Ryan White Part B Program

Standards of Care

Ryan White Part B Program
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TN Department of Health

Table of Contents for Universal Standards

Section	Title	Page
Section 1	General	Page 3
Section 2	Confidentiality	Page 3
Section 3	Client Rights and Responsibilities	Page 4
Section 4	Client Input	Page 4
Section 5	Client Education	Page 5
Section 6	Culturally Appropriate Services	Page 5
Section 7	Eligibility	Page 6
Section 8	Intake and Screening	Page 7
Section 9	Assessment	Page 7
Section 10	Plan of Care	Page 8
Section 11	Monitoring	Page 8
Section 12	Re-Assessment	Page 9
Section 13	Discharge (Termination of Services)	Page 9
Section 14	Record Keeping (Documentation)	Page 9
Section 15	Client Complaint & Grievance	Page 10
Section 16	Staff and Staff Requirements	Page 10
Section 17	Referral	Page 11
Section 18	Operations and Facilities	Page 11
Section 19	Quality Management	Page 11

Universal Standards of Care

These standards are to be used as minimum requirements for all subcontractors of the Ryan White Part B. The Ryan White Part B Grantee and/or staff of the Lead Agency will review agency documentation to ensure that these standards are being met.

Section 1: General
1. Every client is treated with respect, dignity and compassion. 2. Promote client autonomy and informed participation in care. 3. Subcontractors/providers demonstrate a willingness to provide services to all affected communities. 4. Subcontractors/providers demonstrate cultural sensitivity, must have a written plan for providing language translation services, and assistance for clients who are visually or hearing impaired, when necessary. 5. Subcontractors/Providers coordinate services with collateral care providers to ensure efficient service delivery and optimal client services and avoid duplication of services, as appropriate. 6. Involve the client's caregivers, as appropriate and with client consent, in supporting client's optimal well-being. 7. Within existing resources, ensure that services are available and accessible to all individuals in need of and eligible for services. 8. Provider is licensed and accredited by appropriate local, state and/or federal agencies if applicable. 9. Offer services in a safe, timely, reliable, and cost-efficient manner. 10. Maintain a file documenting activities for the promotion of HIV services to low-income individuals.
Section 2: Confidentiality
1. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable local, state and federal law. 2. Subcontractor/provider has in place a policy addressing client confidentiality. Clients are informed of this policy and confirm their understanding of the policy. 3. Subcontractor/provider will have a system of safeguarding client information (written, verbal, electronic). 4. The provider shall have an "Authorization for the Release of Confidential

Information" form, signed by the client prior to the release of any information about the client, as required by state and federal laws including but not limited to the Health Insurance Portability and Accountability Act.

The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule addresses the use and disclosure of individuals' health information - called "protected health information" by organizations subject to the Privacy Rule – called "covered entities." The rule also ensures that individuals' understand and control how their health information is used.

Section 3: Client Rights and Responsibilities

1. The subcontractor/provider shall inform all clients of their rights, obligations, and realistic expectations of service.
2. No client shall be discriminated against with regard to race, color, religion, age, gender, gender identity, marital status, political affiliation, national origin, sexual orientation, or disability.
3. The subcontractor/provider shall have a formal complaint procedure. Clients are informed of this policy and confirm their understanding of the policy. The policy must be posted in a public area.
4. The subcontractor/provider has written policy and procedures to ensure that any incidents of abuse, neglect, or exploitation of clients by a subcontractor/provider are reported to the proper authorities.
5. Each agency will have a policy that protects the rights and outlines the responsibilities of the clients and the agency.
6. All clients have the right to be treated respectfully by staff, and the client's decisions and needs should drive services.
7. Agencies must develop a written Client Rights and Responsibilities Statement that is reviewed with each client, signed by the client, maintained in the client's record and a copy provided to the client during the intake or assessment process annually.
8. The Client Rights and Responsibilities should be posted in an area accessible to the public.

Section 4: Client Input

1. A client survey must be conducted on a yearly basis, including a measure of satisfaction.

2. An ongoing mechanism for client input must be maintained (e.g., suggestion box).
3. Subcontractors/providers must ensure input from consumers (and, as appropriate, caregivers) in service design and delivery through a mechanism chosen by the agency.
4. There must be evidence that the results of customer input, if applicable, has been incorporated into the subcontractor/provider's plans and objectives.
5. The subcontractor/agency will have a procedure for internal review and evaluation of Continuous Quality Improvement processes.

Section 5: Client Education

The subcontractor/provider shall have an agency plan for each funded service for conducting client education, including:

1. Education on HIV disease
2. HIV transmission
3. The role and importance of HIV and primary medical care (including assessment of whether the person has seen their HIV medical doctor according to the latest guidelines established by the Public Health Service and/or Health Resources & Services Administration/HIV/AIDS Bureau (HRSA/HAB))
4. Medications (including assessment of medication adherence) and oral health

Section 6: Culturally Appropriate Services

1. Provider services should allow access to care (services, information, materials) in a manner that factors in the language needs, health literacy, culture and diversity of the populations served
2. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
4. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
5. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.*

** Standards are from National Standards for Culturally and Linguistically*

Section 7: Eligibility

Ryan White Part B Eligibility

1. Providers must document that clients receiving services are eligible for Ryan White Part B:
   - Have a diagnosis of HIV/AIDS
   - Have a household income, which does not exceed the percentage of the Federal Poverty Level as determined by the Ryan White Part B program
   - Is a resident of Tennessee
2. There must be documentation that clients have been properly screened for other service resources as appropriate to verify that Ryan White is payer of last resort, e.g., 3rd Party Insurance, Food Stamps, etc.
3. There must be a written policy to ensure veterans receiving Veterans Administration (VA) health benefits are classified as uninsured exempting them from the payer of last resort requirement. This includes being eligible for prescription drugs.
4. Documentation of Ryan White eligibility complies with TDH requirements and must be updated every six months.
5. When presenting for services, client will be informed of the eligibility requirements for services, either in writing or verbally, in a manner that he or she is able to understand.
6. Services are made available to any individual who meets program eligibility requirements subject to the availability of funding. Clients cannot be denied services due to pre-existing conditions.
7. If applicable, reason for program ineligibility must be documented in the client's record.
8. Service providers/agencies must have written eligibility policy/standards, consistent with the eligibility requirements of the funding source(s) in the service area.
9. Affected individuals (people not identified with HIV) may be eligible for services in limited situations, but these services for affected individuals must always benefit people living with HIV. Services may be provided to individuals affected with HIV only in the circumstances described below.
   - The service has as its primary purpose enabling the affected individual to participate in the care of someone with HIV or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care

services that assist affected individuals with the stresses of providing daily care for someone who is living with HIV.
- The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a Ryan White HIV/AIDS Program (RWHAP) client's portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income HIV-infected family member, or child care for children, while an infected parent secures medical care or support services.
- The service promotes family stability for coping with the unique challenges posed by HIV.
- Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member.

10. Where applicable, additional eligibility for each specific service must be complied with beyond Universal Standards.

Note: In instances where the person served is a person affected by HIV, such as caregivers, partners, family and friends, verification of HIV status of the infected person is required when available.

Section 8: Intake and Screening

1. Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.
2. Additional Ryan White Part B Elements required:
   - Date of intake
   - Ryan White demographic and statistical information as defined by the Part B Program
   - HIV /AIDS diagnosis and if appropriate, other medical diagnosis
   - Insurance Information
   - Method of payment for services
   - Client or guardian signature of authorization*

Section 9: Assessment

After each client is determined eligible for the service, individual client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative

resources.

- Identifying client's goals, strengths, and challenges
- Psychosocial
- Medical History/Physical Health
- Financial Resources
- Services Needs
- Religious
- Educational
- Social functioning

Section 10: Plan of Care

1. A written Plan of Care must be developed prior to service delivery and with the participation and agreement of the client or guardian. The purpose of the plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and attainable.
   - Basing plan of care on meaningful assessments and shall have specific, attainable, measurable objectives.
2. Additional elements required:
   - Where applicable, document coordination and follow up of medical treatment.
   - A client may disagree with the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and client signature.

Section 11: Monitoring

1. Monitoring is an ongoing process related to the assessment and planning sections above. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.
2. Additional Part B elements required:
   - The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided
   - Monitored information must be documented to aid in the client re-assessment (If applicable, provide the rationale(s) for client non-compliance in the plan.)

Section 12: Re-Assessment
Re-assessment is an on-going process that may occur throughout the process of receiving services. Every six months, the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for services and review/update of the plan of care. The purpose of the re-assessment is to address the issues noted during the monitoring phase.
Section 13: Discharge (Termination of services)
1. The objective of discharge is to ensure a smooth and systematic transition for: • a client no longer needing services • a client assessed as ineligible for the service • to assist provider agencies to more easily monitor caseloads. The process includes a discharge or case closure summary in the client's record. The discharge/case closure documentation will include a reason for discharge and a transition plan to other services or other provider services is applicable. Discharge may be initiated by the client or service staff. 2. Essential elements include: • Conditions which result in a client's discharge/termination from services may include: o Attainment of goals. o Non-compliance with stipulations of written plan. o Change in status which results in program ineligibility. o Client desire to terminate services. o If a client's actions put agency personnel or others at risk. • Client has the right to an appeal process when services are terminated as per the agency's written Grievance Policy. • Client must be provided information regarding transfer to an outside agency.
Section 14: Record Keeping (Documentation)
1. Providers must collect client level data per HRSA Ryan White Services Report (RSR) reporting requirements. 2. Client records must be maintained in an orderly manner. The purpose of this requirement is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by

the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

- Documentation shall be recorded on paper or electronically
- Documentation shall be prepared, completed, secured, maintained, and disclosed in accordance with regulatory, legislative, statutory, and organizational requirements.

Section 15: Client Complaint & Grievance

1. The subcontractor/provider must have a formal complaint and grievance procedure. Clients are informed of policy and procedures during initial intake, reviewed periodically as needed, and shall confirm their understanding of the policy.
2. The grievance procedure must include:
   - Staff responsible
   - Required documentation
   - Review process
   - Time frames
   - Maintenance of confidentiality
   - Process for advising consumer and staff of outcome
   - Appeals process
3. Provider complaint and grievance policy must be posted in publicly accessible areas.

Section 16: Staff Requirements

1. Staff receives annual training and is knowledgeable regarding HIV/AIDS and the affected community.
2. Staff members have a clear understanding of their job description and responsibilities.
3. The staff shall be appropriately certified or licensed as required by the state or local government for the provision of services and shall abide by ethical standards as outlined by their respective professional associations.
4. There are written personnel and agency policies, including a formal complaint procedure for staff.
5. A job performance evaluation is conducted annually for each Ryan White Part B funded position.
6. Agency must document that staff have required education and experience to perform their respective job duties.

Section 17: Referral
1. Subcontractors/providers demonstrate comprehensive knowledge of the community resource network of related health and social services organizations to ensure referrals to a wide-base of HIV-related services. 2. A current list of provider agencies that provide services by referral is maintained and updated. 3. Subcontractors/providers make appropriate referrals to collateral services when clients have additional service needs beyond the scope of Part B services. 4. Provision of all Ryan White Part B funded services and referrals are documented. 5. A client must be informed of service provider options and given an opportunity to choose providers within funded providers.
Section 18: Operations and Facilities
1. Subcontractor/provider demonstrates compliance with physical and programmatic accessibility requirements designated by the Americans with Disabilities Act (ADA). 2. Facility meets the applicable Occupational Safety and Health Administration (OSHA) requirements. 3. Service delivery hours should accommodate target populations and the facility must be accessible by public transportation or provide for transportation assistance, and have procedures in place for after hours and/or emergencies. 4. The facility must develop written client material that describes available services and eligibility requirements. 5. The subcontractor/provider shall maintain a safe environment for provision of services. This shall include adopting a written policy about the agency's right to refuse services to clients who: • Threaten physical abuse to staff or other clients • Are being verbally or physically abusive of /to staff or other clients • Engage in sexual harassment of staff or other clients • Possess illegal substances or weapons while accessing services
Section 19: Quality Management
Providers must develop a quality management/improvement plan in accordance with Part B requirements, including a procedure for internal review and evaluation.

STANDARDS OF CARE

Overview:
The Standards of Care are developed by the Standards of Care (SOC) Committee in each Part B regional consortia/planning group area. These standards are to be used as minimum requirements for all subcontractors of the Ryan White Part B Program. The Ryan White Part B Grantee and/or staff of the Lead Agency monitor agencies to ensure that these standards are being met.

Purpose of SOC:
To set minimum standards for provision of care for persons receiving Ryan White services. These standards are set as the key activities for each service that when followed, provide quality services. Quality services support a person's ability to engage and adhere to HIV medical treatment protocols and address social barriers that impede a person's ability to adhere to care.

Standards beyond the minimal are critical to excellent care and are contained in professional standards of care, generally accepted principles of health care provision, research-based practices of care, etc. It is expected that Ryan White Part B providers are familiar with these standards and incorporate them into their practice.

Relationship to Monitoring and Technical Assistance:
Providers will be monitored for compliance with these standards. A "monitoring tool" will be used by the Grantee and/or Lead Agency to carry out the monitoring; this tool will reflect the elements of these Standards of Care. After monitoring is completed, if significant non-compliance with standards OR professional standards of care are noted, the provider will be offered training and/or technical assistance and complete a corrective action plan.

Note on Units of Service: Units of service are set by the Grantee office, not the Standards of Care.

Table of Contents for Service Areas

AIDS Drug Assistance Program Treatments (ADAP)	Page 14
Early Intervention Services (EIS)	Page 16
Emergency Financial Assistance (EFA)	Page 21
Food Bank/Home Delivered Meals	Page 23
Health Insurance Premiums	Page 26
Housing	Page 28
Linguistics	Page 30
Medical Case Management (MCM)	Page 32
Medical Nutrition Therapy	Page 36
Medical Transportation	Page 39
Mental Health Services	Page 42
Non - Medical Case Management (NMCM)	Page 45
Oral Health Services	Page 48
Outpatient/Ambulatory Care	Page 52
Outreach	Page 58
Psychosocial Support Services	Page 60
Referral Services	Page 63
Substance Abuse Services –Outpatient	Page 65
Notes	Page 67

AIDS Drug Assistance Program (ADAP)

HRSA Definition: The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide Food and Drug Administration (FDA) -approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. ADAP recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate. Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge/Termination: N/A
Documentation: Universal Standards apply. ***Additionally:*** Medication formulary must include pharmaceutical agents from all the classes approved in HHS Clinical Practice Guidelines for use of Antiretroviral Agents in HIV-1 infected adults and adolescents and meets the minimum requirements from all approved classes of medications according to HHS treatment guidelines.

Staff Requirements: Universal Standards apply.

Early Intervention Services (EIS)

HRSA Definition: Early intervention services (EIS) includes counseling individuals with respect to HIV/AIDS; referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. HIV education, including risk prevention and adherence counseling are a part of every patient encounter. EIS:

1. Assists clients with linkage to and follow-up on participation in out-patient HIV medical care (primary focus); In order to address barriers to care, assists clients in linkage to and follow up on participation in other Ryan White core medical services (e.g., oral health, home health, hospice, ADAP, other prescription assistance, insurance assistance, mental health, substance abuse, medical case management and nutritional counseling), other Ryan White support services; and other non-Ryan White community services;
2. Develops formal relationships with "Points of Entry" and informal relationships with other community "contacts" who are engaged in the provision of HIV testing. Points of Entry are those entities that have identified at least three (3) HIV+ cases in the last year and entities with a significant number of persons who have dropped out of HIV medical care as determined by the Part B Grantee.
3. Emphasizes patient "engagement" in HIV medical care, with a focus on reducing barriers to engaging in care and service. EIS is a transition service that connects persons to Medical Case Management services. EIS is located in HIV medical settings or in community settings where formal linkages with these HIV medical settings exist. Treatment engagement includes but is not limited to the following activities:
    - Determines current status of linkage to medical care in general and HIV medical care, including determining readiness for engaging in care;
    - Teach and support self-management and health literacy;
    - Educate and/or reinforce the importance of consistently maintaining HIV medical care; and
    - Education with regard to HIV prevention, transmission, safer sex, risk factors and risk behavior management.

Part B requirement: EIS services must include the following four components:

1. Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV- infected recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
   HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
2. Referral services to improve HIV care and treatment services at key points of entry.
3. Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care.
4. Outreach Services and Health Education/Risk Reduction related to HIV Diagnosis
5. At this time testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures) is not covered under EIS as the State has adequate testing resources.

STANDARD
Eligibility: Universal Standards apply. Additionally: 1. Must follow TDH requirements regarding Ryan White service eligibility process. 2. The agency must check the TDH Eligibility Database to ensure that the client does not currently have an existing Ryan White CM or MCM (Ryan White requires one primary case manager per client.) 3. EIS services are specifically designed to be provided to: • HIV+ persons who have been "lost to care" (out of HIV outpatient medical care for one year or greater); or • HIV+ persons who have been out of HIV medical care for at least six (6) months with documented clinical risk factors of high viral load, low T-cell count, acute opportunistic infection, co-morbidity of acute/chronic illness that impact HIV health or persistent psychosocial circumstances; or • Person Living with HIV/AIDS (PLWHA) who are in medical care, but have

identified issues that adversely impact retention in care; or • HIV+ women who are pregnant; or • HIV+ persons or are currently scheduled to be released from incarceration and will be released within 180 days and have documented significant clinical issues that negatively impact ability to engage in HIV medical care; or • HIV+ persons who are newly diagnosed
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply. ***Additionally:*** In each area there is focus on identifying the specific barriers the client/patient has or may experience in accessing medical care, remaining in care and/or adhering to medical treatments.
Plan of Care: Universal Standards apply. ***Additionally:*** A written plan of care must be developed with the participation and agreement of the client or guardian.
Monitoring: Universal Standards apply. ***Additionally:*** The needs and status of the client will be reassessed every 6 months in a face to face encounter. Phone call follow up is required at least quarterly.
Reassessment: Universal Standards apply. ***Additionally:*** Each client must be reassessed every 6 months minimally or as the need arises.
Discharge/Termination: Universal Standards apply.
Documentation: Universal Standards apply. ***Additionally:*** Category under which client qualifies for EIS (e.g., lost to care) must be documented. Documentation is required for: 1. Referrals for health care and supportive services; 2. Referrals from key points of entry; 3. Linkage to care; 4. Training sessions to help clients understand and navigate HIV system of care.

Staff Requirements: Universal Standards apply.

Additionally:

1. Minimum Education/Experience requirements:
   All EIS Specialists hired by subcontractor/provider agencies that are funded in whole or part to provide EIS services with Ryan White Part B funds must possess at a minimum a high school(HS) diploma or General Education Diploma (GED).
2. Supervision:
   - Supervision of EIS Services must be provided by an MSW to ensure that both medical and psychosocial clinical processes are appropriately addressed.
   - MSW Supervisor - Supervisor will demonstrate efforts to ensure quality management of care through consultation and/or training of staff. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g. record keeping. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.
3. Training: EIS specialists and their supervisors must have opportunities to participate in relevant annual training for at least five hours per year.

**In some case a waiver may be obtained, please see Notes at the end of this document.*

Additional Requirements:

1. Establish Memoranda of Understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive.
2. Document provision of all four required EIS service components, with Part B or other funding.
3. Document the number of referrals for health care and supportive services.
4. Document referrals from key points of entry to EIS programs.
5. Document training and education sessions designed to help individuals navigate and understand the HIV system of care.
6. Establish linkage agreements with testing sites where Part B is not funding testing but is funding referral and access to care, education, and system navigation services.
7. Obtain written approval from the grantee to provide EIS services in points of

entry not included in original scope of work.

8. Health education and literacy training is provided that enables clients to navigate the HIV system.
9. EIS is provided at or in coordination with documented key points of entry.
10. EIS services are coordinated with HIV prevention efforts and programs.

Emergency Financial Assistance (EFA)

HRSA Definition: Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, 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.

Part B requirement: This service includes the provision of short-term emergency financial assistance to clients with HIV/AIDS for utilities (gas, electricity, water and sewer). Short term emergency financial assistance is defined as necessary for the client to: a) gain or maintain access to medical care, adherence to medical care/treatments and/or wellness and b) address financial need that arises from high and/or unexpected medical costs.

STANDARD
Eligibility: Universal Standards apply. Additionally: 1. The client's name must be on the bill and/or account. 2. Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs and is limited to 21 weeks of support per year or a $500 dollar amount cap.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge/Termination: N/A
Documentation: Universal Standards apply. ***Additionally:*** A record of services documenting service recipients' eligibility and need for EFA, specific utility paid for and cost must be maintained.
Staff Requirements: Universal Standards apply.
Additional Requirements: 1. The payment must be made directly to vendors based on need and actual bill. 2. Demonstrate coordination with other area emergency financial assistance resources to avoid duplication of services.

3. Direct cash payments to clients are prohibited and the client's name must be on the bill and/or account. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

Food Bank/Home Delivered Meals

HRSA Definition: Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following: personal hygiene products, household cleaning supplies, and water filtration/purification systems in communities where issues of water safety exist.

Part B requirement: Food Bank/Home Delivered Meals is to provide the nutrition and personal hygiene items to enhance a person's health status. Services fund the provision of:

- **Food Bank**. A food bank is a central distribution center within an agency's catchment area or home delivery providing groceries for indigent clients with HIV/AIDS and their families.
- **Food Vouchers**. This service provides certificates or cards, which may be exchanged for food a cooperating supermarkets, or meals at clinics or social service agencies.
- **Home Delivered Meals**. This service provides nutritionally balanced home delivered meals for clients with HIV/AIDS who are indigent, disabled or homebound, and/or who cannot shop for or prepare (or have others to shop and prepare) their own food. This includes the provision of frozen and hot meals.
- **Non-Food Products**. This service provides reimbursement for the cost of non-food products, such as personal hygiene products, to be provided to eligible individuals through food and commodity distribution programs. Ryan White Part B funds may not be used for household appliances, household products, car care products, pet foods or products, or baby care items (e.g., diapers, formula, layette items, etc.), or for the purchase of clothing. Personal care kits must be provided from the agency's central distribution center.

STANDARD
Eligibility: Universal Standards apply.

Additionally: 1. Providers must document that those clients receiving services have been properly screened and/or referred for other community resources as appropriate by the primary case manager.
Intake and Screening: Universal Standards apply. ***Additionally:*** Completed by Case Managers
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply. ***Additionally:*** A record of services provided documenting service recipients; eligibility and need for food and specific service and amount provided must be maintained.
Staff Requirements: Universal Standards apply.
Additional Requirements: 1. Direct cash payments to clients are prohibited. General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable. 2. Facilitate or arrange at least quarterly nutrition education for recipients to increase nutrition/food management and preparation skills. 3. **Food Bank:** The provision of this service will be limited to $30 worth of groceries per week. Households with more than one client with HIV/AIDS will be entitled to $30 per adult member with HIV/AIDS. Families with minors (under the age of 18) will be entitled to provisions based on family size. Providers must specify criteria processes and procedures utilized to determine allotment provided for dependents, which should take into account factors such as age, special nutritional needs, etc. Providers must

demonstrate their capacity to provide foods suited to special client needs.

4. **Food Vouchers:** Provision of food vouchers for any one client is limited to $30 per week, $100 per month, and $500 per year. Clients with HIV/AIDS with dependent children (under 18 years of age) are eligible for an additional $25 per month in food vouchers for each dependent child, up to an additional $500 per year for a household/family with dependent children.
5. Providers must ensure vouchers are utilized for appropriate purchases and cannot be used for tobacco and/or alcohol products.
6. **Home Delivered Meals:** Providers must demonstrate their capacity to provide nutritious food suited to special client needs. Providers will be required to demonstrate that they will adhere to generally accepted nutritional standards for provision of meals to persons with HIV/AIDS. Providers responsible for the preparation of meals will be required to adhere to state and/or local health department regulations for the preparation of food.
7. **Non-Food Products:** The provision of this service will be limited to $20 per kit twice a year per client. Clients with dependent children (under 18 years of age) are eligible for an additional $15 in kit items.
8. Provider must maintain compliance with all federal, state and local laws regarding provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certification. (HAB 2013)
9. Any purchase of water filtration system(s) must be pre-approved by the Lead Agency and TDH and provide written justification for need.
10. Funds may not be used to purchase clothing.

Health Insurance Premium & Cost-Sharing Assistance

HRSA Definition: Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part B recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part B recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services.
- RWHAP Part B recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV. Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients.
- Paying cost-sharing on behalf of the client.

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply.

Additionally:

1. Documentation of an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles to lower the costs of having the client in the ADAP program.
2. Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications.
3. Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection.
4. Assurance that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by Ryan White.
5. Ryan White Part B cannot pay for emergency room and inpatient copays and deductibles.

Staff Requirements: Universal Standards apply.

Housing

HRSA Definition: Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services. Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation. Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. The necessity of housing services for the purposes of gaining or maintain access to HIV medical care and treatment must be documented in writing by a case manager/care manager/medical care manager; 2. A person must be ineligible for or have exhausted Housing Opportunities for People With AIDS (HOPWA) funds in order to be eligible for this service. 3. Unless approved by a supervisor and the Plan of Care documents activities to make housing cost meet the following standard (e.g., new employment, move to more affordable housing), a person's monthly rent must be less than 50% of their gross family/individual income in order to be eligible for this service. If housing costs are more than 50% of their gross income, client must provide documentation of what their income is used to pay.

4. A person must have the legal right to reside in the housing unit 5. Housing environment must be in compliance with all applicable local and state housing codes and must meet HUD's habitability standards (24 CFR 574.310(b)(2)).
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply. ***Additionally:*** The assessment must include: 1. Emergency rental assistance needs; 2. Evaluation and documentation of the client's contribution, financial and otherwise, toward addressing and solving his/her housing problems; 3. Other factors that may qualify or disqualify the client from certain types of housing programs and services.
Plan of Care: Universal Standards apply. ***Additionally:*** Must include a housing component, that includes: 1. a strategy to ensure progress towards long-term stable housing and moving from assistance to self-sufficiency, including a strategy for identifying a funding source for long term housing; 2. ensures that consumers are receiving assistance to help develop skills that will enable them to attain and maintain permanent housing (e.g., budget management); 3. identifies strategies to avoid a housing emergency or crisis from developing in the future.
Monitoring: Universal Standards apply.
Reassessment: Universal Standards apply.
Discharge: Universal Standards apply.
Documentation: Universal Standards apply. ***Additionally:*** 1. Documentation of current rent and lease agreement. 2. A record of services provided documenting service recipients, eligibility, amount and duration of payment must be maintained. 3. Documentation of client's utilization of Ryan White funding (Part A & B) for housing services must be maintained in order to comply with HRSA's policy regarding the limit of twenty-four (24) months cumulative lifetime period of

eligibility. Therefore, providers must comply with the requirements specified by the funding source.
Staff Requirements: Must comply with staff requirements specified in Part B Case Management/ Medical Case Management Standards of Care. Staff must also possess knowledge of local, state and federal housing programs and how to access these programs.
Additional Requirements: 1. Must demonstrate coordination with other area emergency financial assistance and housing provider programs in order to avoid duplication of services. 2. Must ensure that case managers maintain current information about other housing resources in the area including but not limited to HOPWA housing. 3. Must ensure that staff is knowledgeable about the role of housing and case management interventions in improving HIV health care outcomes. 4. Direct cash payments to clients or family members are prohibited and funds cannot be used for mortgage payments. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable. 5. No person can receive more than a lifetime twenty-four (24) cumulative months of housing service from Ryan White funds.

Linguistic Services

HRSA Definition: Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

Part B requirement: Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

STANDARD
Eligibility: Universal Standards apply
Intake and Screening: Universal Standards apply
Assessment: Universal Standards apply
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply. ***Additionally:*** 1. A record of services provided documenting Linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of Ryan White-eligible services in both group and individual settings. 2. Document the provision of linguistic services, including: • Number and types of providers requesting and receiving services. • Number of assignments. • Languages involved and types of services provided – oral interpretation or written translation. Whether interpretation is for an individual client or a group.
Staff Requirements: Universal Standards apply.

Additionally: Services are provided by appropriately trained and qualified individuals holding appropriate State or local certification.

Medical Case Management (MCM)

HRSA Definition: Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed 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). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized Plan of Care
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the Plan of Care
- Re-evaluation of the Plan of Care at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
  In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Part B requirement: All MCM positions must follow and use the TDH MCM Manual and the TDH Eligibility Database

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. Must follow TDH requirements regarding Ryan White Part B service

eligibility process. See TDH MCM manual, Section 1, for more details. 2. The agency must check the TDH Eligibility Database to ensure that the client does not currently have an existing Ryan White CM or MCM (Ryan White requires one case manager per client.)
Intake and Screening: Universal Standards apply. ***Additionally:*** 1. Client must participate in initial intake and screening procedures. 2. See TDH MCM Manual, Section 1, for more details.
Assessment: Universal Standards apply. ***Additionally:*** In each area, the Case Manager is focused to identifying the specific barriers the client has or may experience in accessing medical care, remaining in care and/or adhering to medical treatments.
Plan of Care: Universal Standards apply.
Monitoring: Universal Standards apply. ***Additionally:*** The needs and status of the client receiving Case Management will be reassessed every 6 months.
Reassessment: Universal Standards apply.
Discharge/Termination: Universal Standards apply. ***Additionally:*** See the TDH MCM Manual for more specific information.
Documentation: Universal Standards apply. ***Additionally:*** 1. There must be documentation that all the following activities are being carried out for all clients: • Initial assessment of service needs. • Development of a comprehensive, individualized plan of care. • Coordination of services required to implement the plan. • Continuous client monitoring to assess the efficacy of the plan. • Periodic re-evaluation and adaptation of the plan at least every 6 months, during the enrollment of the client. 2. Client records must include:

- Types of services provided.
- Types of encounters/communication.
- Duration and frequency of the encounters.

3. Documentation in client records of services provided, such as:
   - Client-centered services that link clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible.
   - Coordination and follow up of medical treatments.
   - Ongoing assessment of client's and other key family members' needs and personal support systems.
   - Treatment adherence counseling.
   - Client-specific advocacy.

See the TDH MCM Manual (Core duties) for additional information.

Staff Requirements: Universal Standards apply.

Additionally: TDH MCM Manual outlines education and experience guidelines for the position of Medical Case Management. These are minimum standards, each agency contracted to provide HIV/AIDS Medical Case Management Services has the authority to adopt the minimum standards or develop more stringent standards.

See TDH MCM Manual for specific minimum educational/experience requirements for MCM positions.

1. Minimum educational/experience requirements: See TDH MCM Manual
2. Supervision: See TDH MCM Manual
3. Training: See TDH MCM Manual

**In some cases a waiver may be obtained, please see the TDH MCM Manual for more details.*

Medical Nutrition Therapy

HRSA Definition: 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.

Part B requirement: TDH funds cannot be used for nutritional supplements. Medical Nutrition Therapy (MNT) is defined as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a Registered Dietitian or nutritional professional. ** MNT is a specific application of the Nutrition Care Process (developed by the American Dietetic Association, currently known as Academy of Nutrition and Dietetics***) in clinical settings that are focused on the management of diseases. MNT involves in-depth and individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease. All services performed under this service category must be pursuant to a medical provider's referral and based on a nutrition plan developed by the registered dietitian or other licensed nutrition professional.

** TDH funds cannot be used for nutritional supplements*
***Medicare MNT legislation, 2000.*
**** Academy of Nutrition and Dietetics, eatright.org*

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply. ***Additionally:*** Clients will have a comprehensive assessment by a qualified licensed/registered dietician that is to be completed within the first 2-3 primary care visits with the primary care provider. The initial assessment shall include, but

is not limited to:

1. Chief complaint.
2. Past medical and surgical history with detailed HIV/AIDS history.
3. Family and social history including substance abuse and mental health history.
4. Weight status (changes and comparisons to national standards).
5. Food and drug allergies.
6. Food restrictions, including religious-based.
7. Diet history and current nutritional status, including current intake.
8. Nutrition-related knowledge and practices.
9. Nutritional concerns.
10. Current medications and relevant laboratory data.

Plan of Care: Universal standards apply.

Additionally:

1. Staff must follow guidelines in the Nutrition Care Process.
2. Referrals to Nutritional Services should be provided as appropriate for both acute problems and for health maintenance.
3. Consults should be completed the same day as referral, if possible.
4. Providers of MNT shall, in conjunction with the client, develop a nutritional plan with goals and intervention strategies to determine progress made in desired outcomes or nutrition care that will be reviewed and updated as conditions warrant (at a minimum of every six months). The nutritional plan must include:
    - Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food
    - Date service is to be initiated
    - Planned number and frequency of sessions
    - The signature of the registered dietitian who developed the plan

Monitoring: As conditions warrant (at a minimum of every six months).

Reassessment: Universal standards apply.

Discharge/Termination: Universal Standards apply.

Documentation: Universal Standards apply.

Additionally:

1. If food is provided, the chart must say where food is provided to a client under this service category
2. Client file is maintained that includes a physician's recommendation and a nutritional plan
3. Nutritional supplements and food provided, quantity, and dates
4. The signature of each registered dietitian who rendered service, the date of service
5. Date of reassessment
6. Termination date of medical nutrition therapy
7. Any recommendations for follow up.

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff must adhere to DHHS and education guidelines provided by the Academy of Nutrition and Dietetics
2. Staff must be trained and knowledgeable about primary care, HIV/AIDS disease and treatment, available resources that promote the continuity of care, and multi-disciplinary medical care practices.
3. Staff must be licensed/certified to practice within their concentrated area consistent with city, county, state and federal laws and the Accreditation Council for Education in Nutrition and Dietetics (ACEND) and must maintain the required supervision, training and continuing education as required.

Additional Requirements: Agencies providing Medical Nutritional Therapy will have written guidelines to generate automatic referrals for this service in addition to direct consults from medical providers.

Medical Transportation

HRSA 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.

Part B requirement: TDH funds cannot be used for the purchasing or leasing of vehicles.

STANDARD
Eligibility: Universal Standards apply. Additionally: Clients receiving transportation passes must be documented as having been properly screened for other transportation resources as appropriate. When clients qualify for other funding sources for transportation, they will not be eligible for Ryan White Part B funding for this service. 1. Mileage reimbursement: • To qualify for mileage reimbursement, the client must demonstrate, if needed, that a caregiver provided transportation assistance. • To qualify for mileage reimbursement, non-clients must: 1) be an eligible staff person and/or unpaid volunteer of the agency and 2) have proof of the appropriate insurance and other liability issues either personally or through agency coverage. 2. Taxicab reimbursement: To qualify for reimbursement for taxicab transportation, the client must: • Have a medical emergency or severely inclement weather which prohibits the use of other transportation sources and/or; • No available public transportation or other resource.
Intake and Screening: N/A
Assessment: N/A
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A

Documentation: Universal Standards apply.

Additionally:

1. A record of services provided documenting service recipients, eligibility, method and cost of service and amount must be maintained.
2. Documentation must contain the level of services/number of trips provided, the reason for each trip and its relation to accessing health and support services, trip origin and destination, client eligibility, the cost per trip and the method used to meet the transportation need.

Staff Requirements: Universal Standards apply.

Additionally:

1. Agency must ensure that any staff hired as drivers are subject to at a minimum mandatory pre-employment as well as random and post-accident drug screenings to be conducted by a certified, approved laboratory facility.
2. Use of volunteer drivers appropriately addresses insurance and other liability issues.

Additional Requirements:

1. No cash payments are provided to clients. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
2. **All:** Demonstrate coordination with other area transportation agencies and services, TennCare Special Transportation and other existing transportation programs to avoid duplication of services.
3. **Agency Based:** Provided in combination with core services to clients of Ryan White Part B funded programs. They must be in compliance with all state regulations regarding transportation including driver's license; appropriate insurance and other liability issues; and/or any applicable state regulations. It can be used to provide free transportation to and from core medical service and support services for eligible clients with HIV/AIDS in vehicles a) directly operated by the service provider or b) through a subcontract with a

provider of transportation services. Any agency providing direct transportation has written procedures developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service, and will be in-serviced annually. The agency will maintain a copy of each in-service and sign-in roster with names both printed and signed and maintained in each driver's personnel file. Any agency providing direct transportation ensures that children under 16 are not transported without an adult escort. State law regarding height and weight mandates for car seats and/or booster seats for children must be observed. Necessity of a car seat or booster seat should be documented on the Transportation Log by staff when an appointment is scheduled by a client. Agency must ensure the safety of any vehicles used to transport clients for services. There must be safety standards in place that at a minimum ensure the vehicles are in good repair and equipped for adverse weather conditions.

4. **Mileage Reimbursement**: Mileage will be reimbursed at no more than the current Tennessee Department of Health rate. Provider agencies may state their own rate as long as Ryan White funded reimbursement does not exceed the current TDH rate.
5. **Transportation passes**: provides public transportation passes to eligible clients with HIV/AIDS attending core medical and support service appointments.
    - Clients receiving five or more Ryan White funded services a month may be eligible to receive a monthly bus pass.
    - Clients receiving less than five Ryan White funded services a month may be able to receive one-day bus passes.

Mental Health Services

HRSA Definition: Mental Health Services are the provision of outpatient psychological and psychiatric screening, 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.

Note: Mental Health Services are only available to HIV infected clients

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. Individuals served must have a documented mental health diagnosis/diagnostic feature. 2. Upon initial contact with client, agency will assess client for emergent/urgent or routine mental health needs. 3. Provider confirms client eligibility for services. The process to determine client eligibility must be completed in a timely manner so that screening is not delayed.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: Universal Standards apply. ***Additionally:*** 1. The plan must be reflective of mental health diagnosis/diagnostic feature and severity of mental health symptoms and as needed and serves as a vehicle for linking clients to other needed mental health services. 2. The plan must document treatment modality, recommended number of sessions and include recommendations for follow-up.

Monitoring: Universal Standards apply.

Reassessment: Universal Standards apply.

Discharge: Universal Standards apply.

Documentation: Universal Standards apply.

Additionally:

1. For group sessions: A log documenting service recipients served, begin and end date of session(s), session topics, number and length of session(s).
2. The client file must contain a detailed treatment plan for each eligible client that includes:
   - The diagnosed mental illness or condition
   - The treatment modality (group or individual)
   - Start date for mental health services
   - Recommended number of sessions
   - Date for reassessment
   - Projected treatment end date
   - Any recommendations for follow up
   - The signature of the mental health professional rendering service
   - Documentation of service provided to ensure that services provided are allowable under Ryan White guidelines and contract requirements and are consistent with the treatment plan

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff Requirements:
   - Include all required elements from state licensure rules (e.g., 0940-05-14).
   - Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications, including cognitive impairment and generally accepted treatment modalities and practices.
   - Services must be provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.
2. Supervision:
   - Supervision of mental health services must be provided to ensure that both medical and psychosocial clinical processes are appropriately

addressed.
- Supervision must be provided by qualified licensed professionals in effort to ensure quality medical management of care through consultation and/or training of staff.
- Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.

3. Training:
   - Staff and their supervisors must have opportunities to participate in relevant annual training for at least five hours per year.

Additional Requirements:

1. Must provide access to mechanisms for urgent and/or emergency care when needed, such as in the case of a suicidal client.
2. Providers must maintain formal and informal collaboration/linkages with mental health and substance abuse service organizations within Part B coverage area.

**In some cases a waiver may be obtained, see Notes at the end of this document*

Non-Medical Case Management Services

HRSA Definition: Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized Plan of Care
- Continuous client monitoring to assess the efficacy of the Plan of Care
- Re-evaluation of the Plan of Care at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Part B requirement: 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.

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. Must follow TDH requirements regarding Ryan White service eligibility process. 2. The agency must check the TDH Eligibility Database to ensure that the client does not currently have an existing Ryan White CM or MCM (Ryan White requires one case manager per client.)
Intake and Screening: Universal Standards apply.

Assessment: Universal Standards apply.
Plan of Care: Universal Standards apply.
Monitoring: Universal Standards apply.
Reassessment: Universal Standards apply. ***Additionally:*** Each client must be reassessed every 6 months minimally or as the need arises.
Discharge/Termination: Universal Standards apply.
Documentation: Universal Standards apply.
Staff Requirements: Universal Standards apply. ***Additionally:*** 1. Minimum educational/experience requirements for case management positions: All case managers hired by subcontractor/provider agencies that are funded in whole or in part to provide case management services through Ryan White Part B funds, must possess one of the following: • Bachelor level degree in a health or human services related discipline or a Tennessee licensed BSN with equivalent to two year of full time professional case management in a public service agency. Or • Bachelor level degree in Social Work with equivalent to two years of full time professional case management in a public service agency (an appropriately supervised BSW internship may count for one year's experience). Or • Master level degree in a health or human services related discipline with equivalent to one year of full time professional case management in a public service agency. 2. Supervision: Supervision of Case Management Services must be provided by an MSW to ensure that both medical and psychosocial clinical processes are appropriately addressed. • MSW Supervisor - Supervisor will demonstrate efforts to ensure quality management of care through consultation and/or training of staff. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), case manager job performance, and

skill development (e.g. record keeping). • Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting. 3. Training: See TDH MCM Manual. *In some case a waiver may be obtained, please see Notes at the end of this document.*
Additional Requirements: 1. Agency must provide assurances that any transitional case management for incarcerated persons meets contract requirements.

Oral Health Care

HRSA Definition: Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Part B requirement: Cosmetic dentistry for cosmetic purposes only is prohibited.

<table>
<tr><th>STANDARD</th></tr>
<tr><td>Eligibility: Universal Standards apply.

Additionally: The following criteria must be met for a client to be eligible for Oral Health services under Ryan White Part B -
1. Medical Case Manager (MCM) determines eligibility based upon eligibility requirements specified in Universal Standards of Care. Medical Case Manager or designee explores available resources, (e.g., insurance) before certifying a client eligible for services under Ryan White, Part B and then provides a client with a list of approved dental providers. The MCM assists the client in selection of the dental provider indicating their choice in the application materials sent to the Dental Administrative Agency (DDA).
2. If a person has dental insurance, verification in writing from insurance carrier stating that benefits have been exhausted is required.

Priority
Clients will be served in the order listed below:
1. Clients who have initiated but not completed treatment, from an approved dental treatment plan, at the end of the previous grant year.
2. Clients currently on a waiting list. (In the order they were added) from the previous funding year.
3. First come, first served until funding is exhausted; at that time a waiting list will be established.</td></tr>
<tr><td>Intake and Screening: Completed by Medical Case Managers or Case Managers.</td></tr>
<tr><td>Assessment: Universal Standards Apply.</td></tr>
</table>

Additionally:

Routine Care

1. Dental assessment and cleaning must occur in conjunction with each other and on the same day.
2. A comprehensive oral assessment is conducted prior to treatment and is ongoing if necessary and should include:
   - Comprehensive health history;
   - Client's knowledge, ability and performance history for routine personal oral hygiene;
   - Hard and soft tissue examination;
   - Documentation of patients presenting complaints;
   - Charting of cavities;
   - Applicable X-rays of the teeth;
   - Periodontal screening (evaluation of gums, gingival health);
   - Intra-oral exam, including evaluation for HIV-associated lesions;
   - Pain assessment; and
   - Written diagnoses, where applicable.

Emergency Care

1. Dental assessment and cleaning must occur in conjunction with each other and on the same day.
2. An emergency exam is conducted prior to treatment and should include:
   - Documentation of patients presenting complaints
   - X-ray(s) of affected area(s), where applicable
   - Limited problem focused exam
   - Written diagnoses, where applicable.

Plan of Care:

Routine Care

After initial assessment, the oral health care provider must submit a signed oral health care treatment plan to the DAA in a manner specified by the DAA. The dental provider must discuss the "approved treatment plan" with the patient and the patient can request a copy from the DAA. The plan should address: cavities, missing teeth, periodontal condition, extractions and replacement teeth, and oral hygiene instructions. The plan should include referral to primary care facility or

physician for medical care, as needed. <u>Emergency Care</u> After the emergency exam is completed, the oral health care provider must follow DAA procedures for emergency treatment. The dental provider must discuss the “emergency treatment” with the patient and provide the patient with written details of the work to be completed. The plan should include referral to primary care facility or physician for medical care, as needed.
Monitoring: Monitoring is defined in the oral health care treatment plan.
Reassessment: See Assessment.
Discharge: Services are terminated once the approved treatment plan is completed, or if the client ends services, or if the client does not comply with service procedures.
Documentation: 1. Medical Case Managers must complete patient referral and eligibility documentation as specified by the DAA. 2. Dental providers must complete patient referral, care and financial documentation as specified by the Dental Administrative Agency (DAA) in order to be reimbursed for services rendered. 3. The DAA must maintain a current list of approved dental providers and provide this list to Medical Case Managers and the person responsible for record keeping and payment, on an annual basis, or whenever a change occurs, or upon request of the MCM. 4. The DAA must maintain a file on each client receiving services. Documentation must include, but is not limited to, progress notes, referrals made, financial records and appropriate oral health care forms as required by the Part B grantee.
Staff Requirement: 1. Dental provider must maintain an undisciplined license to practice in the State of Tennessee and current registration. 2. Dental providers shall adhere to the standards of care as specified in the Tennessee Dental Practices Act.
Additional Requirements: 1. Client must receive dental services from an approved dental provider and only those services in the approved treatment plan.

2. Individuals participating in the program are capped at a limit per grant year set by the TDH.
3. The Medical Care Manager will ensure that the client is familiar with the Dental Policy and expenditure limitations. All costs in excess of the established expenditure limitations are the sole responsibility of the client.
4. The DAA is responsible for processing and managing the process of applications from dental providers and for maintaining records for the approved dental providers. In addition, the DAA is responsible for verifying on an annual basis that all providers have and maintain a valid Tennessee dental license and are not under restriction.
5. The dental provider must comply with payment procedures and rates specified by the DAA per Ryan White Part B requirements.
6. Clinical decisions are informed /supported by the American Dental Association Dental Practice Parameters. (HAB 2013)

Outpatient/Ambulatory Health Services

HRSA Definition: Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Part B requirement:

1. Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.
2. Outpatient care includes referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services).

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply. ***Additionally:*** 1. Clients in need of routine medical care will be scheduled to be seen for an

initial appointment within 30 calendar days from the eligibility verification date.

2. Clients will receive standardized comprehensive psychosocial and environmental assessment during a face to face contact from an appropriate program staff immediately following eligibility determination. Refer to Medical Case Management standards for more detailed information.
3. If Medical Case Management is not available at the medical provider's site, the medical provider will refer the client to medical case management within two business days.

Assessment: Universal Standards apply.

Additionally:

1. Clients will have a comprehensive initial intake and assessment which will be completed within the first two primary care visits scheduled with the primary care provider. The initial assessment shall include, but is not limited to the following:
   - Chief complaint
   - Past medical and surgical history with detailed HIV/AIDS history
   - Family and social history including substance abuse and mental health histories
   - Allergies to medications
   - Current and past medications, specifically HIV therapies
   - Current nutrition including supplements
   - Any present illnesses or concerns
   - Screening for diseases associated with risk factors (Hepatitis A, Hepatitis B, Hepatitis C, and Sexually Transmitted Infections)
2. Client's initial assessments will include a comprehensive physical examination in accordance with the most current published the Department of Health and Human Services' Guidelines for Use of Antiretroviral Agents in HIV infected Adults and Adolescents (DHHS Guidelines). The physical evaluation shall include , but is not limited to the following:
   - Vital signs
   - Systems inspection, inclusive of dermatological examination
   - Neurological examination
   - Genital, oral and rectal exams as appropriate (This may be deferred, but should generally be done by the second medical visit.)

- Breast examination

3. Appropriate baseline testing including laboratory and radiology values, will be performed within the first two primary care visit scheduled with the primary care provider. Tests shall be inclusive of but not limited to the following:
   - Complete Blood Count (CBC) with platelets
   - Syphilis screening
   - Toxoplasmosis serology (unless previously positive)
   - Chemistry profile, including serum transaminases and lipid profile
   - Urinalysis
   - Screening for chlamydia, gonorrhea, and trichomoniasis for clients who are sexually active, as per DHHS STD guidelines
   - Glucose-6-phosphate dehydrogenase screening in appropriate racial or ethnic groups (unless previously tested)
   - CD4+ lymphocyte count
   - Viral load measurement
   - For patients with pretreatment HIV RNA >1,000 copies/mL – genotypic resistance testing prior to initiation of therapy; if therapy is to be deferred, resistance testing may still be considered
   - Cervical cytology screening for women and adolescent females, if appropriate. Liquid based cytology is the preferred approach for HPV testing.
   - Routine assessments for opportunistic infections
   - Blood test and/or chest x-ray if indicated
4. Immunization status of the client will be reviewed during the initial assessment. Vaccines appropriate to clients' current immunization and health status should be offered according to protocol.
5. Referrals to specialists (e.g., dentists, ophthalmologists, nutritionist, etc.) should be provided as appropriate.

Plan of Care:

1. Providers shall, in conjunction with the client, develop a comprehensive multi-disciplinary plan of care that will be reviewed and updated as conditions warrant or at minimum of every six months.
2. Providers shall develop and initiate a client treatment adherence plan that is consistent with DHHS Guidelines for clients who are being treated with an antiretroviral (ARV) medication regimen. The plan shall be reviewed and

updated as conditions warrant.
3. Providers shall conduct an adherence evaluation related to medication regimen and appointment schedules at least annually.
4. Agency staff shall act as a liaison between the client and other service providers to support coordination and deliver of high quality care.
5. Agencies will have a referral process for care of HIV related problems outside of their direct service area.

Monitoring: N/A

Reassessment: N/A

Discharge/Termination: N/A

Documentation: Universal Standards apply.

Additionally:
1. Completed according to generally accepted medical practice standards and state requirements.
2. Contain an up-to-date "Problems List" separate from progress notes which clearly prioritizes problems for primary care management.
3. Contact information for ancillary continuing health care (e.g., mental health provider, OB/GYN or other continuing specialty services.
4. Client records must include:
   - Dates and frequency of services provided.
   - Documentation that services provided are for the treatment of HIV related infection.
   - Signature of licensed provider of services.
5. Documentation that tests are:
   - Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider.
   - Consistent with medical and laboratory standards approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory Improvement Amendments (CLIA) Program.

Staff Requirements: Universal Standards apply.

Additionally:
1. Staff adheres to generally accepted medical practice standards and state requirements

2. Agency staff is trained and knowledgeable about primary care, HIV/AIDS disease and treatment and available resources that promote the continuity of client care.
3. Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van.

Additional Requirements:

1. Providers are required to use the latest version of United States Public Health Service (PHS) HIV treatment guidelines.
2. Clients will be assessed for educational, nutritional and psychosocial needs. Appropriate referrals will be made.
3. Agency staff will inform clients of their responsibility for scheduling appointments, being on time, and calling the provider to cancel or reschedule if an appointment cannot be kept.
4. Provider will screen sexually active clients for sexually transmitted diseases annually. Clients at high risk shall be screened at least every six months. If a client has been screened at another facility, the client's primary medical care chart shall contain copies of the appropriate documentation.
5. Providers shall assess risk behaviors and offer or refer clients as needed for lifestyle education and counseling services regarding such areas as exercise, smoking cessation, risk reduction and safer sex practices.
6. Providers shall offer clients not currently on antiretroviral (ARV) therapies, who qualify for ARV treatment by DHHS guidelines, education and counseling on the risks and benefits of antiretroviral therapy at least twice a year.
7. Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects
8. Providers must demonstrate strong linkages with funded providers, including Medical Care Management and Early Intervention Service providers. This must be in the form of a written Memorandum of Understanding. MOUs must contain at least the following:
   - Description of how Outpatient Provider and Medical Case Management & EIS providers share information on:
     - Patient scheduled appointments and missed appointments, labs, medications, medical records and insurance status.
     - Arising issues that can impact patient health status or ability to adhere to medical treatment.

9. Providers must make labs and other medical information available upon request to requesting agency as soon as possible or within at least 3 – 5 business days.

Outreach Services

HRSA Definition: Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services

Part B requirement: Outreach must be 1) targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, 2) targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior, 3) conducted at times and in places where there is a high probability that individuals with HIV infection will be reached and 4) designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness.

Note: Funds may not be used to pay for HIV counseling or testing.

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** Individuals identified through epidemiologic data and/or appear in the targeted population that either need testing services or referral to HIV services.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge/Termination: N/A
Documentation: Universal Standards apply. ***Additionally:*** Programs must document 1. Program design and implementation

2. Target areas and populations
3. Outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care
4. Data showing that all Request For Proposal (RFP) and contract requirements are being met with regard to program design, targeting, activities, and use of funds

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff are required to have a minimum of a High School Diploma or GED; although, a Bachelor's level degree in Social Work or a health related field and a minimum of 1 year of experience is preferred.
2. Staff is trained and knowledgeable about HIV/AIDS, the affected communities and available resources. Training specific to outreach activities should include (but not limited to) the following:
   - HIV/AIDS Counseling (and testing when applicable),
   - Referral to medical care
   - Personal safety
   - Adherence counseling
   - Non-violent crisis intervention
   - Cultural diversity
   - Psychosocial issues specific to HIV/AIDS.

Additional Requirements:

1. Programs must develop outreach safety protocols.
2. Programs must document that outreach services:
   - Are planned and delivered in coordination with local HIV prevention outreach programs and avoid duplication of effort.
   - Target populations known to be at disproportionate risk for HIV infection.
   - Target communities whose residents have disproportionate risk or establishments frequented by individuals exhibiting high-risk behaviors.
   - Are designed so that activities and results can be quantified for program reporting and evaluation of effectiveness.

Psychosocial Support Services

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

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

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

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

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

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

Part B requirement:

- Part B has decided not to fund child abuse and neglect counseling.

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply.
Assessment: Completed by Case Manager
Plan of Care: N/A

Monitoring: N/A

Reassessment: N/A

Discharge : N/A

Documentation: Universal Standards apply.

Staff Requirements:

Support Activities: Must have a high school diploma or GED equivalent. And at least one of the following:

1. One or more year(s) full time relevant experience in health or human services field.
2. Life experiences with HIV/AIDS and/or affected.
3. One of more year(s) documented addiction recovery.

Note: Persons with these qualifications may conduct support activities and HIV support group with appropriate supervision.

Peer Support:

1. Must be PLWHA;
2. Possess a high school diploma or GED equivalent; and
3. Professional or volunteer experience related to human services, preferably in an HIV/AIDS service organization.

Note: Persons with these qualifications may conduct support activities and HIV support group with appropriate supervision.

Pastoral Care:

1. Must have attained a bachelor's degree in religion or theology or a master's of divinity degree from an accredited institution and/or have experience as a minister, preacher, pastor, priest, rabbi or other spiritual leader
2. Must be ordained or otherwise designated in conformity with the customs of a church, temple or other religious group or organization. Such customs must provide for such ordination or designation by a considered, deliberate, and responsible act
3. One or more year(s) experience in delivering Pastoral Care services

Note: Persons with these qualifications may conduct support activities, HIV support

group and bereavement counseling.

Bereavement Support:

1. Must have attained a bachelor's degree in social work, counseling, psychology, pastoral care, or specialized training or experience in bereavement theory or counseling
2. One or more year(s) in providing bereavement support counseling.

Note: Persons with these qualifications may conduct support activities and HIV support group with appropriate supervision.

*In some cases a waiver may be obtained, please see Notes at the end of this document.**

Supervision:

Agencies are required to have implemented a supervisory process that addresses the relevant skill level and/or needs of the staff providing services.

Peer supportive services:

Supervision of peers must be conducted by an individual with experience in human services field to provide 1) frequent and consistent opportunities to receive encouragement, 2) individualized support, 3) coaching on how to perform a helping role and 4) guidance on how to address personal challenges.

Note: Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.

Training:

1. Individuals who hold certification and/or licensure as a part of their job duties must maintain that in good standing with the respective governance bodies.
2. Agencies providing Psychosocial Support Services must document efforts to assist staff and supervisory staff in securing on-going education and training to better perform their respective job duties.
3. Psychosocial Support Services staff and their supervisors must have opportunities to participate in relevant training for at least five (5) hours per year.

Referral for Health Care and Support Services

HRSA 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. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Part B requirement: Referral for health care and support services is only to be used where these services are not provided as a part of Ambulatory/Outpatient Medical Care or Case Management.

STANDARD
Eligibility: Universal Standards apply. Additionally: The agency has procedures in place for documentation and screening of all referrals.
Intake and Screening: Universal Standards apply.
Assessment: N/A
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge : N/A
Documentation: Universal Standards apply. ***Additionally:*** 1. A log documenting service recipients screened, completed applications, and referrals made. 2. There must be documentation of the number and type of referrals that are made. 3. The agency must maintain documentation demonstrating that services and

circumstances of referral services meet contract requirements.
Staff Requirements: Universal Standards apply. ***Additionally:*** Staff must have a High School Diploma or GED.

Substance Abuse Outpatient Care

HRSA Definition: Substance Abuse 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 drug-free treatment and counseling
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** Individual provided treatment must have a substance use diagnosis (can be provided with documentation or assessment of a current or previous substance use diagnosis).
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: Universal Standards apply. ***Additionally:*** 1. The plan must be reflective of current or previous substance abuse diagnosis and severity of need and as needed and serves as a vehicle for linking clients to other needed substance abuse services. 2. The plan must document treatment modality, recommended number of sessions and include recommendations for follow-up.
Monitoring: Universal Standards apply.
Reassessment: Universal Standards apply.
Discharge: Universal Standards apply.
Documentation: Universal Standards apply.

Additionally:

1. For group sessions: A log documenting service recipients served, begin and end date of session(s), session topics, number and length of session(s).

Staff Requirements: Universal Standards apply.

Additionally: Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications as well as substance abuse, including cognitive impairment and generally accepted treatment modalities and practices.

Supervision:

1. Must be provided to ensure that both medical and psychosocial clinical processes are appropriately addressed.
2. Must be provided by qualified licensed professionals in effort to ensure quality medical management of care through consultation and/or training of staff.
3. Must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.

Training: Staff and their supervisors must have opportunities to participate in relevant annual training for at least five (5) hours per year.

Additional Requirements:

Providers must maintain formal and informal collaboration/linkages with mental health and substance abuse service organizations within the Part B county coverage.

***In some cases a waiver may be obtained, see Notes at the end of this document*

Notes:

Note 1: *Requirements for clinical supervision may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Grantee or the Lead Agency who will in turn seek approval of the modification/waiver from the Tennessee Department of Health. Along with the waiver, the following documentation must be included to merit the modification/waiver:*

1) *relevant reasons and justification for such action*
2) *specific information as to why the person providing clinical supervision has sufficient:*
   - *education (e.g., Master's Degree in a Health or Human Services field),*
   - *certification,*
   - *licensure, and*
   - *clinical experience.*

Note 2: *In such cases where a medical case manager was employed prior to the implementation of the Standard and does not meet the given qualifications, the aforementioned modification/waiver provision. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to insure that the medical case manager receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.*

Note 3: *Peers who do not meet the educational requirements and require a waiver may be medical case managers/EIS specialists if they meet the above requirements and they are an employee.*

Note 4: *Experience requirement may be waived. The agency seeking a waiver must request such in writing to the Grantee or Lead Agency who will in turn seek approval of the waiver from the Tennessee Department of Health. Documentation of the request for waiver must include relevant reasons and justification for such action and specific information why the person to be hired has sufficient education, certification, licensure and/or experience to merit the/waiver. In addition to a written statement of relevant education/experience, the agency seeking waiver must present a written plan to insure that the staff person receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.*

Note 5: *Educational and experience requirements for psychosocial support may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Lead Agency who will in turn seek approval of the modification/waiver from the Tennessee Department of Health. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to be hired as psychosocial support staff has sufficient education, certification, licensure and/or experience to merit the modification/waiver. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to insure that the psychosocial support staff receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.*

Note 6: *In such cases where a psychosocial support was employed prior to the implementation of the Standard and does not meet the given qualifications, there is need to use the aforementioned modification/waiver provision. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to insure that the staff person receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.*