COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
HIV PLANNING GROUP

HIV SERVICE STANDARDS
FOR RYAN WHITE CARE AND TREATMENT SERVICES AND PREVENTION SERVICES

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* Note service categories also funded under Ryan White Part B via the California Department of Public Health (CDPH) and are subject to the standards developed by the CDPH.

Introduction

What Are Service Standards?

Service standards outline the elements and expectations an HIV service provider follows when implementing a specific service category. The purpose of service standards is to ensure that all HIV service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a funded agency or provider may offer within a state, territory, or jurisdiction.

Service standards are essential in defining and ensuring that consistent quality care is offered to all clients. They set a benchmark by which services are monitored, and sub-grantee contracts are developed.

Why Are Service Standards Important?

Service standards are important to various stakeholders, with the goal to improve client and public health outcomes.

- Consumers - Service standards ensure the minimal expectation for consumers accessing or receiving RWHAP funded services within a state, territory, or jurisdiction.
- Service Providers - Service standards define the core components of a service category to be included in the model of service delivery for each funded service category.
- Grantee - Grantees are responsible for ensuring the development, distribution, and use of the service standards. Service standards are important to ensure that services are provided to clients in a consistent manner across service providers.
- Quality Managers - Service standards are the foundation for the clinical quality management program and provide the framework and service provision from which processes and outcomes are measured.
- Planning Bodies - Service standards assist planning bodies with understanding what activities are being provided

Universal Standards

Intake Requirements

To receive Ryan White services, clients must establish eligibility by providing:

- Documentation of HIV infection (only required one time at initial enrollment)
- Documentation of residency in San Diego County
- Documentation that their income does not exceed 500% of the federal poverty level
- Documentation of insurance status and any other third-party payers.

Once a client has established eligibility, they will be enrolled in the Ryan White program. Clients maintain their enrollment by completing an annual re-enrollment at 12 months. For mid-year recertifications, clients do not need to provide additional documentation unless there has been a change in residency, income, or insurance status. Documentation of residency, income and insurance status is required for all annual re-enrollments.

Beginning in March 2021, once a client has established eligibility, they will appear on a secure eligibility list, updated weekly, at which time they can receive services from any Ryan White Part A or B provider in San Diego County without having to provide any additional documentation to establish eligibility for Ryan White services.

For all service categories except Emergency Financial Assistance and Housing, clients can receive services for up to 30 days before providing all documentation required to complete enrollment.

At the time of intake, providers are required to verify that any client seeking Ryan White Services has been enrolled in the AIDS Regional Information and Evaluation System (ARIES). For clients who are new to the Ryan White system of care, providers must obtain a signed ARIES consent form from the client and enter new client into ARIES. All service utilization data will then be reported in the ARIES system. Clients who do not sign an ARIES consent form are not eligible to receive Ryan White Part A and B funded services.

Also, at the time of intake, providers are required to assess needs of client and their ability to meet these needs through Ryan White services or offer appropriate referrals. To the degree that telehealth appointments are appropriate for, continue to be allowable by third party payors and are provided to clients, information regarding the potential availability of telehealth services as well as the availability of assistance with the provision of necessary equipment and some limited internet access will be provided.

Within 90 days of intake or recertification, providers also assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, and service location. Service information and assessment is also provided regarding temporary housing services, food services, emergency financial assistance, mental health services and substance use treatments, and available transportation. Such information will be provided to clients and documented in ARIES at least once a year thereafter.

[Measure: ARIES note indicating date service information/referrals were provided.]

Additionally, providers are required to review client rights and responsibilities, complaint and grievance policies and confidentiality and sharing of protected health information.

Providers of prevention services must integrate the Local Evaluation Online (LEO) Privacy Notice into intake processes. Clients need to be presented with a privacy notice and are not required to consent to having their personal information entered into LEO in order to receive services.

Standard	Measure
Clients must meet local and federal program requirements to be eligible to receive Ryan White Part A/B services	Documentation of annual enrollment and mid-year recertification retained in client file OR documentation in client file that the client appears on the Ryan White eligibility list.
Clients seeking Ryan White funded services are enrolled in ARIES and sign a consent form	Documentation of consent form is required and retained in client file
Clients seeking prevention services are presented with a privacy notice	Documentation of provision of privacy notice are retained in client file

Service providers must be mindful of the amount of paperwork required and seek to consolidate as feasible. Clients are encouraged to communicate if they do not understand any part of the intake process.

Client Rights and Responsibilities

Clients have the right to receive services that address their needs, as well as refuse services. Clients may actively engage in decision making. Clients also have the right to involve their family members and/or other identified support persons in support of their care if they wish. Consent will be required in order for any information to be shared directly by providers with such persons. All providers must have written policies and procedures regarding client rights and responsibilities. Clients are informed of these rights and responsibilities during intake and a written copy is made available.

Clients are informed of expectations when accessing services. If a client does not meet these expectations, the provider is responsible for informing the client of needed changes and a contract may be implemented in order for client to continue receiving services. Failure to comply with a contract may require additional corrective action. Clients will not be denied service due to knowledge of current or prior substance use.

Clients shall not be denied services from a provider based on client's unwillingness to participate in other services.

Standard	Measure
Clients are informed of their rights and responsibilities	Documentation of client rights and responsibilities during intake

Complaint and Grievance Process

In the event clients feel that they are not being heard or services are not being delivered in a way that addresses their needs after providing input, they have the right to make a formal complaint. Clients are to be actively engaged in the services they receive, during assessment, planning and delivery phases. This includes regular feedback to providers regarding their needs and when the services are not meeting their needs.

All providers are required to have written policies and procedures for an internal client complaint process. The policy will identify staff responsible, an appeal process, tracking system, follow-up procedures, and a timeline. Service providers will use relevant federal, state and county regulations for investigating and resolving complaints. A copy of the complaint policy will be displayed in an observable location where services are provided. Complaints and investigation results will be forwarded by the provider to the County within 24 hours of both the receipt and resolution of the complaint.

In addition to the internal complaint process, all providers are required to have written grievance policy and procedure for escalation of unresolved complaints. In addition to the internal complaint process, information on how clients may contact the County of San Diego's HIV, STD and Hepatitis Branch will be provided.

Grievance procedures must specifically note that there will be no retaliation against clients for filling a verbal or written grievance. They also must clarify that clients will not be suspended or terminated from services based on filing a complaint or grievance.

Clients will be informed of the complaint and grievance policies during intake. Providers will also post a copy of the Client Service Evaluation form ("Goldenrod") in an observable place. Copies of the form must be easily accessible to clients, along with a stamped self-addressed envelope to the County for review. The form may also be accessed, completed, and submitted on the HIV Planning Group website at www.sdplanning.org. Providers shall not require a client to give a form directly to them.

The following is the Goldenrod process:

1. Staff at the HIV, STD and Hepatitis Branch will process this service evaluation. If the client wishes to be contacted, staff will reach out to them within three (3) business days of receiving the form. The client will be asked for additional information (if needed) and asked if the client is comfortable sharing their name with the agency.
2. County staff will contact the agency to report the issue. The agency will be asked to respond to the client either directly or through County staff, and to follow-up in writing to staff within thirty (30) days describing the resolution.
3. Notify the Ryan White Program Manager if there are concerns.

Standard	Measure
Clients' rights are protected, and clients have access to complaint and grievance processes and are made aware of such processes and the outcomes	Documentation of a complaint and grievance policies and client orientation of processes
Clients can file a complaint and grievance without being subject to retaliation	Verification of confidential Client Service Evaluation "Goldenrod" (available in English and Spanish) and mechanism to mail form in an observable location at sites where services are provided

Case Closure

Case closure is a systematic process for removing clients from an active caseload. A case can be reopened in the event the clients' situation and reasons for closure change.

The process includes formal client notification regarding pending case closure and the completion of a case closure summary to be maintained in the client chart. Clients are considered active providing they receive services at the minimal interval as defined by the individual service standard. Case closure may be initiated by a provider and/or client and may occur for the following reasons:

- Case resolved and/or successful attainment of goals
- Client relocated outside San Diego County
- Client initiated case closure of services
- Client does not adhere to treatment plan
- An inability to contact client for 120 days
- Client exhibits inappropriate behavior
- Client's health needs cannot be adequately addressed by the service
- Client's care is transferred to another provider

A case closure summary will be completed for each client and provided to the client when possible for each occurrence of case closure for the following service categories:

- Medical / Dental
- Medical / Non-medical Case Management
- Mental Health / Psychiatry
- Outpatient / Residential Substance Use Disorder Treatment
- Legal
- PARS

Standard	Measure
Client's case is closed based upon at least one of the approved criteria	A case closure is noted in the client chart For specified service categories, a case closure summary including the following: • Most recent assessment and/or diagnosis • Care plan at time of closure • Referrals not yet completed • Reason for case closure For clients who drop out of care without notice, case closure summary including the above and the following: • Documentation of attempts to contact client, including written correspondence and results of these attempts

Termination of Services

A provider may terminate a case (permanently close) when:

- Client is deceased
- Client demonstrates repeated non-adherence
- Client exhibits inappropriate behavior in violation of specific written policies of the provider
- Client violates confidentiality of other client(s)

The client shall be notified in writing with the reason for termination and provided a list of alternative sources of care and support services.

A termination of service summary will be completed for each client, included in the client's record, and provided to the client upon request.

Standard	Measure
There is documentation with reason(s) for termination in the client record	A termination of service summary including the following documentation: • Most recent assessment and/or diagnosis • Care plan at time of termination • Referrals not yet completed • Reason for termination
Staff determine client eligibility for other programs and re-instatement in services	Documentation of "inactive status" and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

Competency in Service Design and Delivery

Local epidemiology in San Diego County indicates that HIV disproportionately impacts some of the County's communities, including gay, bisexual, and other men who have sex with men, Black/African American persons, Hispanic/Latinx persons, Transgender persons, persons who inject drugs, and persons who are age 50 or older. These disproportionalities and disparities result largely from marginalization, oppression, discrimination, and stigma, along with historical and current structural racism, homophobia, transphobia/gender non-binary phobia, and ableism. These disproportionalities also show up in socio-economic status, poverty, educational attainment, stable employment, stable housing, involvement with carceral systems, and access to systems that support whole-person well-being. Finally, other San Diego communities experience disparities in access to services due to their low proportion of the overall epidemiology, such as women and youth living with or vulnerable to HIV.

In 2020 and 2021, the HIV Planning Group conducted a community engagement project, resulting in several recommendations to ensure the HIV service delivery system funded by the County of San Diego can better serve its residents. These recommendations include developing, implementing, and evaluating the effectiveness of systems that:

1. Ensure staff who interact with clients or who have control over systems that clients interact with receive education about the realities of lived experiences of clients served, including discussions of inequitable access, inequitable outcomes, and how both personal interactions and systemic barriers can lead to disparate outcomes.
2. Ensure clients receive education and support to advocate for what they need, speak out when their needs are not being adequately addressed, and receive timely and adequate responses and supports to address their needs.
3. Ensure that clients can communicate in ways they are most comfortable (*e.g.,* Spanish, American Sign Language, Adaptive and Assistive Communication.)
4. Ensure that all entry points can assess whole-person and whole-family wellness, and when requested can provide support in accessing additional services and supports.

5. Ensure that client support needs are assessed, and reasonable accommodations are available to allow clients to participate in and receive benefit from services.
6. Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success.

To eliminate disparities, all providers must have the ability to provide appropriate and acceptable services to potential and current clients, including persons of color; gay men and other men who have sex with men; men or women vulnerable to HIV; bisexual men and women; transgender individuals; gender non-binary and gender non-conforming individuals; persons who use substances; persons with mental health concerns; and disabled persons. Providers who serve any of these groups must make reasonable accommodations in service provisions to ensure all clients can participate fully in services and achieve the same outcomes.

All providers must have policies and procedures that address cultural humility and competency, diversity, and inclusiveness. Provider's intake procedures will assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, adaptations and accommodations for disabilities, and service location. Staff working directly with clients must receive a minimum of four hours of cultural humility and competency training each year.

Providers will identify staff and volunteers who can provide bilingual/bicultural services to individuals who need or prefer to communicate in other languages. If there are no staff members or volunteers who can perform this function, the provider will develop alternate methods to ensure language appropriate services are available.

Providers will assess and ensure the training and competency of individuals who deliver language services to assure accurate and effective communication between clients, staff, and volunteers to transcend language barriers and avoid misunderstanding and omission of vital information.

Standard	Measure
Agency policies address cultural humility and competency, diversity, inclusiveness.	Documentation in policies of cultural humility and competency, diversity, and inclusion requirements.
Intake procedures assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, adaptations and accommodations for disabilities, and service location needs.	Intake documents, policies and/or procedures that demonstrate assessment of required components.
Staff receive a minimum of four hours of annual training on cultural humility and competency	Documentation of all staff trainings on cultural humility and competency
	Copies of curricula, handouts, and any other documentation kept on file that indicate discussions related to inequitable outcomes and interpersonal and systemic sources of disparate outcomes
Staff and volunteers are bilingual and can address the language needs of the populations they serve. If there are no appropriate bilingual staff or volunteers, a plan is in place to ensure language needs are met	Copies of staff credentialing or other indicators that staff are bilingual and can address language needs of client populations served. Copy of written plan to address language needs

Provider has available written materials in languages appropriate for communities being served.	Materials available in appropriate languages
Clients receive education and support to advocate for what they need, speak out when their needs are not being adequately addressed, and receive timely and adequate responses and supports to address their needs.	Documentation that clients received support and education to advocate for what they need. Documentation that client concerns were documented and addressed timely and adequately.
All entry points assess whole-person and whole-family wellness, and when requested can provide support in accessing additional services and supports.	Documentation that all entry points assess whole-person and whole-family wellness and linkage to needed services and supports.
Client support needs are assessed, and reasonable accommodations are available to allow clients to participate in and receive benefit from services.	Documentation of assessment of client needs
Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success.	

Privacy and Confidentiality

All providers must develop written policies and procedures that address security, confidentiality and access and operations.

- All physical case and electronic files are secured at all times
- All activities that relate to client data have appropriate safeguards and controls in place to ensure information security
- All employees and volunteers working have signed a confidentiality agreement
- All staff orientation materials include client confidentiality policies and procedures and indicate how they are communicated to staff and volunteers

Policies and protocols regarding confidentiality and sharing of protected health information are explained to clients and a confidentiality agreement is signed by clients and maintained in their case files. Except in the case of medical and dental referrals, a separate Release of Information form must be signed by clients in order for information to be shared.

The form must contain:

- Name of the program or person permitted to make the disclosure
- Name of the client
- Party with whom information will be shared
- Purpose and content (kind of information to be disclosed) of the disclosure; information related to mental health, substance use disorder and HIV status require specific consent to release information
- Effective date of Release of Information (when does the form no longer authorize the exchangeof

information)

- Client's signature or legal representative's signature

Provider must ensure a private, confidential environment for clients to discuss their case(s).

Standard	Measure
Providers develop written policies and procedures that address security, confidentiality, access, and operations	Documentation of policies and procedures
All files are secured	Files inspected and noted during site visits
Staff and volunteers will receive training on privacy and confidentiality	Documentation of all staff/volunteer trainings on privacy and confidentiality
	Copies of the curriculum and handouts etc. kept on file (if training is provided by the provider)

Childcare Services

Service Category Definition

Intermittent childcare services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or Ryan White HIV/AIDS Program (RWHAP)-related meetings, groups, or training sessions.

Purpose and Goals

The goal is to provide childcare services for children of HIV-positive individuals receiving Ryan White program services during Ryan White-related appointments, group sessions or meetings.

Intake

Services are available to children (infancy through 12 years of age) living in the household of individuals with a confirmed HIV diagnosis and their affected family members while attending medical visits, related appointments, and/or Ryan White-funded meetings, groups, or training sessions. Case managers and service providers will arrange this service.

Key Service Components and Activities

The service consists of a variety of childcare options for children between the ages of infancy and twelve years of age to address the needs of families, including provision and coordination of/with on-site childcare and off-site/out stationed childcare at other community service sites or locations. Specifically, providers may:

- Offer assistance to improve access to subsidized childcare programs at the YMCA Childcare Resource Center, San Diego Head Start and other community-based programs
- Offer assistance to clients who need licensed childcare or babysitting on a regular basis to determine eligibility and ability to access other programs
- Provide on-site service in conjunction with other services
- Offer services through in-house childcare workers or a licensed domestic service agency
- Offer a children's activities program, with age-appropriate activities, toys, and other supplies

Services are also available, if permitted at the appointing clinic, for parents and caregivers attending medical, dental, and mental health care appointments, including support groups, on-site. Childcare is prioritized for appointments so family members can access support service needs but may be available for other purposes as determined appropriate. For parents and caregivers utilizing on-site services, at least one parent or caregiver must remain on-site.

Standard	Measure
Staff will maintain records on who received childcare services and the type of service	Documentation of clients who received childcare services and the types of services received

Personnel Qualifications

On-site Childcare is provided as cited in California Code of Regulations, Title 22, Division 12, Chapter 1, Section 101158 (http://www.dss.cahwnet.gov/getinfo/pdf/ccc1.PDF).

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

The determination of need for childcare services will be made by case managers, substance abuse counselors, primary care, or oral health providers and/or other service providers and will only be available during the duration of the client's RW service.

Standard	Measure
Staff will assess clients' needs for childcare services	Documentation of the clients' need for childcare services from the appropriate provider
Staff will maintain records on the number of hours childcare services are provided	Documentation on the number of hours childcare was provided to clients

Early Intervention Services

Service Category Definition

Early intervention services is a combination of four services that are conducted to increase an individual's awareness of their HIV status and, if needed, facilitate access to the HIV care system using HIV testing, referral services, health literacy/education and linkage to care as a bridge to medical care, medication access and treatment adherence.

Purpose and Goals

The goal of early intervention services is to decrease the number of individuals with HIV/AIDS by increasing access to care, identify individuals with HIV/AIDS and link them to appropriate health and support services. Services include testing, outreach, education and referrals to health care and support services.

Intake

Early intervention services are for:

- Individuals who do not know their HIV status and need to be referred to counseling and testing
- Individuals who know their status and are not in care and need assistance to enter or re-enter HIV-related medical care

Key Service Components and Activities

Early intervention services focus on the identification of individuals through outreach at key points of entry and delivery of the following four key services:

- Targeted HIV testing
- Referral services
- Access and linkage to HIV care and treatment services
- Outreach and health education and health literacy training that enable clients to navigate the HIV system of care

All four components must be present. Individuals who test positive are referred for and linked to health care and supportive services. Health education and health literacy training are provided to clients to assist them in navigating the HIV care system.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation showing that: • Individuals who test positive are appropriately referred for and linked to health care and supportive services • Health education and health literacy training are provided that enables clients to navigate the HIV system • Services are provided at or in coordination with documented key points of entry • Services are coordinated with HIV prevention efforts and programs

Standard	Measure
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Personnel Qualifications

Staff providing testing under early intervention services will meet the State requirements for training for HIV counseling and testing using the OraQuick rapid HIV -1/2 antibody test and the OraQuick rapid hepatitis C virus (HCV) antibody test (as needed) as outlined at http://www.cdph.ca.gov/programs/aids/Pages/OAHIVTestResources.aspx.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure, degrees, certifications and/or completion of training
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Outreach workers will determine each individual's knowledge of their HIV status and direct the individual to the appropriate service or resources.

- For individuals who do not know their HIV status, refer them to testing
- For individuals who know their status, are positive, are not in care and need assistance, help them enter or re-enter HIV-related medical care through the appropriate service (as determined by the circumstances)
- For individuals who know their status and are negative, refer them to the appropriate prevention resources and services.

Individuals are referred to HIV testing and those who test positive are referred for and linked to appropriate health care and supportive services such as outpatient/ambulatory health services, medical case management and substance abuse care.

Standard	Measure
Staff will direct individuals to the appropriate services and resources	Documentation that all individuals were directed to the appropriate services based on the HIV status and need

Emergency Financial Assistance and Housing

Service Category Definition

Emergency financial assistance:
Emergency financial assistance provides limited one-time or short-term payments to assist the Ryan White HIV/AIDS Program client with an emergent need for paying for essential utilities, limited supplemental rental assistance, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Housing:
Housing services provide limited short-term assistance to support emergency, temporary or transitional housing to enable clients or families to gain or maintain outpatient/ambulatory health services. Housing- related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Purpose and Goals

Housing and emergency financial services are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. The goal of these services is to prevent negative client outcomes as a result of emergency financial and housing difficulties by providing financially stable living situations and environments which enables clients to access or maintain medical and other necessary care and treatment services and improve compliance with medical regimens that improve health outcomes.

Intake

Any Case management program may refer and are responsible for determining clients' need and eligibility for emergency financial assistance and housing assistance. Clients must provide valid proof of the qualifying financial and/or housing emergency. Case managers will coordinate client application intake and initiation of financial assistance services. Case managers may also provide information on other relevant services during the intake process. A new application must be completed for each subsequent emergency. For housing emergencies clients must access other subsidized housing, either tenant or project based prior to accessing Ryan White services.

Key Service Components and Activities

Emergency financial assistance:
Emergency financial assistance provides fiscal support for essential services through either one-time or short-term payments to agencies or the establishment of voucher programs. Services include payments for:

- Utilities (water, electricity, and gas)
- Food (including groceries and food vouchers)
- Medications (on the ADAP formulary)

Emergencies are defined as facing potential loss of basic utilities resulting from past due payments, access to needed medications, food, or housing. Funds provided are intended to help client through a temporary, unplanned crisis.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any payment made by this service will be as the payer of last resort

Housing:

Housing assistance is provided in the form of:

- **Emergency housing assistance** offers temporary assistance with housing needs, including:
- Short-term hotel/single room occupancy (SRO) stays of up to 2 weeks at establishments identified and approved of by the Emergency Assistance provider, with extensions possible with prior approval from the County. Payment for stay must be made directly to the hotel/SRO by the Emergency Assistance provider, or with prior approval, the referring case management agency who will be reimbursed by the Emergency Assistance provider; and/or
- Up to 2 months' rent assistance for individuals establishing new housing or facing eviction from current housing. Assistance amount is based upon Fair Market Value for the zip code the housing is located in.
- **Partial Assistance Rent Subsidy (PARS) program** is a short-term, forty-eight (48) month maximum partial rental assistance program designed to transition clients to more stable housing arrangements.

All clients are required to work with their case managers to develop a care plan with the goal of eventual self-sufficiency. Individuals on PARS can continue past the 48-month enrollment cap providing adherence to their individual care plan can be demonstrated. There is no lifetime cap per client.

Standard	Measure
Staff verifies clients' eligibility clients' eligibility and needs based upon applications submitted by case manager.	Retention of the Emergency Assistance Request Form and EARP Budget Worksheet in clients' chart as verification of eligibility.
Staff monitors utilization of services and release funds.	Documentation of services provided/offered to clients with the dates of the services and proof of payment.

Exclusions

Housing services may not:

- Be used for mortgage payments
- Be in the form of direct cash payments to clients
- Be used for rental or security deposits. Such deposits are typically returned to clients as cash which would violate the prohibition on providing cash payments to clients.

Assessment and Service Plan

Case managers will determine the need for financial and housing assistance. Clients will need to submit proof of the need (i.e., past due electrical bill, shut-off notice, eviction warning notices). Emergency financial assistance and housing assistance funds can only be used as a last resort for payment of services and items, and complete or partial assistance with housing payments.

Housing plan: Case managers will develop individualized housing plans for clients covering how each client will receive short term, transitional and emergency housing services. Each plan will include a strategy to assist the client in obtaining stable housing.

Standard	Measure
Staff will ensure that all services provided are accessed appropriately and for a period of time defined by each financial or housing assistance type.	Documentation of services and payments to verify that: • All services provided to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee • Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and food stamps), or medications • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients • Emergency funds are allocated, tracked, and reported by type of assistance • Ryan White is the payer of last resort • All service providers are for short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care • Type of housing-related services provided including housing assessment, search, placement, advocacy, and the fees associated with them • Mechanisms are in place to allow newly identified clients access to housing services

Food Bank/Home Delivered Meals

Service Category Definition

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food.

Purpose and Goals

The goal of this contract is to improve and promote better health in clients living with HIV who are unable to prepare their own food will be provided a minimum of two meals a day, three days per week.

Intake

The determination for the need for food bank or home delivered meals services are made by case managers.

Exclusions

Individuals who are physically and/or mentally capable of preparing their own meals do not qualify for home delivered meal services but may still be eligible for food vouchers and food bank services.

Key Service Components and Activities

This service provides food items to clients including, hot meals or a voucher program to purchase food. The service also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Unallowable costs include:

- Permanent water filtration systems for water entering a home
- Household appliances
- Pet foods
- Other non-essential products

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of all potential clients and their needs
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and client progress on a standard food bank/home delivered meals form
	Maintain a single record for each client

Standard	Measure
Staff ensures clients are connected to the appropriate services when needed	Documentation that all services provided are: • Limited to food bank, home-delivered meals, and/or food voucher program • The types of non-food items provided are allowable • If water filtration/ purification systems are provided, community has water purity issues

Personnel Qualifications

Providers will possess the appropriate licensure/certification for food banks and home delivered meals in accordance with California regulations.

Standard	Measure
Staff will meet minimum licensure qualifications	Documentation of compliance with federal, state, and local regulations including any required licensure or certification for the provision of food banks and/or home-delivered meals
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Case managers will conduct an assessment of each clients need for services and follow-up assessments as needed. Meal plans will be approved by a registered dietitian. Each client's food distribution plan will be determined at the time of the initial intake/assessment.

Standard	Measure
Staff will complete an initial assessment for client need of services	Documentation of assessment for need
Staff will complete appropriate follow-up of each client's need for service	Documentation of follow-up assessments

Health Education / Risk Reduction

Service Category Definition

Health Education/Risk Reduction (HE/RR) is the provision of education and information to clients living with HIV and how to reduce the risk of HIV transmission. It includes education, referral and related service navigation to clients living with HIV to improve their health and their partners to prevent HIV transmission. Topics covered may include:

- Education and information on the importance of achieving viral suppression including having an undetectable viral load which results in improved personal health outcomes, as well not transmitting HIV (Undetectable = Untransmittable, U=U)
- Education and information on the importance of preventing infection and transmission of Sexually Transmitted Infections (STI) and their impact on personal health outcomes
- Treatment adherence education and information
- Education and information on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for clients' partners and treatment as prevention (TasP)
- Education and skills building to increase clients' ability to advocate for needed services, including education regarding the service planning

Services are intended to complement and not replace other funded HIV prevention activities.

Purpose and Goals

Health Education/Risk Reduction services are intended to provide education and information to clients living with HIV and their partners about risk reduction, health care literacy, and treatment adherence.

Intake

Health Education/Risk Reduction services are delivered only to clients who are eligible to receive Ryan White funded care and/or support services and their partners. If the Health Education/Risk Reduction Services provider is the client's first contact with HIV Care Program, the client is screened for eligibility as described in the Universal Standards. HIV- partners engaging in high-risk activities may be referred to other HIV prevention and support services.

Exclusions

- Affected individuals (partners and family members not living with HIV) are only eligible if receiving services concurrently with the client.
- Health Education/Risk Reduction may not be delivered anonymously. However, all information is confidential.

Key Service Components and Activities

Health Education/Risk Reduction services educate clients living with HIV on how to improve their health and how that reduces the risk of HIV transmission to others. And concurrent HIV negative partners may be included in service delivery. Services may include:

- Provision of information about available medical and psychosocial support services
- Education and information on HIV transmission and how to reduce the risk of transmission including being virally suppressed (U=U)
- Services can be provided in-person, virtually or using social media platforms
- Optional individualized plans that support and sustain health behaviors to reduce, limit, and ultimately eliminate HIV related health risks. A plan is not required but may be a subcomponent of the client's Care Plan.
- Navigation support to access PrEP and PEP services for the individual's HIV negative sex and needles sharing partners. These services are documented in the Ryan White client's chart, as the HIV negative partners are not eligible to receive services separately.

Health Education/Risk Reduction may be provided in individual and group settings and must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

Standard	Measure
Staff ensure clients living with HIV are provided information about available medical and psychosocial support services.	Descriptions of information and referrals provided to client are noted with date in client's file.
Staff ensure clients living with HIV receive education on how to improve their health and reduce the risk of HIV transmission to others including U=U.	Descriptions of the education delivered to clients are noted with date in client's file.
Staff provide referrals to PrEP and PEP services for client's HIV negative partners and provide navigation assistance as needed.	Referrals to PrEP, PEP and navigation are documented with date in client's file.
Staff ensure clients are referred for medical and support services as appropriate.	Referrals to medical and support services are documented with date in client's file.

Personnel Qualifications

Staff providing Health Education/Risk Reduction Services are health and peer educators that are trained and knowledgeable about HIV and familiar with available HIV resources in the area.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate completion of training
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff receive training to deliver services competently	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Individual plans are not required for this service category, although they may be a useful tool and are recommended in some circumstances and in consultation with the client. Client failure to achieve goals will not result in termination of services.

Standard	Measure
Staff develop a Health Education/Risk Reduction individualized plan as appropriate. Provider may assist clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action - Target date for completion of each action - Results of each actions	Documentation of Health Education/Risk Reduction plan when applicable, signed and dated by the client and health educator and placed in client's file.

Home Health Care

Service Category Definition

Home health care services are medical treatments that are provided in the clients' homes by licensed health care workers such as nurses.

Purpose and Goals

The goal of home health care services is to provide home health services to people living with the HIV disease who have no other means of paying for such services (i.e. Medi-Cal, Medicare, private insurance, etc.).

Intake

The provision of home health care is limited to clients with HIV diagnosis who are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities. Personal care services are excluded. To receive home health care services clients must have received a written referral from a medical provider.

Key Service Components and Activities

Home health care is the provision of services in the home that are appropriate to a client's needs. Services are performed by entities licensed or certified by the State of California to provide home health. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

Services may also include skilled nursing care; physical, occupational therapy, and speech/language therapy; medical social work intervention; durable medical supplies and infusion therapy, including chemo therapies, and attendant services.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard home health care form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for deemed ineligible for home health care or deemed ready to be transitioned out of these services

Personnel Qualifications

All home health care services are provided by certified health care workers such as nurses (registered and licensed vocational) who possess the appropriate certification for the State of California (http://www.cdph.ca.gov/certlic/occupations/Pages/AidesAndTechs.aspx) in accordance with Health and Safety Code Section 1725-1742 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1725.&lawCode=HSC). All home health staff will practice in accordance with applicable local, state, and federal regulations.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate certification
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Primary care physician will determine the need for home health care services.

Standard	Measure
A physician will certify that the client's need for home health care services	Documentation of a physician certification that the client's condition requires home health care in lieu of hospitalization
Staff will record all services provided for each client	Documentation of the: • Types of services provided • Number of the services provided • Duration of the services • Dates and locations of the service
Staff will ensure that all services provided are appropriate to meet each client's needs and are provided in accordance with federal, state, and local guidelines	Documentation of all services provided showing that: • Services are limited to medical therapies in the home and exclude personal care services • Services are provided by home health care workers with appropriate licensure as required by State and local laws

Hospice Services

Service Category Definition

Hospice care is provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal clients.

Purpose and Goals

The goal of hospice care is to provide outpatient end-of-life care through existing non-profit agencies to people living with the HIV disease who have no other means of paying for such services (e.g. Medi-Cal, Medicare, private insurance, etc.)

Intake

To receive hospice services, a client must be certified as terminally ill by a physician and have a defined life expectancy of six months or less. Counseling services provided in the context of hospice care are consistent with the definition of mental health counseling. Palliative therapies are consistent with those covered under respective state Medicaid programs.

Key Service Components and Activities

Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard hospice services form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services offered to clients
	Completion of the Client Transition Plan for deemed ineligible for hospice services or deemed ready to be transitioned out of these services

Personnel Qualifications

All providers will possess the appropriate and valid licensure as required by the State of California pursuant to the California Health and Safety code Sections:

- 1745:https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=2.&title=&part=&chapter=8.5.&article=1,
- 1748:https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1748.&lawCode=HSC and
- 1749:https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1749.&lawCode=HSC

Standard	Measure
Staff will meet minimum qualifications and possess the appropriate licensure	Documentation of the appropriate and valid licensure of provider as required by the State of California
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and supervisors

Assessment and Service Plan

To meet the need for hospice services, a physician will certify that a client is terminally ill and has a defined life expectancy as established by the recipient.

Standard	Measure
A physician will certify that the client's illness is terminal	Documentation of a physician certification that the client's illness is terminal as defined under Medicaid hospice regulations (having a life expectancy of six months or less)
Staff will provide the appropriate services to clients and meet state and federal guidelines	Documentation of the types of services provided, and assurance that they include only allowable services
	Documentation that assures that all services meet Medi-Cal and other applicable state and federal requirements including: • Counseling services that are consistent with the definition of mental health counseling, including treatment and counseling provided by mental health professionals (psychiatrists, psychologists, or licensed clinical social workers) who are licensed or authorized within the State where the service is provided • Palliative therapies that are consistent with those covered under the respective State's Medi-Cal program
All services will be provided in the appropriate settings	Documentation of the locations where hospice services are provided, and assurance that they are limited to a home or other residential setting or a non-acute care section of a hospital designated and staffed as a hospice setting

Housing Case Management

Service Category Definition

Housing Case Management is a form of non-medical case management services that focuses solely on housing needs. Specific services can include:

1) Support in locating and moving into affordable housing
2) Support in finding suitable roommates or other shared living settings
3) Support with eviction prevention
4) Support with obtaining emergency financial assistance
5) Support with managing money

Housing case management does not provide support or guidance for accessing other services, and it is required that housing case managers closely coordinate client needs outside of housing with medical or non-medical case managers as part of a treatment team approach.

All clients enrolled in the Partial Assistance Rental Subsidy (PARS) program must also enroll in housing case management.

Purpose and Goals

The goal of housing case management is to develop self-sufficiency for housing by helping clients to secure affordable housing, manage their money effectively to achieve their self-selected goals, and identify needed support systems to ensure they can remain stably housed.

Frequency of Services

The manager and the client will agree to the frequency of meeting which will occur at least quarterly.

Standard	Measure
The case manager and the client will agree to the frequency of meeting which will occur at least quarterly.	Case notes documenting contacts between the client and the case manager
The case manager will assess any support needs the client might need to be successful and provide those support needs. Clients who seek additional support in their appointments will receive those supports and those supports will not be used as a condition for terminating services.	Case notes documenting contacts between the client and the case manager

Intake

Case managers will assess clients' needs based upon a standard assessment tool developed by the provider and approved by the Recipient. The assessment must include the following:

1) Assessment of client goals, including where in San Diego County the client would like to live and ideal living environment
2) Assessment of individual needs due to medical conditions and disabilities, as well as support needs in securing affordable housing, such as transportation and system navigation assistance
3) Assessment of all forms of income available to the client as well as their monthly expenses
4) Assessment of the client's rental history, credit rating, and any involvement with the criminal justice system, or any other barriers to housing
5) Assessment of client self-sufficiency and ongoing support needs for the client to remain stably housed, including a list of three places to contact the client for appointment reminders and other relevant information regarding their housing needs

Upon intake, all eligible clients will be required to enroll in all available housing assistance waiting lists, including Section 8, Housing Opportunities for Persons with AIDS (HOPWA), and Tenant-Based Rental

Assistance (TBRA).

Standard	Measure
Clients will have their needs based on a standard assessment tool.	Documentation of the standard assessment tool that includes the components 1-5 above

Housing Transition Plan

Because all housing support provided under Ryan White is temporary, a housing transition plan is required to ensure clients maintain housing self-sufficiency at the conclusion of assistance. A housing transition plan serves as the guiding document for housing case management activities, and it is based upon the results of the initial assessment. The housing plan must be reviewed during all in-person visits.

A housing plan must include the following:

- Clear definition or description of priority areas (finding roommate, finding more affordable housing or other permanent housing arrangements)
- Referral and linkage to services that address any identified support needs
- Measurable objectives and specific action steps to be taken by the client and the case manager with timelines
- Mutually developed outcomes and goals

The housing plan must be developed within 60 days of enrolling in housing case management and no later than 90 days after enrolling in PARS. The client & case manager should review the plan regularly, and at least every quarter.

Standard	Measure
The housing plan must be developed within 60 days of enrolling in housing case management and no later than 90 days after enrolling in PARS.	Documented housing plan in client file that was signed 60 to 90 days after enrollment in PARS
The client & case manager should review the plan regularly, and at least every quarter.	Documentation in client's file that the housing plan was reviewed at least quarterly

Service Process

The housing case manager will meet at least quarterly with the client to assess progress, provide feedback, and modify or adjust objectives based upon client experiences. Client contact will be face-to-face, virtual or phone depending on client preference and need. All contacts between the case manager and the client will be documented in case notes.

Wherever possible, continuity of care will be maintained by minimizing changes to the individual case manager assigned to work with the client. When a change of an individual case manager is necessary, providers will work to ensure the transition of care is as smooth as possible.

Standard	Measure
Client and case manager will meet at least quarterly.	Document in client's file of quarterly meeting
Client and case manager will determine mode of meeting (face-to-face, virtual or phone) depending on client preference and need.	Documentation in client's file of preference and needs around meetings were assessed

Personnel Qualifications

Housing case management services are provided by individuals trained in or experienced with the local HIV service delivery system and who have at least a high school diploma or GED equivalency with a minimum of two years professional or volunteer experience.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate education/experience
Staff will receive a relevant job description details roles and responsibilities.	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent.	Documentation of a training plan that includes specific topics (e.g. available resources for housing), identification of the trainer, and a timeline for all newly employed staff

Legal Services

Service Category Definition

The category of Legal Services allows for the provision of professional services rendered by legal advocates who are licensed to offer such services by local governing authorities.

Purpose and Goals

The goal of Legal Services is to provide high quality legal advice, representation, and referrals to persons living with HIV/AIDS.

Intake

To be eligible for legal services, clients shall have a confirmed diagnosis of HIV or AIDS. Services can also be provided to family members and others affected by a client's HIV disease when the services are specifically necessitated by the person's HIV status.

Key Service Components and Activities

Legal services provided are as follows:

- Legal services to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits,
    - Ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
    - Preparation of:
        - Healthcare Power of Attorney/Advance Health Care Directives
        - Durable Powers of Attorney

  Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.
- Permanency planning to assist clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Preparation for custody options for legal dependents including guardianship, joint custody, or adoption

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of the needs of all potential clients
	Documentation with a description of how the service is necessitated by the client's HIV status

Standard	Measure
Staff maintains records regarding appropriate services that were rendered to clients	Documentation of all allowable services, which involve legal matters directly necessitated by an individual's HIV status, such as: • Preparation of Powers of Attorney and Advance Health Care Directives • Services designed to ensure access to eligible benefits • Permanency planning
	Documentation should also assure: • That Ryan White serves as the payer of last resort

Personnel Qualifications

Staff providing services are required to be attorneys, licensed by the state of California and members in good standing with the State Bar of California. Licensed volunteer attorneys, law students, law school graduates and other legal professionals (all under the supervision of a qualified staff attorney) may be used to expand program capacity.

All staff providing direct legal consultation services will do so in accordance with the current American Bar Association's Model Rules for Professional Conduct (http://www.abanet.org/cpr/mrpc/mrpc_home.html) and the State Bar of California's Rules of Professional Conduct (http://rules.calbar.ca.gov/Rules/RulesofProfessionalConduct.aspx).

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff will provide services in accordance with current State and federal guidelines.	Documented verification that all staff who provide direct legal services have read and understand the state and federal rules of conduct

Assessment and Service Plan

Staff will assess client's needs on intake and provide the appropriate consultation as needed.

Standard	Measure
Staff will maintain files of each client's case	Maintain case files for each legal matter
	Documentation on: • The types of services provided • Hours spent in the provision of each service • Referrals made in lieu of providing services

Medical Case Management

Service Category Definition

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Case managers will function as a part of the interdisciplinary team. Services specifically link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the needs and personal support systems of the client.

Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Purpose and Goals

The goal of medical case management services is to improve overall health outcomes for clients in support of the HIV care continuum, by linking to and maintaining them in appropriate care and treatment services while increasing self-sufficiently.

Intake

Medical case management staff operate as part of the clinical care team in the provision of services. Clients may be referred to medical case managers by primary care providers or other clinical staff. Medical case managers will assess each client's need for the service based on an assessment tool. Clients must demonstrate that they are unable to access or remain in HIV medical care as determined by medical care managers on the basis of whether or not:

- Client is currently enrolled in outpatient/ambulatory health services
- Client is following his/her medical plan
- Client is keeping medical appointments
- Client is taking medication as prescribed

Exclusions

Clients who receive HIV medical case management from any other funding source are not eligible for this service. Clients who are determined not to have a need for the services based on their initial assessment may be referred to non-medical case management services. Likewise, clients who are enrolled in care and in compliance with their treatment plans may also be directed to non-medical case management if they require assistance or guidance in obtaining access to certain medical, social, community, financial and other needed services.

Key Service Components and Activities

These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the needs and personal support systems of the client. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client monitoring to assess the efficacy of the plan
- Periodic reevaluation and adaptation of the plan, at least every 6 months
- On-going assessment of clients' needs and personal support systems
- Coordination and follow up of medical treatments
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- Coordination and linkage to services required to implement the plan such as:
    - Health care
    - Psychosocial services
    - Benefits/entitlement counseling and other services
- Referrals assisting clients to access other public and private programs for which they may be eligible (e.g., Medi-Cal, Medi-Cal Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services)

This includes all types of case management, including face-to-face meetings, telephone calls, and any other forms of communication.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard medical care management form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for deemed ineligible for medical care management or deemed ready to be transitioned out of these services

Personnel Qualifications

Medical case management services are provided by a medical case manager who meets one or more of the following requirements:

- Master's in Social Work or related field with a minimum of one-year experience working in the field of HIV/AIDS, or a medical setting, or related field; or
- Bachelor's degree in social work or related field, or a registered nurse, and a minimum of two years of experience working in the field of HIV/AIDS, a medical setting or other related field.
- Three years of full-time work of direct consumer service experience under the supervision of a health or human service professional.
- Work or volunteer experience in the field of HIV/AIDS that demonstrates competency to provide case management to persons with HIV/AIDS.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

At the initiation of medical case management services, providers must conduct a comprehensive assessment of each client, to include factors that affect access to and retention in medical care:

- Health status
- Medical care and providers
- Activities of daily living
- Mental health status
- Substance abuse assessment/screening
- Income, benefits, and health insurance status
- Employability and/or employment status
- Family/social support system
- Living situation/environment
- Partner services needs and options
- Other factors affecting ability of client to access health and social services

During the initial assessment, Providers should also ensure that they assess both Income Supports and Health Care Supports for clients:

- **Income Supports:** An evaluation for income support benefits that includes consideration of all public, private and community resources such as the following:
    - General Relief
    - CalFresh (Food stamps)
    - Unemployment
    - State Disability Insurance
    - Supplemental Security Income

- Social Security Disability Income
- Private short-term disability insurance
- Private Long-Term Disability insurance
- Housing

The Income Support assessment includes reviewing the impact of employment on benefits. Medical case managers refer clients to state vocational rehabilitation and other employment readiness programs as appropriate.

- **Health Care Supports:** An evaluation for health care benefits includes but is not limited to the following:
  - Medi-Cal
  - Medi-Cal Part B
  - Private medical insurance, including, but not limited to HMOs, PPOs, etc.
  - OA HIPP (health insurance premium payment program
  - Medi-Cal HIPP (Medic-Cal funded health insurance premium payment program)
  - AIDS Drug Assistance Program (ADAP)
  - Covered California
  - Health Care Funding

Standard	Measure
Case managers routinely assess client's access to medical care and any barriers to care	Documentation of: • Initial assessment of service needs and continuous client monitoring to assess the efficacy of the plan • Types of services provided • Types of encounters and communication conducted with clients • Duration and frequency of the services and/or encounters • Re-evaluation and adaptation of the plan at least every 6 months • Encounters/communication provided • Services needed and provided
Case managers monitor client medication adherence	Documentation of coordination and follow up of medical treatments

Mental Health Services

Service Category Definition

Mental health services are the provision of outpatient psychological, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Psychiatric services related to medication is covered in a separate service standard.

Purpose and Goals

The goal of mental health services is to provide outpatient, assessment, diagnosis, and treatment to persons living with HIV.

Intake

Providers will conduct a comprehensive client intake process. This process determines a client's need for mental health services and the extent of services that need to be provided. A client intake will be completed for all clients who request or are referred to mental health services. The intake process also acquaints the client with the range of services offered and determines the client's interest in such services. Mental health services are allowable for HIV-infected clients only.

Key Service Components and Activities

Key activities for mental health services include:

- Initial comprehensive assessment including documentation of diagnosis and determination of needs
- Development of individual treatment plans
- Treatment provision in individual, family, and/or group settings, crisis intervention and psychiatric consultation.
    - **Individual Counseling/Psychotherapy**: Frequency and duration of individual counseling or psychotherapy is determined based upon client need or as outlined in the Treatment Plan.
    - **Family and Conjoint Counseling/Psychotherapy:** The overall goal of family and conjoint counseling/psychotherapy is to help the client and his/her family improve their functioning, given the complications of living with HIV. The frequency and duration are based on upon client needs or as outline in the Treatment Plan.
    - **Group Treatment:** Group treatment can provide opportunities for increased social support vital to those isolated by HIV. Provider will assure an appropriate clinician facilitates the groups and limit the groups to a maximum of 12 persons per group (unless it is a couples-specific group).
        - Group counseling sessions consists of face-to-face contact between one or more therapists and a group of no fewer than two Ryan White eligible clients.
    - **Crisis Intervention:** This is an unplanned service provided to an individual, couple or family experiencing psychosocial stress. Crisis interventions are provided in order to prevent deterioration of functioning or to assist in the client's return to baseline functioning. Client safety will be assessed and addressed. This service may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

- **Psychiatric consultation:** Providers will provide psychiatric referrals as appropriate.

- Referral/coordination/linkages
  - **Referral/Coordination:** Providers will establish linkages and collaborative relationships with other providers for client referral to ensure integration of services and better client care, including, but not limited to, additional mental health services (psychiatric evaluation and medication management, neuropsychological testing, day treatment programs and in-patient hospitalization); primary care, case management, dental treatment, and substance use treatment.
- Development of follow-up plans if needed
- Case closure

Standard	Measure
Staff assesses clients' eligibility and needs	Documentation of interviews and assessments all potential clients and their respective needs
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients
	Maintain a single mental health record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Personnel Qualifications

All mental health practitioners will have training and experience with HIV related issues and concerns. It is recommended that practitioners participate in continuing education and training on issues related to HIV and mental health. At a minimum, practitioners providing mental health services to people living with HIV will possess knowledge about the following:

- HIV disease process and current medical treatments
- Psychosocial issues related to HIV
- Cultural issues related to communities affected by HIV
- Mental disorders related to HIV and/or other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimes
- Diagnosis and assessment of HIV-related mental health issues
- HIV legal and ethical issues
- Knowledge of human sexuality, gender, and sexual orientation issues
- Substance use theory, treatment, and practice

In accordance with State licensing and practice rules and regulations, all direct services will be provided by culturally sensitive, linguistically appropriate, and competent licensed counselors or duly supervised interns.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State of California
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Comprehensive **Assessment:** This is an assessment completed during a face-to-face interview in which the client's history and current presentation are evaluated to determine diagnosis and treatment plan. This assessment will be provided to all persons receiving individual, family/conjoint, and/or group psychotherapy. Persons receiving crisis intervention or drop-in psychotherapy groups only do not require this assessment. The assessment will be based on clinical standards appropriate to the modality chosen with knowledge of HIV risk and harm reduction.

Reassessments: A reassessment is ongoing and driven by client need, such as when there is significant change in the client's status. The reassessment will be documented in the client chart.

Treatment Plans: Treatment plan is developed with the client and is required for persons receiving individual, family/conjoint, and/or group psychotherapy. The provider will continue to address and document existing and newly identified treatment plan goals. The Treatment Plan will include at minimum:

- Diagnosed mental illness or condition
- Treatment modality (group or individual)
- Date for mental health services
- Recommended number of sessions
- Date for reassessment
- Projected treatment end date
- Any recommendations for follow up
- Signature of the mental health professional rendering service

Regular follow-up procedures are provided to encourage and help maintain a client in treatment. The documentation of attempts to contact the client will be in the progress notes. The follow-up may include telephone calls, written correspondence, and direct contact.

Standard	Measure
Staff will assess client's condition and needs	Documentation of comprehensive assessment
Staff will develop a treatment plan. Staff will also monitor and continuously reassess clients' needs	Documentation of the existence of a detailed treatment plan.
Staff will ensure that services meet Ryan White and local guidelines and are consist with the treatment plan	Documentation of service provided to ensure that: • Services provided are allowable under Ryan White, state, and local guidelines • Services provided are consistent with the treatment plan

Medical Nutrition Therapy

Service Category Definition

Medical Nutrition Therapy refers to the provision of services that includes nutritional supplements provided outside of primary care visit by a licensed dietitian.

Purpose and Goals

The goal of medical nutrition therapy is to enhance the nutritional status of clients by preventing dietary deficiencies and promoting the maintenance of healthy weight and body composition ensuring the maximum effectiveness of antiretroviral treatment and that clients stay in care.

Intake

Clients must be referred by a medical provider to receive medical nutrition therapy services. All services are based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Dietitians will do initial assessment to determine the dietary needs of the clients.

Key Service Components and Activities

Medical nutrition therapy includes:

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

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Standard	Measure
Staff maintains records of eligibility, intake, and assessments for each client	Documentation of eligibility, intake, comprehensive assessments, and individual nutritional needs
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for clients deemed ineligible for medical nutrition therapy or deemed ready to be transitioned out of these services

Personnel Qualifications

Medical nutrition therapy services are provided by registered dietitians. All registered dietitians will practice according to the Code of Ethics of the American Dietetic Association http://www.eatrightpro.org/resources/career/code- of-ethics).

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Assessment for medical nutrition therapy services is made by a medical provider who will make referrals to the registered dietitian. Nutritional plans are developed by the registered dietitian who creates individualized plans, schedules, and follow-up sessions with clients to monitor progress.

Standard	Measure
Staff will create a nutritional plan	A written nutrition plan that outlines each client's needs and progress. Plan will have the signature of registered dietitian who developed the plan
Staff assesses clients' needs and provides appropriate services	Documentation of all services provided including nutritional supplements and food provided with quantity and dates (with signature of registered dietitian)
Staff ensures appropriate and routine follow-up with clients	Documentation of planned number and frequency of sessions and any recommendations for follow-up with signature of registered dietitian

Medical Transportation

Service Category Definition

Medical transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Purpose and Goals

The goal of medical transportation is to provide assistance to people with HIV in accessing non-emergency, assisted or non-assisted transportation services to improve access to appointments and ensure linkage to and retention in care.

Intake

Case managers will assess the need for transportation services to determine if clients do not have access to transportation that meets their needs.

Key Service Components and Activities

Three key types of transportation services are provided:

- **Unassisted Transportation:** Reserved for individuals who are unable to access or stay in HIV medical care as determined by medical case managers.
    - Transportation is provided in the form of bus and train passes. Day passes may be issued for individuals who do not qualify for the disabled monthly passes and for those eligible for disabled monthly passes who have fewer than three medical or support service visits.
        - Individuals who receive day passes can be issued two extra day passes to cover unexpected or emergency medical visits. Clients are limited to two unused emergency day passes at a time.
    - Disabled monthly passes may be issued for individuals who qualify for the disabled monthly pass and have more than three medical or support service visits in a one-month period.
- **Assisted Transportation:** Only used for transportation to core medical services (e.g., Medical, dental, mental, medical case management and substance abuse counseling appointments). ADA Para-Transit passes, and certified medical transport ***may*** be used if a client is unable to access unassisted transportation **and** does not already qualify from another program or funding source.
- Transportation provided in an agency or personally owned vehicle.

Other forms of transportation may include but are not limited to: taxis, ride sharing programs and/or mileage reimbursement.

Unallowable services include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a personally owned vehicle
- Payment of any other costs associated with a personally owned vehicle such as lease, loan, insurance, license, or registration fees

Standard		Measure
Staff maintains records of eligibility, intake, and assessments		Documentation of eligibility and need
		Maintain a single record for each client
Staff ensures clients are connected to the appropriate transportation services when needed		Documentation (on a standard transportation services form) of all services provided/offered to clients with justification based on need

Non-Medical Case Management

Service Category Definition

Non-medical case management services provide guidance and assistance in accessing medical, social, community, legal, financial, and other services needed by people living with HIV. Non-medical case management services may also include assisting eligible clients to obtain access to other public and private programs and resources for which they may be eligible, such as Medi-Cal, Medi-Cal Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, health insurance Marketplace plans. This category does not include treatment adherence.

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.

Purpose and Goals

The goal of non-medical case management services is to improve access to medical, social, community, legal, financial, and other needed services for clients while increasing self-sufficiency.

Intake

Case managers will assess clients need for the service based on an assessment tool. Clients must demonstrate that they are able to access or remain in HIV medical care to qualify for non-medical case management services.

Exclusions

Clients who receive HIV non-medical case management from any other funding source are not eligible for this service. Clients who aren't determined to have a need for the services based on their assessment may be referred to other services.

Key Service Components and Activities

These services include several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the Ryan White Program recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six months with adaptations as necessary
- Ongoing assessment of the client's needs and personal support systems

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments all potential clients utilizing a client screening tool
	Documentation that any transitional case management for incarcerated persons meets requirements

Standard	Measure
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for deemed ineligible for services or deemed ready to be transitioned out of services

Personnel Qualifications

Non-medical case management services are provided by individuals trained in or experienced with the local HIV service delivery system and who have at least a high school diploma or GED equivalency with a minimum of two years professional or volunteer experience.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate education/experience
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

An individual care plan serves as the guiding document for case management activities, and it is based upon the results of the initial assessment. The individual care plan must be monitored regularly during client visits, and they should be updated and/or modified at least every six months of client enrollment.

An individual care plan is based on the completed comprehensive assessment and includes all of the following:

- Clear definition or description of priority areas for needed services
- Measurable objectives and specific action steps to be taken by the client and the case manager with timelines
- Expected outcomes and goals
- Maintained progress notes
- Documentation of phone or face-to-face contact at least once every 30 days with client to discuss changes and progress and meeting goals of Individual Care Plan.
- Updates after reassessment at least once every six months, or more frequently as needed
- Documentation of allencounters via phone or face to face least once every 30 days with client to discuss changes and progress and meeting goals

Regular follow-up procedures are provided to encourage and help maintain a client in medical care. The documentation of attempts to contact the client shall be in the progress notes. The follow-up may include telephone calls, written correspondence, and direct contact.

Wherever possible, continuity of care will be maintained by minimizing changes to the individual case manager assigned to work with the client. When a change of an individual case manager is necessary, providers will work to ensure the transition of care is as smooth as possible.

Standard	Measure
An individual care plan is developed for each client based on the comprehensive assessment.	Documentation of an individual care plan that shows coordination of services required to implement the plan
Case manager will maintain client records of services provided and will attempt to follow-up with a client to retain the client in care	Documentation of all: • Dates of encounters (phone or face-to-face contact) • Types of encounters • Duration of encounters • Key activities, including benefits counseling and referral services
Providers will minimize disruptions in care due to staff turnover	Where applicable, documentation of transition of clients among providers and demonstration of attempts to resolve any resultant care continuity issues that might arise

Oral Health Care

Service Category Definition

Oral Health Care services include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. Services are available to those enrolled in Ryan White, regardless of where HIV medical care is received.

Purpose and Goals

The goal of Oral Health Care services is to ensure accessible dental and dental specialty care and to enable adherence to HIV/AIDS treatment plans, which is consistent with the United States Public Health Services Guidelines. In addition, oral healthcare is designed to interrupt or delay the progression of HIV-related and general oral health conditions, thereby improving oral health outcomes and preventing further deterioration resulting from oral disease. All services and interventions must be based on proven and evidence-based clinical methods and in accordance with legal and ethical standards. The services delivered shall reflect a philosophy that affirms a patient's right to privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Intake

Oral Health Care activities include outpatient assessment, diagnosis, treatment, and palliative care, as well as preventative care, provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. Patient intake is required for all patients who request Oral Health Care services and shall be initiated at the time a patient presents for services. Intake is a time to gather registration information and provide basic information about Oral Health Care and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. Practitioners shall provide an appropriate level of information that is helpful and responsive to patient need. Oral Health Care staff shall conduct the patient intake with respect and compassion.

Key Service Components and Activities

- Exams and x-rays
- Cleanings (prophylaxis)
- Fluoride treatments
- Tooth removal
- Fillings
- Emergency services
- Minimally invasive services
- Caries arrest services
- Other medically necessary dental services
- Denture relines
- Root canals (front and back teeth)
- Prefabricated crowns
- Partial and full dentures
- Periodontal maintenance
- Deep cleanings (scaling and root planing)
- Laboratory crowns
- Sedation

Implants are not a benefit of the Ryan White Dental Program.

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed. Exceptional medical conditions include, but are not limited to:

i. cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
ii. severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

iii. skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).

iv. traumatic destruction of jaw, face, or head where the remaining osseous structures are unable to support conventional dental prostheses.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard medical care management form
	Maintain a single record for each client
Staff ensures clients are engaged in HIV medical care and connected to other services as necessary.	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for clients who are deemed ineligible for oral health services or deemed ready to be transitioned out of these services
Oral evaluation is performed at baseline and at follow-up visits in accordance with practice guidelines and clearly documented in the medical record	Documentation in medical record
Treatment plan is in the medical record, includes all required elements, and is updated at each oral health visit	Documentation of treatment plan and updates
Needs for dental specialty services are identified, and patients who require such services are linked to them within the required timeframe	Documentation of need for dental specialty services and referral for services

Personnel Qualifications

Professional diagnostic and therapeutic services under this service category must be provided by one of the following clinicians licensed by the State of California and operating within the scope of their license:

- Dentist (DMD/DDS)
- Dental Assistant
- Dental Hygienist

Other professional and non-professional staff may provide services appropriate for their level of training, education, and licensure as part of a care team in coordination with or under the supervision of a clinician in a manner consistent with State of California requirements for licensure or certification. These staff may include, but are not limited to:

- Dental Laboratory Technician
- Treatment/Referral Coordinator

Any non-clinician staff providing services must be 1) supervised by a clinician; 2) hold current licensure as required by the State of California when applicable; 3) provide services appropriate for their level of training/education; and 4) be trained and knowledgeable about HIV.

All staff providing Oral Health Care services must have training appropriate to their job description and the training necessary to provide care to those with HIV. Training should be completed within 60 days of hire. Topics should include:

- General HIV knowledge, such as HIV transmission, care and treatment, monitoring, and prevention

- Privacy requirements and Health Information Privacy and Accountability Act (HIPAA) regulations
- Local system of HIV care

Ongoing Training: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of 1) in-person, 2) articles, 3) home studies, or 4) webinars, and must be clearly documented and tracked for monitoring purposes.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Maintenance of all required licensure and certification. Documentation of a training completion and competency assessments as appropriate

Assessment and Service Plan

Initial Assessment
At the start of Oral Health Services, a baseline dental evaluation must be conducted.

Dental and Medical history. The provider shall perform a complete dental and medical history for every new patient. This should include:

- Client's chief complaint
- HIV medical care provider
- Current medication regimen(s) and adherence, including HIV medications
- Alcohol, drug, and tobacco use
- Allergies
- Usual oral hygiene
- Date of last dental examination, and name of last dentist if known

Oral examination. Each patient should be given a comprehensive oral examination and assessment.
An Oral Examination should include:

- Caries (cavities) charting
- X-rays: Full mouth radiographs or panoramic and bitewing x-rays
- Complete oral hygiene and periodontal exam
- Comprehensive head and neck exam
- Complete intra-oral exam, including evaluation for HIV-associated lesions or sexually transmitted infections (STIs)
- Soft tissue exam for cancer screening
- Pain assessment

Preventative Care and Maintenance
Oral health education shall include:

- Instruction on oral hygiene, including proper brushing, a strategy to remove plaque from between the teeth, and mouth rinses
- Counseling regarding behaviors that may influence oral health (e.g., tobacco use, unprotected oral sex, body piercing)
- General health conditions that may compromise oral health
- The effect of nutrition on oral health.

Clients should be scheduled for routine oral health maintenance visits, as follows:

- Routine examination. Prophylaxis and when needed fluoride varnish or silver diamine fluoride (SDF) twice a year
- Comprehensive cleaning at least once a year
- Other procedures, such as root planing/scaling as needed

Standard	Measure
Conduct a baseline dental evaluation that shall include at a minimum: • Medical history • Oral examination • Education	Performance of a timely initial assessment, including evidence of a medical history, oral examination, and education as specified above, as well as provision and documentation of applicable referrals/linkages, will be monitored via site visit chart review.
Clients should always be provided with information regarding prevention, early detection of oral disease, and preventive oral health practices, including what to do if having a dental emergency.	All client contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the client chart.
Clients will receive an oral examination by an oral health provider at least annually. The oral examination should include fluoride varnish application and an oral cavity exam.	Clients who received an oral examination by an oral health provider.

Treatment Plan

Oral Health providers should create an individualized dental treatment plan for each patient. The plan should:

- Identify and prioritize the patient's caries control status and dental care needs
- Include preventative and restorative care
- Incorporate client input
- Describe the proposed interventions and treatment schedule
- Include any referrals and linkages to specialty care or other needed services
- Be signed and dated by the provider

The treatment plan should be reviewed at each appointment and revised as needed.

Standard	Measure
Clients requiring specialized care should be referred for and linked to such care via the client's case manager and/or Ryan White oral health provider with documentation of that referral in the client file and available upon request.	Development and revision of individualized treatment plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits.

Outpatient/Ambulatory Medical Care Services

Service Category Definition

Outpatient/ambulatory health services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, and urgent care facilities for HIV-related visits.

Emergency department visits are not considered outpatient settings. See **2020 RWPCP Provider Handbook** for a list of provider locations.

Primary activities for OAHS include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratorytesting
- Treatment and management of physical and mental/behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment (by referral if pediatric services are not available onsite)
- Prescription and management of medication therapy
- Early intervention and risk assessment
- Continued care and management of chronic conditions
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology
- Telehealth

Primary medical care for the treatment of HIV includes the provision of care that is consistent with the United States (US) Public Health Service (PHS)'s Clinical Guidelines and the San Diego HIV Planning Group Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Current PHS guidelines are available online at https://aidsinfo.nih.gov/guidelines. Current Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS are available online at http://www.sdplanning.org/downloads/practice-guidelines/.

Diagnostic testing includes only testing procedures and applications as approved by the Health Resources and Services Administration (HRSA) for funding under the Ryan White Act. The policy describing the use of Ryan White Act Program funds for HIV diagnostics and laboratory tests is available online at https://hab.hrsa.gov/sites/default/files/hab/Global/hivdiagtestpn0702.pdf.

Purpose and Goals

The goal of OAHS is to ensure accessible HIV/AIDS primary and medical specialty care and to enable adherence to treatment plans, which is consistent with the US PHS Guidelines. In addition, OAHS are designed to interrupt or delay the progression of HIV disease, prevent and treat opportunistic infections, prevent onward transmission of HIV, and promote optimal health. All services and interventions must be based on proven and evidence-based clinical methods and in accordance with legal and ethical standards. The services delivered shall reflect a philosophy that affirms a patient's right to privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Intake

Patient intake is required for all patients who request OAHS and shall be initiated at the time a patient presents for services. Intake is a time to gather registration information and provide basic information about OAHS and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. Practitioners shall provide an appropriate level of information that is helpful and responsive to patient need. Medical care provider staff shall conduct the patient intake with respect and compassion.

Intake and ART shall take place as soon as possible, especially for those who are newly diagnosed with HIV. If there is an indication that the patient may be facing imminent loss of medication or is facing other forms of medical crisis, the intake process will be expedited, and appropriate intervention may take place prior to formal intake.

Key Service Components and Activities

Key service components and activities include the following:

Medical Evaluation: Proper assessment/evaluation of patient need is fundamental to medical care services. OAHS providers shall provide a thorough evaluation of all patients to determine the appropriate level of care and to develop a therapeutic treatment plan. Each patient living with HIV who is entering into care should have a complete medical history, physical examination, laboratory/diagnostic evaluation, and counseling regarding the implications of HIV infection. The purpose is to confirm the presence of HIV infection, obtain appropriate baseline historical and laboratory data, assure patient understanding about HIV infection, and initiate care as recommended by the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS, which are available at http://www.sdplanning.org/downloads/practice- guidelines/. Baseline information then is used to define management goals and plans.

Comprehensive Health and Psychosocial Assessment: Patients living with HIV infection must often cope with multiple medical, social, and psychiatric issues that are best addressed through a multidisciplinary approach to the disease. The evaluation must also include assessment of mental illness, nutritional status, oral health, substance use, economic factors (e.g., unstable housing), social support, high-risk behaviors, and other factors that are known to impair the ability to adhere to treatment and that increase risk of HIV transmission. Once evaluated, these factors should be managed accordingly. Psychosocial assessments shall be conducted by providers of OAHS annually. More details about the components of the psychosocial assessment are available in the Mental Health Services Service Standards for Ryan White Care and Treatment, which are available at http://www.sdplanning.org/downloads/service-standards/page/3/.

Treatment Provision: All medical care will be consistent with the PHS treatment guidelines (www.aidsinfo.nih.gov/) and the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS (http://www.sdplanning.org/downloads/practice-guidelines/) and will be guided by the care needs expressed in the treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their patient's presenting problems. Medical treatment and the prescription of antiretroviral and prophylactic medications shall conform to the standards of care recognized within the general community and supported by published clinical research for the patient's condition.

Treatment provision is documented through progress notes, treatment plans, problem lists, and medication lists.

Medical Subspecialty Care. In order to fully comply with the PHS Guidelines, medical specialty services are provided by tertiary care providers for medical services that are beyond the scope of Ryan White outpatient/ambulatory primary medical care clinics. Specialty medical care services include the provision of outpatient infectious disease and other specialty medical care, including but not limited to: Obstetrics, Hepatology, Neurology, Oncology, Immunology, Pulmonology, Ophthalmology, Dermatology, Radiation Oncology, and Psychiatry. Specific services include diagnostic testing, preventive care and screening, practitioner examination, medical history, and treatment of common physical and mental conditions.

OAHS providers are responsible for assessing a patient's need for specialty care, completing prior authorization as needed, and providing appropriate referrals as needed. Medical specialty care appointments shall be provided within three (3) weeks of the request for service or sooner if the medical condition warrants. Specialty care services are considered consultative and, as such, patients shall be referred back to the original outpatient/ambulatory clinic for ongoing HIV medical care.

Medical subspecialty care shall be limited to those services authorized by the County of San Diego HSHB specialty services provider. A prior authorization form authorizing medical specialty care services shall be completed for each specialty referral. A copy of the specialty referral, in addition to a copy of a signed prior authorization form, shall be retained in each patient's service record. All referrals to medical specialty care shall be tracked and monitored by both the referring provider and the medical specialty care administrator.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments for all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients in the medical record
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for clients who are deemed ineligible for the Ryan White Primary Care Program or deemed ready to be transitioned out of certain services
Medical evaluation is performed at baseline and at follow-up visits in accordance with practice guidelines and clearly documented in the medical record	Documentation in medical record
General health assessment is performed and documented in the medical record	Documentation of general health assessment, findings, and actions taken
Treatment plan is in the medical record, includes all required elements, and is updated at each medical visit	Documentation of treatment plan and updates
Needs for medical specialty services are identified, and patients who require such services are linked to them within the required timeframe	Documentation of need for medical specialty services and referral for services

Personnel Qualifications

Professional diagnostic and therapeutic services under this service category must be provided by one of the following clinicians licensed by the State of California and operating within the scope of their license:

- Physician (MD/DO)
- Physician's Assistant (PA)
- Nurse Practitioner (NP)

Other professional and non-professional staff may provide services appropriate for their level of training, education, and licensure as part of a care team in coordination with or under the supervision of a clinician in a manner consistent with State of California requirements for licensure or certification. These staff may include, but are not limited to:

- Nurses (RN, LVN/LPN)
- Medical assistants (MA)
- Pharmacists
- Pharmacy assistants
- Health educators

Any non-clinician staff providing services must be 1) supervised by a clinician; 2) hold current licensure as required by the State of California when applicable; 3) provide services appropriate for their level of training/education; and 4) be trained and knowledgeable about HIV.

All staff providing OAHS must have appropriate training which should be completed within 60 days of hire.

Topics should include:

- General HIV knowledge, such as HIV transmission, care and treatment, monitoring, and prevention

- HIV counseling and testing
- Privacy requirements and Health Insurance Portability and Accountability Act (HIPAA) regulations
- Navigation of the local system of HIV care

Ongoing Training: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of 1) in-person, 2) articles, 3) home studies, or 4) webinars, and must be clearly documented and tracked for monitoring purposes.

Standard	Measure
Staff are competent	Maintenance of all required licensure and certification. Documentation of a training completion and competency assessments as appropriate.

Assessment and Service Plan Initial Assessment:

1. **Medical Evaluation:** At the start of OAHS, a baseline medical evaluation must be conducted. This evaluation should be performed in accordance with HHS guidelines, HIV primary care guidelines, and the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS, and must include the following components as described in the local guidelines:
    a. Complete history, which includes general background, current/lifetime sexual history, current/lifetime substance use history, HIV care history, and general medical history
    b. Review of symptoms and physical examination
    c. Laboratory testing, which includes recommended baseline laboratory tests for PLWH, as well as testing for sexually transmitted infections (STIs) and tuberculosis
2. **HIV Education:** Patients should always be provided with information regarding the results of diagnostic tests, prognosis, risks and benefits of treatment, instructions on treatment management and follow-up, and treatment adherence. In addition, they should be given HIV risk reduction and prevention education.
3. **Partner Services:** Partner Services is defined as a confidential service that provides a safe way for PLWH to tell their sexual or needle-sharing partners that they may have been exposed to HIV, to provide education and information about HIV, and to link to HIV testing. For clients who are not virally suppressed, information and counseling should be offered, and referrals made for clients according to established processes.
4. **Referral/Linkage:** Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request. These services may include, but are not limited to, treatment adherence counseling, Ryan White Oral Health, Ophthalmology (if CD4<50 cells/mm^3), case management (if eligible), medical nutrition therapy, clinical trials, mental health, substance abuse, and partner services (including HIV pre- exposure prophylaxis or PrEP). Providers should assess for transportation needs and ensure that transportation is available, using available services.
5. **Documentation:** All patient contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the patient chart.

Treatment Plan:

OAHS providers should create an individualized treatment plan for each patient that identifies and prioritizes the patient's medical care needs and incorporates client input. All treatment plans must be signed and dated by a provider and should follow national and local guidelines, including review and reassessment of the plan at each care appointment.

Treatment Provision:

Antiretroviral treatment is recommended for all PLWH, regardless of CD4 count, and should be provided as soon as possible after diagnosis. Same-day treatment is encouraged when feasible and where available. If same-day treatment is offered, use of an integrase inhibitor-based regimen is recommended. Treatment regimens should be selected based on HHS guidelines, as stated in the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS.

Standard	Measure
Baseline evaluation and reassessments are conducted in accordance with HHS guidelines and the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS	Annual quality assurance (QA) review of patient medical record
Practitioners shall document results and outcomes of visit	Signed and dated progress notes in patient medical record
Treatment plans must be completed and/or reviewed and revised at each routine medical visit and must be signed and dated by the medical care practitioner who completed the assessment/evaluation	Signed and dated treatment plan documented in patient medical record
Treatment is consistent with US PHS guidelines	Documentation in medical record

Psychosocial Support Services

Service Category Definition

Psychosocial Support Services are group services provided to offer support regarding the emotional and psychological issues related to living with HIV. They differ from Mental Health services as they can be provided by non-mental health professionals, including trained peers.

Purpose and Goals

The objective of Psychosocial Support Services is to increase client self-efficacy and create a broad-based support system, by promoting problem solving, increased service access and development of selfcare steps towards diseases self-management. In addition, to provide a central and dedicated support contact in order to address and minimize crisis situations and stabilize clients' psychological health status to maintain their participation in the care system.

Intake

Services may be accessed through referral from another Ryan White HIV care and/or support service. Individuals may also self-refer, contingent upon verification of Ryan White eligibility. If the Psychosocial Support Services provider is the client's first contact with HIV Care Program, the client must be screened for eligibility as described in the Universal Standards of Care.

Key Service Components and Activities

Key activities of Psychosocial Support Services may include:

- HIV support groups
- Services may be provided by a trained staff or volunteer, including peers
- Funds can be used for cover the cost of both salaries and stipends to facilitators

Psychosocial Support Services must be offered in a way that addresses barriers to accessing health care and uses resources to support positive health outcomes for clients. When relevant, these services should be coordinated with a client's overarching Care Plan.

Exclusions

Funds under this service category may not be used to pay for food or transportation. Providers can identify alternative funding sources to allow for the provision of refreshments and meals during service delivery.

Funds under this service category may not be used to pay for professional mental health services.

Each group is one Unit of Service (UOS). When clients attend group-related services, sign-in sheets should be maintained and UOS should be allotted for each client (e.g., if five clients attend a one-hour support group, the service should be recorded for each client).

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation that psychosocial services funds are used only to support eligible activities listed above.
Staff ensures clients are connected to the appropriate services when needed.	Documentation of all services provided/offered to clients.

Personnel Qualifications

Psychosocial Support Services providers are not required to be licensed or registered in the State of California. However, providers should be trained and knowledgeable in HIV-related issues such as available services, treatment, eligibility services, etc. Services may be provided by paid staff or volunteers. Individual supervision and guidance must be available to all staff as needed. All HCP-funded staff and volunteers providing Psychosocial Support Services must complete an initial training session related to their job description and serving those with HIV. Training, as well as ongoing annual training as appropriate for their position. Training must be clearly documented and tracked for monitoring purposes. Training topics must include:

- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Standard	Measure
Staff will meet minimum qualifications	Documentation of completion training sessions and the ongoing annual training.
Staff will 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	Documentations in personnel/volunteer file.

Prevention Services Overview

HIV Prevention Services reduce the transmission of HIV by reaching and serving populations of focus vulnerable to HIV, including both people living with HIV (PLWH) and HIV negative individuals. The specific service categories are defined by those providing funding to the County of San Diego, Public Health Department – HIV, STD & Hepatitis Branch, including the Centers for Disease Control and Prevention and the State of California Department of Public Health. Currently funded services include, but are subject to change based upon guidance from funders:

- Outreach
- Condom Distribution
- Social Media
- Linkage/Navigation
- Partner Services
- HIV Testing

In addition to adhering to all guidance from funders, service providers shall involve PLWH and HIV negative individuals who are disproportionately impacted by HIV, in planning, design, and implementation of HIV prevention activities. Providers are expected to maintain the priority population's ongoing involvement in an advisory capacity.

Outreach

Service Category Definition

Outreach services promote access to and engagement in appropriate services for people vulnerable to HIV infection, people newly diagnosed or identified as living with HIV and those lost or returning to HIV medical care. Services include identification and providing information/education and referral. When appropriate, staff conducting outreach may accompany clients to initial visits to medical care, case management or navigation services. These services must align with all funder requirements.

Purpose and Goals

Outreach services identify persons who might benefit from a range of HIV services, educate prospective clients about the benefits of the services, and provide linkage to services for clients who agree to participate. For those unaware of their status to make them aware of their status and link them to care or, for those that know their status, to engage or reengage them in prevention and care as appropriate. Outreach activities are focused on individuals in priority populations. Outreach contacts may be conducted one-on-one in person and online (depending on the funding source).

Initial Contact

Outreach contacts are for:

- Individuals who do not know their HIV status and need referral to HIV testing
- Individuals who are vulnerable to HIV that would benefit from Pre-Exposure Prophylaxis (PrEP) education and/or navigation services
- Individuals living with HIV that are not in care and need assistance to engage or re-engage in HIV primary medical care

Exclusions

- Outreach conducted under Ryan White Part A funds may not include online outreach activities
- Outreach conducted under Centers of Disease Control and Prevention (CDC) funds may include online outreach activities
- Outreach programs cannot pay for HIV counseling or testing services.

Standard	Measure
Individuals that are vulnerable to acquiring or transmitting HIV are contacted through outreach	Document all in person and online outreach activities with location of contact

Key Service Components and Activities

Outreach services include the provision of the following three activities:

- Identification of people who do not know their HIV status and if eligible linkage into Ryan White Outpatient/ Ambulatory Health Services or other HIV prevention, care, and treatment services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status if eligible into Ryan White Outpatient/Ambulatory Health Services or other HIV prevention, care, and treatment services

Outreach services are:

- Conducted at times and in places where there is a high probability that individuals vulnerable to or living with HIV infection congregate
- Designed to provide quantified program reporting of activities and outcomes to inform local evaluation of effectiveness
- Planned and delivered in coordination with local HIV continuum of prevention and care and treatment outreach programs to avoid duplication of effort and to address any gaps in services
- Focused on populations known, through local epidemiologic data or review of service utilization data or strategic planning process, to be disproportionately vulnerable to HIV infection

Standard	Measure
Contact appropriate priority and vulnerable populations for services and ensure services are effective and applicable	Document outreach services: • Are planned and delivered in coordination with all local HIV outreach programs to avoid duplication of effort and address any service gaps • Are conducted with priority populations known to be at disproportionately vulnerable to HIV infection • Are conducted with priority communities whose residents have disproportionate risk or establishments frequented by individuals vulnerable to HIV infection • Are designed so that activities and results can be quantified for program reporting and evaluation of effectiveness

Assessment and Service Plan

Outreach workers will determine each individual's knowledge of their HIV status, vulnerability to acquire or transmit HIV and direct the individual to the appropriate service or resources.

- For individuals who do not know their HIV status, refer them to HIV testing
- For individuals who know their status and are negative, refer them to the appropriate prevention resources and services
- For individuals who know their status, are positive, are not in care and need assistance help them engage or re-engage in HIV primary medical care through the appropriate service, as determined by the circumstances

Standard	Measure
Direct individuals to the appropriate services and resources	Document all individuals are directed to the appropriate services based on the HIV status and need

Condom Distribution

Service Category Definition

Venue-based distribution is an HIV and sexually transmitted disease (STD) prevention strategy that helps increase the availability and accessibility of condoms and lubricant in an effort to prevent the spread of HIV. All activities align with funder requirements and the County of San Diego San Diego Condom Distribution Partner Program protocol.

Purpose and Goals

Identify, engage, and collaborate with venues that are frequented by persons vulnerable to HIV and STD infections in communities disproportionately impacted by HIV and STDs. These communities include those marginalized by social, economic, or other structural conditions in addition to communities within the general population in areas of San Diego County with high HIV incidence. Making condoms and lubricant widely available through the program is integral to successful HIV prevention.

Venue Enrollment

Regional providers contact venues to assess readiness to participate in venue-based condom distribution program. Eligible venues, or locations that serve clients and patrons who are populations of focus vulnerable to HIV.

Standard	Measure
Assess the venue for participation in the venue-based condom distribution program	Provider and venue complete Venue Readiness Assessment (VRA)
Enroll qualifying venue for participation in the venue-based condom distribution program	Based on the VRA, qualifying venue contact and provider complete the Participating Venue Information (PVI) form
Maintain up to date records of participating venues	Regional provider forwards documentation to the local program coordinators (Provider and County)

Key Service Components and Activities

Venue-based condom and lubricant distribution is a structural intervention that provides communities with resources needed to prevent the spread of HIV. Venues are enrolled and contacted quarterly to ensure proper display and storage of condoms and lubricant.

Standard	Measure
Venue orders condoms and lubricant directly	Complete customized order form for the California AIDS Clearinghouse (CAC)
Venue receive, display and store condoms and lubricant properly	Regional provider conducts quarterly Venue Progress Checks (VPC)

Assessment and Service Plan

Maintain proper storage, ample supply, and diverse venue locations by tracking the venue sites monthly and performing venue progress checks (VPC) with each venue on a quarterly basis.

Standard	Measure
Track and update list of venues	Document number and name of location in Monthly Progress Reports (MPR)
Venue ensures proper storage and placement of condoms and lubricant	Document on VPC storage and placement of condoms and report completed VPCs in MPR

Social Media

Service Category Definition

Social media platforms and websites are utilized to provide information to communities vulnerable to or living with HIV including those marginalized by social, economic, or other structural conditions in addition to communities in the general population within San Diego County with high HIV incidence. All activities align with funder requirements and the San Diego Materials Review Panel and Site Certification protocols.

Purpose and Goals

Social media platforms and websites are utilized to engage and educate communities vulnerable to or living with HIV to reduce transmission through prevention education. This form of outreach creates access to information and how to access services. This structural intervention provides communities with resources needed to prevent the spread of HIV. Making sexual health education, testing information, and condom distribution sites widely available is integral to successful HIV prevention.

Website and Social Media Review and Certification

Regional websites are developed reviewed and maintained. Review is conducted by a local Materials Review Panel (MRP) composed of community members and public health representative to assess appropriateness based on community standards and accuracy of information.

Standard	Measure
Websites and media information are reviewed and approved as appropriate based on community standards	Materials are submitted to MRP for review and documentation is provided and retained with suggested modification and/or approval
Websites and media platforms are certified based on the kind of information on the site/platform	Certification is documented and kept on file
Social/sexual networking sites are utilized for education, promotion, and resources	Social/sexual networking interactions are tracked and reported monthly

Key Service Components an Activities

The regional websites and social media platforms provide accurate and relevant information Countywide to communities vulnerable to and living with HIV. This information is designed to connect community members with education, testing, navigation, and resources available within select regions of the County. These efforts are conducted with the support of a countywide technical assistance provider.

Standard	Measure
Websites and media provide information on services related to HIV prevention, testing, primary medical care, and support services	Regional providers track and report web hits from regional websites and metrics from social media platforms monthly
Messaging is cross promoted, accurate and supports initiatives of the County (e.g. Getting to Zero and Undetectable=Untransmittable)	Countywide technical assistance provider reports aggregate web hits from regional websites and metrics from social media platforms monthly

Assessment and Service Plan

Regional websites and social media platform information dissemination are tracked and reported monthly. Testing is conducted with messaging to assess the most effective way to reach priority populations.

Standard	Measure
Social media activities contain current and accurate appropriate messaging	Content in regional websites is reviewed by MRP prior to posting. A/B testing informs messaging

Linkage / Navigation

Service Category Definition

Navigation services link people to necessary services: medical care, health care benefits, and social support services. The term linkage incorporates the process for getting an HIV negative individual on PrEP or an HIV positive individual on Antiretroviral Therapy (ART) as well as providing any needed support services to obtain and be retained in care. These services must align with all funder requirements.

Purpose and Goals

Navigation is a service to help a person obtain timely, essential, and appropriate HIV-related medical care and social support services that will optimize their health and prevent HIV acquisition and transmission. Goals include linking HIV negatives individuals to PrEP to prevent the acquisition of HIV and HIV positives individuals to care to achieve and maintain HIV viral load suppression. This supports the scientifically proven facts that taking PrEP daily helps to prevent HIV. Those who are HIV positive and undetectable cannot transmit HIV (U=U). People with HIV who achieve an undetectable viral load cannot sexually transmit the virus.

Intake

Recruitment and initial contact with service recipients includes sharing information about navigation services, assessing eligibility for assistance programs and readiness to engage in services.

Standard	Measure
All persons who are unaware of their HIV status are referred to HIV testing	Document referrals to HIV testing (see standard on testing)
All persons who test negative are eligible and referred to PrEP navigation and other support services as appropriate	Document HIV negative services recipients who are eligible, screened and accept or reason did not accept service
All persons who test or are known to be positive are eligible and referred to ART navigation and other support services as appropriate	Document HIV positive services recipients and any barriers to initiate and/or maintain engagement in care or reason did not accept service

Key Service Components and Activities

Navigation activities include linking service recipients to the HIV prevention or care system and referral, linkage and assistance with insurance enrollment, transportation, and other supportive services. As well as efforts to dismantle barriers to timely and consistent care and treatment to prevent the acquisition and transmission of HIV as well as improve health outcomes. Navigation programs provide navigation to health care providers, health care benefits, drug assistance program and supportive services.

The training of navigators is essential to ensure staff can meet the needs of service recipients. Recommended approaches include involvement of priority populations in service delivery, safe and secure program environment, trauma-informed approach with consideration of intersectionality, sexual health education, harm reduction, health, and wellness with consideration of social determinants of health, and social networks.

Standard	Measure
Identify HIV care and supportive service providers to which the clients will be referred as follows: • People vulnerable to HIV are linked to PrEP navigation • People newly diagnosed with HIV are linked to HIV care and other services • People previously diagnosed with HIV and out of care are linked to HIV care and other services	Navigators maintain referral lists with PrEP providers, HIV primary care providers and providers of supportive services

Assessment and Service Plan

Navigation and linkage activities are conducted with specific health outcomes related to engagement in care including screening, enrollment, referral to medical provider, acquiring and filling prescription, initiating medication, and following up for retention in care.

Standard	Measure
Clinic/facility establish and update protocols to allow for vulnerable and newly diagnosed persons to be engaged in care as quickly as feasible	Revise and retain protocols as appropriate
Verify client attended the medical appointment	Document release of information and attendance at medical appointment
Link services recipients as quickly as feasible	Document and report on the time from diagnosis (negative or positive) to medical appointment, acquisition of prescription and initiation of medications (PrEP or ART)
Aid to address any barriers to engagement in care	Document efforts to address barriers and delivery or referral to supportive services
Follow up with services recipient as appropriate based on resources and aid address any barriers to retention in care	Document all follow up contacts and efforts to address any barriers

Partner Services

Service Category Definition

HIV Partner Services is a service which assists HIV-positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV. HIV Partner Services is always voluntary, client- centered and confidential for both the person living with HIV and their partner(s). HIV Partner Services is free and offered through local health departments. Many community-based organizations partner with the health department to offer HIV Partner Services for their clients and elicit partner locating and identifying information for submission to the health department for notification.

Note: Surveillance-based Partner Services are strictly a health department function and are not included in this service standard. Additionally, anonymous partner notification is a health department function that is not permitted to be performed by any other entity.

Purpose and Goals

Partner Services helps HIV positive people in notifying their sexual and/or needle sharing partners of possible exposure to HIV. Partners are offered and encouraged to test for HIV and STDs in order to ensure timely identification and linkage to care and are either linked to HIV primary care, if positive, or PrEP, if negative.

Intake / Initial Contact

Persons newly identified with HIV, as well as persons who are not virally suppressed are offered Partner Services. Staff will elicit partner locating information.

Standard	Measure
All persons newly diagnosed with HIV will be offered partner services	Documentation that client was offered Partner Services
All persons living with HIV who are not virally suppressed will be offered partner services.	Documentation that client was offered Partner Services

Key Service Components and Activities

HIV Partner Services provides three options for letting partners know they may have been exposed to HIV and/or STDs and provide linkages to testing and medical care.

- Anonymous Third Party: Specially trained local health department staff notifies partners without

disclosing any information about the original client.

- Dual Disclosure: The client wants to disclose to partners themselves with the support of trained HIV Partner Services staff. Trained staff can provide immediate linkage to services once the client has told the partner of their exposure.
- Self-Disclosure: The client notifies their partner(s), after working with trained Partner Services staff to develop a disclosure plan.

Standard	Measure
Increase number of HIV cases diagnosed	• # of new HIV cases identified • # of HIV positive people who undergo partner services interview • # of partners elicited
Increase number of people who participate in HIV partner services	
Increase number of partners elicited through HIV partner services	

Assessment and Service Plan

Community-based organizations are required to document provision of HIV Partner Services. This includes identifying and locating information for all partners to be notified via third party notification. Separate documentation is required for each partner requiring notification. Community-based organizations can request third party notification from the HIV, STD, and Hepatitis Branch Field Services Unit by calling 619-692-8501. Community-based organizations may contact the same number if assistance is needed eliciting partner information.

Standard	Measure
Community-based organizations will provide and document referrals for HIV Partner Services	• Data for partners requiring dual- or third-party notification is documented on a form designated by the County of San Diego • Data must be entered into a database identified and maintained by the HIV, STD and Hepatitis Branch

Testing

Service Category Definition

Purpose and Goals

Intake / Initial Contact

Standard	Measure

Key Service Components and Activities

Standard	Measure
	•
	•
	•

Assessment and Service Plan

Standard	Measure

Psychiatric Medication Management Services

Service Category Definition

Psychiatric medication management services are the provision of outpatient psychiatric screening, assessment, diagnosis, and treatment services offered to clients living with HIV. Specifically, these include psychiatric medication assessment, prescription, and monitoring by a licensed psychiatrist or supervised resident or mid-level practitioner. Although they form a separate service category, psychiatric medication management services are part of the comprehensive array of mental and behavioral healthcare services that also may include individual, family, and group counseling and psychotherapy and crisis intervention. These other services are described in the **Mental Health Services Service Standards**.

Purpose and Goals

The goal of psychiatric medication management services is to provide medication assessment, prescription, and monitoring services to people living with HIV in order to alleviate or decrease psychiatric symptoms, stabilize mental health conditions, and improve and sustain quality of life. All services and interventions must be based on proven and evidence-based clinical methods and in accordance with legal and ethical standards. The services delivered shall reflect a philosophy that affirms a patient's right to privacy, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Intake

Patient intake is required for all patients who request or are referred for psychiatric medication management services and shall be initiated at the time a patient presents for services. Intake is a time to gather registration information and provide basic information about psychiatric medication management services and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. In most cases, a client who receives psychiatric medication management services will already be receiving HIV primary care and enrolled in a medical care coordination program.

Providers will conduct a comprehensive client intake process that determines a client's need for psychiatric medications and other mental health services and the extent of services that need to be provided. Practitioners shall provide an appropriate level of information that is helpful and responsive to patient need. Staff shall conduct the patient intake with respect and compassion.

Key Service Components and Activities

Key activities for psychiatric medication management services include:

- Initial comprehensive assessment, including documentation of diagnosis and determination of need for psychiatric medications
- Development of individual treatment plans
- Referral to and/or coordination with other providers to ensure that the client has access to the full array of services that are required for optimal mental and physical health outcomes and coordination of pharmacologic and non-pharmacologic interventions
- Development of follow-up plans, if needed
- Case closure, when a client's condition is stabilized and/or the client can be referred back to the primary care provider for ongoing management

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments for all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Standard	Measure
	Completion of the Client Transition Plan for clients deemed ineligible for psychiatric medication management or deemed ready to be transitioned out of these services

Personnel Qualifications

Psychiatric medication management services are provided by medical doctors who are board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident, registered nurse/nurse practitioner (RN/NP), or physician's assistant (PA) under the supervision of a medical doctor who is board-eligible in psychiatry. Intake may be conducted by other licensed mental health professionals (e.g., psychologists, licensed clinical social workers). All prescriptions shall be prescribed solely by physicians licensed by the state of California or by NPs or PAs who are practicing under their supervision.

All psychiatric medication management practitioners will have training and experience with HIV-related issues and concerns. It is recommended that practitioners participate in continuing education and training on issues related to HIV and mental health. At a minimum, practitioners providing psychiatric medication management services to people living with HIV will possess knowledge about the following:

- HIV disease process and current medical treatments
- Psychosocial issues related to HIV
- Cultural issues related to communities affected by HIV
- Mental health conditions related to HIV and/or other medical conditions
- Mental health conditions that can be induced by prescription drug use
- Adherence to medication regimens
- Diagnosis and assessment of HIV-related mental health issues
- HIV legal and ethical issues
- Knowledge of human sexuality, gender identity, and sexual orientation issues
- Substance use theory, treatment, and practice

In accordance with State licensing and practice rules and regulations, all direct services will be provided by culturally sensitive, linguistically appropriate, and competent providers.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees and board eligibility or certification in psychiatry
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Psychiatric Assessment and Treatment Plans: Psychiatric assessments and treatment plans are core components of a psychiatry visit and should be clearly outlined in the medical record, typically using the "SOAP" format (i.e., Subjective, Objective, Assessment, Plan). Treatment plans should be developed collaboratively with the client. Assessment and treatment plans completed by unlicensed psychiatric providers must be cosigned by a medical doctor board-eligible in psychiatry.

Components of the assessment and plan generally include:

- A statement of the problems, symptoms, or behaviors to be addressed in treatment.
- Goals (desired outcomes) and objectives (measurable change in symptoms or behaviors)
- Interventions proposed (including pharmacologic and non-pharmacologic interventions)
- Appropriate modalities to address the identified problems
- Frequency and expected duration of services

- Service referrals (e.g., day treatment programs, substance use treatment, etc.)

Treatment Provision: All modalities and intervention in mental health treatment, including psychiatric medication management, will be guided by the needs expressed in the assessment and treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment shall conform to the standards of care recognized within the general community and supported by clinically published research for the client's condition. Psychiatric service providers shall adopt and follow performance standards as set forth in the latest HIV mental health guidelines. Programs providing psychiatric services shall be responsible for obtaining and maintaining staff, facility, and referral systems in compliance with American Medical Association standard guidelines.

Ongoing Psychiatric Sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to practices that may facilitate HIV transmission). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. When present in a client's life, the role of spirituality and religion should be understood and utilized as a strength when present. If clients begin to deteriorate physically, emotional distress can be relieved by helping them prepare for disability and even death. For the client whose health has improved, exploration of future goals, including returning to school or work, is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members. Many of these issues may also be addressed by other mental health professionals who are involved in the client's care and perform non-pharmacologic interventions based on the **Mental Health Services Service Standards**.

Psychiatric Evaluations, Medication Monitoring, and Follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines, and specific treatment goals to guide the evaluation, prescription, and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be based on the acuity of the client's condition and the level of need.

Visits may be conducted in-person or via telehealth (telepsychiatry), based on client needs and preference.

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should be regularly counseled about the importance of adherence to psychotropic medications.

The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:

- Use lower starting doses and titrate more slowly.
- Provide the least complicated dosing schedules possible to achieve the desired outcome.
- Concentrate on drug side effect profiles as a means to avoid unnecessary adverse effects.
- Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage.

In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in the client progress notes.

Psychiatrists must coordinate the provision of psychiatric care with primary medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.

Documentation: Treatment provision should be documented through progress notes and include the date and signature of the psychiatrist. For unlicensed psychiatric providers, progress notes will be cosigned by a medical doctor board-eligible in psychiatry.

Progress notes for evaluations, medication monitoring, and follow-up will include:

- Date, type of contact, time spent

- Treatment plan including current medical and psychotropic medications and dosages
- Progress toward psychiatric treatment plan goals
- Interventions and patient's response to interventions
- Referrals provided (e.g., psychotherapy, neuropsychological assessment, case management, medical services, etc.)
- Results of interventions and referrals
- Documentation that the provider has addressed existing and newly identified goals

Informed Consent: Informed consent is required of every patient receiving psychotropic medications.

When starting a new psychotropic medication, providers should ensure that the client understands:

- Medication benefits
- Risks
- Common side effects
- Side effect management
- Timetable for expected benefit

Informed consent for new psychotropic medications should be documented in the client medical record.

Standard	Measure
Psychiatric assessments and treatment plans are developed concurrently and collaboratively with the client and include interventions and modalities to address mental health conditions.	Assessment and treatment plan in client chart to include: • Statement of problem • Goals and objectives • Interventions and modalities • Frequency of service • Referrals
Assessments, reassessments, progress notes, and documentation of informed consent for new psychotropic medications completed by unlicensed psychiatric providers will be cosigned by a medical doctor board-eligible in psychiatry.	Co-signature in client record
Practitioners will use outcome research and published standards of care, as appropriate and available, to guide their treatment.	Progress note signed and dated by psychiatrist detailing interventions in the client file
Treatment, as appropriate, will include counseling about (at minimum): • Prevention and practices that may facilitate transmission, including root causes and underlying issues related to practices that may facilitate HIV transmission • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and dying • Exploration of future goals	Progress note signed and dated by psychiatrist detailing counseling sessions in client file
Progress notes for psychiatric services will document progress through treatment provision.	Signed and dated note to be placed in the client file including: • Date, type of contact, time spent • Treatment plan including current medical and psychotropic medication and dosages • Progress toward psychiatric treatment plan goals

Standard	Measure
	• Interventions and client's response to interventions • Referrals provided • Results of interventions and referrals • Documentation of provider addressing existing and newly identified goals
Prior to initiating psychotropic medications, psychiatry providers will counsel clients on the risks, benefits, and common side effects of the medications.	Documentation in client chart indicating that the patient has been told about and understands: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit

Transition

Clients will be disenrolled from psychiatric medication management services when all action items on the individual care plan are competed, medical care is stabilized, the issue(s) for which the client requested or was referred for psychiatric medication management services are resolved or can be managed on an ongoing basis by the client's primary care provider, and the client meets all of the following criteria:

- Enrolled in HIV medical care
- Following her/his/their medical plan since the previous assessment
    - The medical plan may include other health-related issues (for example, mental health, substance use, smoking, hypertension, gynecological, etc.)
- Keeping medical appointments
- Taking medication as prescribed

Standard	Measure
Staff will document reasons for disenrollment in the client record	Documentation of reason for disenrollment
	Documentation of "inactive status" and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

Referral for Health Care and Support Services, including Peer Navigation Programs

Service Category Definition

Referral for health care and support services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication.

Purpose and Goals

The goal of referrals for health care and support services is to provide culturally and linguistically appropriate referrals throughout San Diego County to direct and link persons living with HIV to medical or support services.

Intake

Referral services are for clients who are currently receiving case management, non-case management, mental health, substance abuse or outreach services.

Key Service Components and Activities

This service may include referrals to assist eligible clients to obtain access to other public and private programs for clients may be eligible such as:

- Medi-Cal
- Medi-Cal Part D
- AIDS Drug Assistance Program (ADAP)
- Pharmaceutical Manufacturer's Patient Assistance Programs
- Covered California or other state or local health care and supportive services
- Core medical and support services
- Office of AIDS Health Insurance Premium Payment (OA-HIPP)

Standard	Measure
Staff will assess client needs and eligibility for services and programs and provide appropriate referrals and follow-up	Documentation that clients were: • Directed to a service in person or through other types of communication • Provided benefits/entitlements counseling and referral consistent with federal requirements • Directed to services that are not part of outpatient ambulatory health services or case management

Standard	Measure
	Documentation of : • All methods of client contact, the frequency and when contact occurred • All methods of providing referrals (including within the non-medical case management system, informally or as part of an outreach program) • All referrals and follow-up provided

Assessment and Service Plan

Staff will determine each client's needs and eligibility for services and programs and direct the client to the appropriate service or resources. Staff will also follow-up with the client and assess their progress in addressing their needs. Staff will also provide referrals to any additional services needed as determined during the follow-up sessions.

Standard	Measure
Staff will direct individuals to the appropriate services and resources	Documentation that all individuals were directed to the appropriate services based on the HIV status and need

Residential Substance Use Services

Service Category Definition

Residential substance use services are the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder.

Purpose and Goals

The goal of residential substance use services is to reduce and/or eliminate the use of illicit drugs, use of prescription medications, and/or alcohol use to improve the overall health and social wellness of adults and HIV/AIDS positive adults.

Intake

To receive residential substance use services clients must have received a written referral from the clinical provider (licensed or license eligible by the State of California) as part of a substance use disorder treatment program funded under the Ryan White Program.

Key Service Components and Activities

Providers will provide residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs. The key components residential substance use services include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Referrals to detoxification services
- Treatment planning
- Discharge planning

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard residential substance use services form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for deemed ineligible for residential substance use services or deemed ready to be transitioned out of these services

Personnel Qualifications

Staff proving services are required to comply with the California Department of Health Care Services Counseling Certification Standards stated at http://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertification.aspx.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Initial Assessment: Providers will conduct initial client assessment for services through the use of standardized instruments. The current assessment tool is the Addiction Severity Index (ASI) Lite Clinical Factors for use with adults.

Treatment Plan: Providers will develop individualized treatment plans for each participant from the client assessment information. The plan will be reassessed and updated every 90 days if needed.

Discharge Plan: Providers will develop a discharge plan with each client at least 30 days prior to the anticipated discharge date that provides support to the client in recovery after completing the program.

Standard	Measure
Staff will assess clients' needs	Documentation of the assessment on a standard instrument
Staff will develop a treatment plan	Documentation of treatment plan that shows: • Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by California in which services are provided • Services are provided only in a non-permanent residential setting
Staff will develop a discharge plan	Documentation of discharge plan

Substance Use Outpatient Care

Service Category Definition

Substance use outpatient care is the provision of outpatient services for the treatment of drug or alcohol use disorders.

Purpose and Goals

The goal of substance use outpatient care is to provide services to reduce and/or eliminate use of illicit drugs, use of prescription medications, and/or alcohol use to improve the overall health and wellness of people living with HIV. Services also promote participation in substance use treatment and recovery programs; and to foster client capability to address medical needs related to HIV and adhere to complex medication regimens.

Intake

To receive substance use outpatient care services client cannot be currently in a residential substance use treatment program.

Key Service Components and Activities

Substance use outpatient care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient behavioral treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention
- Referral resources directing individuals in need of other services beyond the scope of the program
- Treatment planning
- Discharge planning

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan

Providers also provide outpatient substance use treatment, recovery, and ancillary services that include:

- **Non-residential Services:** Services include educational groups, process groups, individual counseling, and recovery supportive activities. Contractor shall determine appropriate treatment service frequency and intensity based upon, client assessment and progress during the program.

Outpatient Substance Use Outreach: Providers conduct outreach to individuals experiencing alcohol and other drug problems, with special attention to reaching high persons who inject drugs and helping them to access treatment and recovery services. This includes the provision of information and education

to alcohol and other drug users to help prevent and minimize the health risks of alcohol and other drug use. Providers will also promote awareness among alcohol and other drug users about the relationship between alcohol and other drug use and the personal health risks of communicable disease such as sexually transmitted infections (STIs) and, for pregnant women, the relationship between use and the risks to their children.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of all potential clients
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard substance use outpatient care form
	Documentation that shows: • The quantity, frequency, and modality of treatment provided • The date treatment begins and ends • Regular monitoring and assessment of client progress • The signature of the individual providing the service and or the supervisor as applicable
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Documentation which demonstrates all services are provided only in an outpatient setting

Personnel Qualifications

Direct substance use outpatient care services are delivered to clients by individuals who possess the appropriate degrees, certifications, licenses, permits, or other appropriate qualifying documentation as required by Federal, State, County, or local authorities.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees or qualifying experience
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan - for Clients Enrolling in Outpatient Services

Initial Assessment: Providers will conduct an initial client assessment for services through the use of standardized instruments. The current assessment tool is the Addiction Severity Index (ASI) Lite Clinical Factors for use with adults.

Treatment Plan: Providers will develop individualized treatment plans for each participant from the client assessment information. The plan will be reassessed and updated every 180 days if needed.

Discharge Plan: Providers will develop a discharge plan with each client at least 30 days prior to the anticipated discharge date that provides support to the client in recovery after completing the program.

Standard	Measure
Staff will assess clients' needs	Documentation of the assessment on a standard instrument
Staff will develop a treatment plan	Documentation of treatment plan
Staff will develop a discharge plan	Documentation of discharge plan