed through support group with correlating sign-in sheets.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
3	* Access and engagement in primary care topics were discussed with the client at least once in a 3 month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
4	* Access and engagement in medical case management was discussed with the client at least once in a six month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
5	Psychosocial client is linked to medical care.	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report).	80%
6	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Psychosocial Support Services

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.