ORLANDO EMA HIV/AIDS SERVICES STANDARDS OF CARE

2017

Orlando EMA HIV/AIDS

Health Services Planning Council

Orlando EMA

Ryan White Part A Office

Standards of Care for HIV/AIDS Services

- Outpatient Ambulatory Health Services (OAHS)
- Local Pharmaceutical Assistance Program (LPAP)
- Oral Health Care
- Early Intervention Services
- Health Insurance Premium and Cost-sharing assistance
- Mental Health Services
- Medical Nutrition Therapy
- Medical Case Management
- Substance Abuse (Outpatient)
- Non-Medical Case Management
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals.
- Medical Transportation
- Substance Abuse Residential Services
- Psychosocial Support Services (Peer Support)

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Introduction

The standards of care in this document were developed by the Orlando EMA Health Services Planning Council with coordination from the Orlando EMA Part A Recipient 's Office. These revised Standards are a consolidation of the existing Standards of Care into a single set that apply to all providers funded for services through the Ryan White Program Part A. The full list of services covered by these standards is provided below.

The process to develop and maintain Standards of Care and indicators is to utilize best practice standards where available for the relevant service categories. Recommendations from a committee of experts will be sought in the development of the Standards of Care. The Planning Council takes the lead in this effort, with extensive Recipient involvement and final approval. The Recipient is responsible for ensuring that these Standards of Care are implemented.

Ryan White funding is available to individuals who are HIV positive, reside in the Orlando EMA (Orange, Osceola, Seminole and Lake counties), and have a combined family income below 400% of the Federal Poverty Level (FPL). A Ryan White family is defined as a group of people related by birth, marriage, adoption, or a legally defined dependent relationship living together. Consumers accessing Ryan White Services shall meet the eligibility guidelines of HIV status, income, residency and identity.

Section I of the Standards of Care applies to all funded service categories and is known as the System Wide Standards of Care. Each section of the System Wide Standards of Care begins with a specific standard and is followed by specific measures.

The following are the funded service categories within the Orlando EMA Ryan White Part A.

- Outpatient Ambulatory Health Services (OAHS)
- Health Insurance Premium & Cost-Sharing
- Local Pharmaceutical Assistance Program (LPAP)
- Medical Case Management
- Medical Nutritional Therapy
- Medical Transportation
- Early Intervention Services
- Emergency Financial Assistance
- Mental Health
- Oral Health Services
- Non-medical Case Management
- Food Bank/Home Delivered Meals
- Substance Abuse Services - Outpatient
- Substance Abuse Residential

In addition to the System Wide Standards, Section II contains additional standards that apply to each specific service category as defined by Health Resources Service Administration (HRSA). The Service-Specific Standards of Care apply to components of service delivery that vary by service category. Providers of these services must comply with the System-Wide Standards in Section 1, as well as the Service-Specific Standards in Section II.

System Wide Service Standards

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS core and support services funded by Ryan White Part A Orlando EMA.

The objectives of the System Wide Standards of Care are to help achieve the goals of each service category by ensuring that programs:

- Have policies and procedures in place to protect consumers' rights and ensure quality of care;
- Provide consumers with access to the highest quality services through experienced, trained and, when appropriate, licensed staff;
- Provide services that are culturally and linguistically appropriate;
- Meet federal and state requirements regarding safety, sanitation, access, public health, and infection control;
- Guarantee consumer confidentiality, protect consumer autonomy, and ensure a fair process of grievance review and advocacy;
- Comprehensively inform consumers of services, establish consumer eligibility, and collect consumer information through an intake process;
- Effectively assess consumer needs and encourage informed and active consumer participation;
- Address consumer needs effectively through coordination of care with appropriate providers and referrals to needed services; and
- Are accessible to all people living with HIV in the Orlando EMA (counties of Lake, Orange, Osceola and Seminole).

1.0 Agency Policies and Procedures

The objectives of the standards for agency policies and procedures are to:

- Guarantee consumer's confidentiality, ensure quality care, and provide a fair process to address consumers' grievances;
- Ensure consumers and staff safety and well-being;
- Facilitate communication and service delivery; and
- Ensure that agencies comply with appropriate state and federal regulations.

All provider agencies offering services must have written policies that address consumer confidentiality, release of information, consumer grievance procedures, and eligibility.

Confidentiality assures protection of release of information regarding HIV status, behavioral risk factors, or use of services. Each agency will have a consumer confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will provide a "***Consent for Release of Medical Information Form***" describing under what circumstances consumer information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and consumer signature). Consumers

shall be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated and are considered no longer binding after one year. A signed consent must be obtained from the consumer granting permission to Ryan White Part A monitoring/evaluation/quality staff to review consumer's records. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization as approved by the Ryan White Part A Office.

A provider agency grievance procedure ensures that consumers have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a policy identifying the steps a consumer should follow to file a grievance and how the grievance will be handled. The final step of the grievance policy will include information on how the consumers may appeal the decision if the consumer's grievance is not settled to his/her satisfaction within the provider agency. The Ryan White Part A approved grievance form should be utilized by all service provides in the network.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	Consumer confidentiality policy.	1.1	Written policy on file at provider agency.
1.2	Grievance procedure.	1.2	Written policy on file at provider agency.
1.3	Agency has eligibility requirements for services, in written form, available upon request.	1.3	Written policy on file at provider agency.
1.4	A complete file for each consumer exists. All consumer files are stored in a secure and confidential location, and electronic consumer files are protected from unauthorized use.	1.4	Files stored in a locked file or cabinet with access limited to appropriate personnel. Electronic files are password protected with access limited to appropriate personnel. Paper copies of all required forms that must be signed by the consumer and/or provider are in every consumer's file.
1.5	Consumer's consent for release of information is determined that includes on-site file review by funders.	1.5	Assigned and dated ***complete Consent for Release of Medical Information Form*** exists for the Ryan White System and for external providers. Each release form indicates the destination of

			the consumer's information or from whom information is being requested before the consumer signs the release. Consent forms have an expiration date of one year. **Note: A separate signed consent must be completed for each external provider.**
1.6	Agency maintains progress notes of all Communication between provider and consumer. Progress notes indicate service provided and referrals that link consumers to needed services. Notes are dated, and in chronological order.	1.6	Progress notes maintained in individual Provider Enterprise (PE) consumer record.
1.7	Policy on Universal Precautions that includes Crisis Management which addresses, at a minimum, infection control (e.g., needle sticks), mental health crises, and dangerous behaviors by consumers or staff.	1.7	Written policy on file at provider agency: documentation of staff training in personnel file.
1.8	Policy and procedures for handling medical emergencies.	1.8	Policy and procedures on file and posted in visible location at site.
1.9	Agency complies with ADA criteria for programmatic accessibility. In the case of programs with multiple sites offering identical services, at least one of the sites is in compliance with relevant ADA criteria.	1.9	Site visit conducted by funder.
1.10	Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.10	Site visit conducted by funder.
1.11	Standardized forms and up-to-date protocols will be utilized across the system to promote and ensure uniform quality of care.	1.11	Required forms in consumer's PE record.

2.0 Consumer Rights and Responsibilities

The objectives of establishing minimum standards for consumer rights and responsibilities are to:

- Ensure that services are available to all eligible consumers;
- Ensure that services are accessible for consumers;
- Involve consumers of HIV/AIDS services in the design and evaluation of services; and
- Inform consumers of their rights and responsibilities as consumers of HIV/AIDS services

HIV/AIDS services funded by the Orlando EMA must be available to all consumers who meet eligibility requirements and must be easily accessible.

A key component of the HIV/AIDS service delivery system is the historic and continued involvement of consumers in the design and evaluation of services. Consumer input and feedback must be incorporated into the design and evaluation of HIV/AIDS services funded by the Orlando EMA; this can be accomplished through a range of mechanisms including consumer advisory boards, participation of consumers in HIV program committees or other planning bodies, and/or other methods that collect information from consumers to help guide and evaluate service delivery (e.g., needs assessments, focus groups, or satisfaction surveys).

The quality of care and quality of life for people living with HIV/AIDS is maximized when consumers are active participants in their own health care and share in health care decisions with their providers. This can be facilitated by ensuring that consumers are aware of and understand their rights and responsibilities as consumers of HIV/AIDS services. Providers of HIV/AIDS services funded by Ryan White Part A must provide all consumers with a Consumer Rights and Responsibilities document that includes, at a minimum, the EMA's confidentiality policy, the agency's expectations of the consumer, the consumer's right to file a grievance, the consumer's right to receive no-cost interpreter services, and the reasons for which a consumer may be discharged from services, including a due process for involuntary discharge. "Due process" refers to an established, step-by-step process for notifying and warning a consumer about unacceptable or inappropriate behaviors or actions and allowing the consumer to respond before discharging them from services. Some behaviors may result in immediate discharge.

Consumers are entitled to access their files with some exceptions: agencies are not required to release psychotherapy notes, and if there is information in the file that could adversely affect the consumer (as determined by a clinician) the agency may withhold that information but should make a summary available to the consumer. Agencies must

provide consumers with their policy for file access. The policy must at a minimum address how the consumer should request a copy of the file (in writing or in person), the time frame for providing a copy of the file (cannot be longer than 30 days), and what information if any can be withheld.

2.0 Consumers Rights and Responsibilities

	STANDARDS		MEASURES
2.1	Services are available to any individual who meets Ryan White Part A Program eligibility requirements.	2.1	Eligibility documentation including the Notice of Eligibility in PE record.
2.2	Programs include input from consumers (and as appropriate, caregivers) in the design and evaluation of service delivery.	2.2	Documentation of meetings of consumer advisory boards, or other mechanisms for involving consumers in service planning and evaluation (e.g., satisfaction surveys, needs assessments) and regular reports to funder.
2.3	Services are accessible to consumers.	2.3	Site visit conducted by funder that includes, but is not limited to, review of hours of operation, location, proximity to transportation, and other accessibility factors.
2.4	Program provides each consumer a copy of the Consumer Rights and Responsibilities and grievance document and as well the Consumer Information check list that informs him/her of the following: • The EMA's consumer confidentiality policy; • The EMA's expectations of the consumer as a consumer of services; • The consumer's right to file a grievance; • The consumer's right to receive no-cost interpreter services; • The reasons for which a consumer may be discharged	2.4	Copy of Consumers Rights and Responsibilities and grievance document and the Consumer Information check list is given to consumers; a copy of the form (or a signature/acknowledgement page) is signed by consumer and kept in PE record.

	from services, including a due process for involuntary discharge; and, • The providers Notice of Privacy Practice		
2.5	Consumers have the right to access their file, with the exception of psychotherapy notes and information that could adversely affect the consumer as determined by a clinician.	2.5	Copy of Consumers Rights and Responsibilities and grievance is signed by consumer and kept in PE records.
2.6	Operating procedures affecting consumer shall be posted.	2.6	The following shall be posted in an area to which consumers have free access: Hours of Operation, Grievance Procedures, Consumer's Bill of Rights and Responsibilities, CAB meeting notices.

3.0 Personnel

The objectives of the standards of care for personnel are to:

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

All staff and supervisors will be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

At a minimum, all staff should be able to provide appropriate care to consumers infected/affected by HIV/AIDS, be able to complete all documentation required by their position, and have previous experience (or a plan for acquiring experience) in the appropriate service/treatment modality (for clinical staff). Clinical staff must be licensed or registered as required for the services they provide.

See the attached service specific standards for additional competencies for service categories.

Staff and program supervisors shall receive consistent administrative supervision. Administrative supervision addresses issues related to staffing, policy, client

documentation, reimbursement, scheduling, training, quality enhancement activities, and the overall operation of the program and/or agency.

In addition to administrative supervision, clinical staff shall also receive consistent clinical supervision .Clinical supervision addresses any issue directly related to client care and job related stress (e.g., boundaries, crises, and burnout).

3.0 Personnel

	STANDARDS		MEASURES
3.1	Staff members have the minimum qualifications expected for their job position, as well as other experience related to the position and the communities served.	3.1	Résumé and application in personnel file reflects the minimum requirements of the job description.
3.2	Staff members are licensed or certified as necessary to provide services.	3.2	Copy of license or certification in personnel file.
3.3	Staff and supervisors know the requirements of their job description and the service elements of the program.	3.3	Documentation in personnel file reflects signed job description.
3.4	Newly hired staff is oriented and begin initial training within 30 days of hire. Ongoing training continues throughout staff's tenure.	3.4	Documentation in personnel file of: a) Completed orientation within 30 days of date of hire; b) Commencement of initial training within 30 days of date of hire; c) And ongoing trainings.
3.5	Staff receives administrative and clinical (as required) supervision monthly.	3.5	Signed documentation on file indicating the date and length of supervision, type of supervision (administrative or clinical), and name of supervisor.
3.6	Volunteer/Interns must possess the necessary knowledge, skills and abilities as well as the capacity, capability and confidence to provide quality services to the HIV consumer.	3.6	Documentation in personnel file

3.7	Staff/Volunteer annual training shall include each of the following: • Confidentiality/HIPPA • Age and Cultural Competence • Community Social Support Resources • Community HIV/AIDS resources • Risk Management Process improvement (Quality Insurance/Quality Assurance) • Customer Service • Ethics • Child and Elder Abuse and Neglect • Domestic Violence • Sexual Harassment • Ryan White Part A Standards of Care and Service Delivery System • HIV Updates • Universal precautions	3.7	Training documentation personnel file.

4.0 Cultural and Linguistic Competence

The objective for establishing standards of care for cultural and linguistic competence is to provide services that are culturally and linguistically appropriate.

Culture is the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, and values of individuals and groups, all which may be influenced by race, ethnicity, religion, class, age, gender, gender identity, disability, sexual orientation, and other aspects of life upon which people construct their identities. In our work with people living with HIV, culture may also include past or current substance use, homelessness, mental health, and/or incarceration, among others.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among individuals that enables effective delivery of services. Linguistic competence is the ability to communicate effectively with consumers, including those whose preferred language is not the same as the provider's, those who are illiterate or have low literacy skills, and/or those with disabilities. Cultural and linguistic competence is a goal toward which all providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities. However, all providers should be involved in a continual process of learning, personal growth, experience, education, and training that increases cultural and linguistic competence and enhances the ability to provide culturally and

linguistically appropriate services to all individuals living with HIV/AIDS.

Culturally and linguistically appropriate services are services that:

- Respect, relate, and respond to a consumer's culture, in a non-judgmental, respectful, and supportive manner;
- Are affirming and humane, and rely on staffing patterns that match the needs and reflect the culture and language of the communities being served; recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and are based on individualized assessment and stated client preferences rather than assumptions based on perceived or actual membership in any group or class.

As part of the on-going process of building cultural and linguistic competence, providers should strive to develop:

- A comfort with and appreciation of cultural and linguistic difference;
- Interpersonal behaviors that demonstrate and convey concern and respect for all cultures;
- The comfort and ability to acknowledge the limits of personal cultural and linguistic competence and the skills to elicit, learn from, and respond constructively to relevant personal and cultural issues during service interactions; and
- A commitment to increasing personal knowledge about the impact of culture on health and specific knowledge about the communities being served.

Ongoing trainings that help build cultural and linguistic competence may include traditional cultural and linguistic competency trainings, as well as a range of trainings that help build specific skills and knowledge to work and communicate more effectively with the communities we serve. The provider agency is responsible for ensuring this training is provided to staff on an annual basis.

4.0 Cultural and Linguistic Competence

	STANDARDS		MEASURES
4.1	Programs recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community.	4.1	Programs have a strategy on file to recruit, retain and promote qualified, diverse, and linguistically culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV/AIDS.
4.2	All staff receives on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically	4.2	All staff members receive appropriate training within the first six (6) months of employment and annually thereafter as needed.

	appropriate services.		Copies of training verification in personnel file.
4.3	Programs assess the cultural and linguistic needs, resources, and assets of its service area and target population(s).	4.3	Programs collect and use demographic, epidemiological, and service utilization data in service planning for target population(s).
4.4	Programs' physical environment and facilities are clean, well-maintained, and accessible to all populations served.	4.4	Recipient observation during site visit.
4.5	All programs ensure access to services for consumers with limited English proficiency in one of the following ways (listed in order of preference): • Bilingual staff who can communicate directly with clients in preferred language; • Face-to face interpretation provided by qualified staff, contract interpreters, or volunteer interpreters; • Telephone interpreter services (for emergency or needs for infrequently encountered languages); or • Referral to programs with bilingual/bicultural clinical, administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter.	4.5	Programs document access to services for consumers with limited English proficiency through the following: • For bilingual staff, résumés on file • demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting; • Copy of certifications on file for contract or volunteer interpreters; • Listings/directories on file for telephone interpreter services; or • Listings/directories on file for referring consumers to programs with bilingual/bicultural clinical, administrative and support staff, and/or interpretation services by a qualified bilingual/bicultural interpreter.
4.6	Consumers are informed of their right to obtain no-cost interpreter services in their preferred language, including American Sign Language (ASL).	4.6	Copy of *Consumers Rights and Responsibilities and grievance* document includes notice of right to obtain no-cost interpreter services (see Universal Standard 2.4).

4.7	Consumers have access to linguistically appropriate signage and educational materials.	4.7	Programs provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc.) in the threshold language of all threshold populations. Programs that do not have threshold populations have a documented plan for explaining appropriate documents and conveying information to those with limited English proficiency.
4.8	Programs conduct on-going assessments of the program and staff's cultural and linguistic competence.	4.8	Programs integrate cultural competence measures into program and staff assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).

A **threshold population** is a linguistic groups that makes up 15% or more of a program's consumers and who share a common language other than English as a primary language. For example, if program XYZ serves 200 consumers and at least 30 of they speak Haitian-Creole as a primary language; that group would be considered a threshold population for that program and Haitian-Creole would be considered a **threshold language**. Some programs may target multiple groups, and therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations

5.0 Intake and Eligibility

The objective of the standards for the intake and eligibility process is to ensure that all consumers meet the eligibility requirements of the Orlando EMA as well as receive all applicable services.

- Collect HIV status documentation
- Collect income documentation
    - Determine the Federal Poverty Level
- Establish residency
- Assess consumer's immediate needs;
- Inform the consumer of the services available and what the consumer can expect if s/he were to enroll;
- Establish whether the consumer wishes to enroll in a range of services or is

interested only in a specific service offered by the provider agency;
- Explain the EMA and agency policies and procedures;
- Collect required consumer data for reporting purposes;
- Collect basic consumer information to facilitate consumer identification and consumer follow up; and
- Begin to establish a trusting consumer relationship.

All consumers who request or are referred to HIV services will participate in the intake process. Intake is conducted by a non-medical case manager, medical case manager, or Early Intervention Coordinator; the case manager/ Early Intervention Coordinator will review the consumers income eligibility, consumer rights and responsibilities, explain the program and services to the consumer, explain the EMA and agency confidentiality and grievance policies to the consumer, assess the consumer's immediate service needs, and secure permission from the consumer to release information.

To maintain eligibility for Ryan White services, consumers must be recertified at least every six months. The primary purposes of the recertification process are to ensure that an individual's residency, income, and insurance statuses continue to meet the eligibility requirements and to verify that Ryan White is the payer of last resort. At least once a year, the recertification procedures must include the collection of more in-depth supporting documentation, similar to that collected at the initial eligibility determination.

At one of the two required recertification's during a year, a consumer's self-attestation that their income, residency, and/or insurance status has not changed is allowed. Self-attestation that there has been a change in income, residency or insurance status requires appropriate documentation of the change, the documentation maybe collected at the consumer's next visit to the provider.

Eligibility is considered complete if the following have been accomplished: (1) the consumer's HIV positive status has been verified and documented; (2) the consumer's documented income is less than or equal to 400% of the FPL (3) the information below (at a minimum) has been obtained from the consumer:
- Proof of HIV status
- Name, address, social security number, phone, and email (if available,);
- ID, Proof of Income, Insurance verification,
- Residency – consumers must reside within the boundaries of the EMA (Orange, Lake Seminole, and Osceola).
- Determination of eligibility and enrollment in other 3rd party Insurance Program including Medicaid and Medicare.
- Preferred method of communication (e.g., phone, email, or mail);
- Emergency contact information.
- Preferred language of communication.
- Enrollment in other HIV/AIDS services including case management and other HIV/AIDS or social services
- Primary reasons and need for seeking services at agency
- Care Plan.

A consumer who chooses to enroll in services and who is eligible will be assigned a case manager who is responsible for making contact with the consumer to set up a time for a more thorough assessment, if necessary, to determine appropriate services. Referrals for other appropriate services will be made if ineligible for Ryan White Part A services. The intake process will begin within a minimum of 48 hours of the first consumer contact with the agency. Ideally, the consumer intake process should be completed as quickly as possible; however, recognizing that consumers may not have on hand the required documentation (e.g., documentation of HIV status), the intake process should be completed within 30 working days of beginning intake.

5.0 Intake and Eligibility

	STANDARDS		MEASURES
5.1	Intake process is completed within 30 working days of initial contact with consumer and documents consumer's contact information (including his/her emergency contact's name and phone number) and assesses his/her immediate service needs and connection to primary care and other services.	5.1	Completed intake, dated no more than 30 days after initial contact, in consumer's file.
5.2	For providers of services other than case management, consumer is asked about connection to case management. If consumer is not connected to case management, provider facilitates a supported referral to case management services.	5.2	Documentation in consumer's file.
5.3	To determine presumptive eligibility for services, consumers reactive test result shall be documented.	5.3	Reactive test result uploaded in PE.
5.4	To determine minimum eligibility for services, consumer's HIV-positive status is confirmed.	5.4	HIV status confirmation will be established by one of the following: • A confirmed positive HIV Antibody Test result confirmed by Western Blot or Immunofluorescence Assay (IFA) or Nucleic Acid Testing (Aptima) by blood, oral fluid or urine. • A positive HIV Direct Viral

			Test such as PCR or P24 antigen. • A positive viral culture result • A detectable HIV-Viral Load or Viral Resistance test result.
5.5	Providers shall assist consumers in applying for other funding sources to confirm Ryan White as payer of last resort	5.5	Documentation of: • Application form or receipt of application • Appeal/denial letter • Communications from other funding sources
5.6	Self–attestation by the consumer that there has been no change in their income, residency or insurance status maybe completed over the phone or during a visit that is in close proximity to their re-certification date.	5.6	Documentation of self-attestation of "no change" shall be reflected in the progress notes in PE and a new "Notice of Eligibility" issued to the consumer.
5.7	Should the consumer indicate that there has been a change in income, residency or insurance status, the Case Manager shall ensure that documentation of the change is received no later than the client's next scheduled appointment with the provider or within 3 days of self–attestation or of the change whichever is sooner.	5.7	Progress notes in PE indicate the change(s) specified during the consumer's self-attestation. Documentation verifying the change(s) shall be uploaded into PE no later than the next scheduled appointment or within 30-days from self-attestation of the change(s) whichever is sooner. Once documentation is received a new "Notice of Eligibility" shall be issued.

6.0 Assessment and Care Plan

The objectives of the standards for assessment and Care Plan are to:

- Gather information to determine the consumer's needs;
- Identify the consumer's goals and develop action steps to meet them;
- Identify a timeline and responsible parties for meeting the consumer's goals;
- Ensure coordination of care with appropriate providers and referral to needed services.

Assessment:
All providers must assess the consumer's needs for the provider's service(s) to develop an appropriate Care Plan. This is not the same as the basic and comprehensive case

management assessment, which is the responsibility of the consumer's case manager (see service-specific standards for Case Management Services) in collaboration with the consumer.

Service assessments include an assessment of all issues that may affect the consumer's need for the provider service. The assessment is a cooperative and interactive information exchange between the staff and the consumer. The consumer will be the primary source of information. However, with consumer consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information, if the consumer grants permission to access these sources. The assessment should be conducted face-to-face within thirty (30) working days of intake, with accommodations for consumers who are too sick to attend the appointment at the provider agency.

It is the responsibility of the staff to reassess the consumer's needs with the consumer as his/her needs change. The reassessment should be done as needed, but no less than once every three (3) months for Medical Case Managed consumers and six (6) months for others. If a consumer's income, housing status, or insurance status/resource has changed since assessment or the most recent reassessment, agencies must ensure that the data in ***PE*** is updated accordingly. The staff member is encouraged to contact other service providers/care givers involved with the consumer or family system in support of the consumer's well-being. Staff members must comply with established agency confidentiality policies (see Standard 1.1) when engaging in information and coordination activities.

Individual Care Plan (ICP):
The purpose of the individual Care Plan (ICP) is to guide the provider and consumer in their collaborative effort to deliver high quality care corresponding to the consumer's level of need. It should include short-term and long-term goals, based upon the needs identified in the assessment, and action steps needed to address each goal. The ICP should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow up. As with the assessment process, service planning is an on-going process. It is the responsibility of the staff to review and revise a client's ICP as needed, but not less than once every three (3) months for Medical Case Managed consumers and six (6) months for others

6.0 Assessment and Care Plan

	STANDARDS		MEASURES
6.1	Within 30 days of consumer contact, initial assessment is conducted of consumer's need for particular service.	6.1	Completed assessment form in the consumer electronic file.
6.2	Within 30 days of consumer contact, ICP is developed collaboratively with the consumer that identifies goals	6.2	Completed IPC in consumer file signed by the consumer and staff person.

	and objectives, resources to address consumer's needs, and a timeline.		
6.3	Reassessment of the consumer's needs is conducted as needed, but no less than once every three (3) months for Medical Case Managed consumers and six (6) months for others.	6.3	Documentation of reassessment in the consumer files (e.g., progress notes, updated notes on the initial assessment, or new assessment form).
6.4	Care plan is reviewed and revised as needed, but no less than once every three (3) months for Medical Case Managed consumers and six (6) months for others.	6.4	Documentation of reassessment in the consumer files (e.g., progress notes, update notes on initial ICP, or new ICP). Updated ICP shall be signed by consumer, staff person, and supervisor.
6.5	Program staff identifies and communicates as appropriate (with documented consent of consumer) with other service provide5rs to support coordination and delivery of high quality care and to prevent duplication of services.	6.5	Documentation in consumer files of other staff within the agency or at another agency with whom the consumer may be working.

7.0 Transition and Discharge

The objectives of the standards for transition and discharge are to:

- Ensure a smooth transition for consumers who no longer want or need services at the provider agency;
- Assist provider agencies in more easily monitoring caseload; and
- Plan after-care and re-entry into service.
- Ensure continuum of care with the agency

A consumer may be discharged from any service through a systematic process that includes a discharge summary in the consumer's record. The discharge summary will include a reason for the discharge and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of available resources available for the consumer for referral purposes. If the consumer does not agree with the reason for discharge, (s) he should be referred to the provider agency's grievance procedure.

A consumer may be discharged from any service for any of the following reasons:

- Consumer dies;
- Consumer requests a discharge;
- Consumer's needs change and (s)he would be better served through services at

another provider agency;

- Consumer's actions put the agency, service provider, or other consumers at risk;
- Consumer moves/relocates out of the service area; or
- The agency is unable to reach a consumer, after repeated attempts including referral to Anti-Retroviral Treatment Access Strategy (ARTAS) or EIS for a period of 6 months

7.0 Transition and Discharge

	STANDARDS		MEASURES
7.1	Agency has a transition and discharge procedure in place that is implemented for consumers leaving or discharged from services for any of the reasons listed in the narrative above.	7.1	Completed transition/discharge summary form on file, signed by consumer (if possible) and supervisor. Summary should include: • Reason for discharge, and • A plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between consumer and agency.
7.2	Agency has a due process policy in place for involuntary discharge of consumers from services; policy includes a series of verbal and written warnings before final notice and discharge.	7.2	Due process policy on file as part of transition and discharge procedure; due process policy described in the Consumer Rights and responsibilities and Grievance document (see Universal Standard 2.4).
7.3	Agency has a process for maintaining communication with consumers who are active and identifying those who are inactive.	7.3	Documentation of agency process for maintaining communication with active consumers and identifying inactive consumers.
7.4	Agency provides consumers with referral information to other services, as appropriate.	7.4	Resource directories or other material on HIV related services are on file and provided to consumers.

8.0 Data and Quality Management

Data Collection and Reporting:
The Orlando EMA utilizes Provide Enterprise (PE) to collect and report data; The Agency shall designate individuals to serve as Registered Users (A Registered User is an individual who is an employee of the Agency and who is designated by the Agency and agreed to by the Recipient.

This term shall not include volunteers as they shall not have access to the EDMS.) No employee of the Agency shall be permitted access to the EDMS without having duly executed a Confidentiality Agreement, a copy of which shall be retained on-site by the Agency. The Agency shall take all reasonable steps to protect the data base server. The agency shall inform the Recipient, in writing, of any misuse by a Registered User or change of positions within the Agency resulting in a discontinued need for access to the system.

The following is a list of some of the reporting requirements:

- Monthly invoices and expenditure reports.
- Monthly narrative report
- Quality outcomes and outcome measures.
- Women, Infants, Children and Youth (WICY) reports.
- Ryan White Services Report (RSR) Client level Data.
- Utilization/demographic data.

Quality Management (QM)
The objective of QM is:

- To identify available HIV-related quality measures and how they are used
- To monitor the delivery of HIV care network service providers.
- To support the implementation of HIV quality measures across public and private insurers and health care systems as health care coverage is expanded.
- To support adherence to current HIV clinical guidelines and federal guidelines.
- To track a standardized set of quality measures across patient populations and public and private insurers to monitor access to high quality HIV care.

Implementation of a Clinical Quality Management (CQM) Program to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent HHS Guidelines for the treatment of HIV/AIDS and related opportunistic infections
- Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services CQM program to include:
    1. A Quality Management Plan
    2. Quality expectations for providers and services
    3. A method to report and track expected outcomes
    4. Monitoring of provider compliance with HHS Guidelines and the EMA/TGA's approved Standards of Care

Network Service Providers are expected to:

- Participate in quality management activities as contractually required; at a minimum:
- Compliance with relevant service category definitions and EMA standards of care Collection and reporting of data for use in measuring performance.

8.0 Data and Quality Management

	STANDARDS		MEASURES
8.1	All eligibility documents must be scanned into the PE within 3 business days.	8.1	Date stamp in the PE is no later than 3 business days after the date of eligibility determination.
8.2	On-going Quality Assurance with regular feedback to staff to promote performance improvement and quality care. Quality Management issues shall be addressed through staff meetings.	8.2	Documentation of at least quarterly Quality Management meetings recording attendance, date, subject matter, steps taken to resolve identified problems with times frames for resolution.
8.3	Semi-Annual Consumer Satisfaction Surveys shall be conducted and results utilized as appropriate to improve service delivery.	8.3	Consumer Satisfaction Surveys to include: • Rating of services, perception of treatment by staff, satisfaction with services provided, fair access to services provided. • Incorporate results from consumer satisfaction surveys into written goals and objectives
8.4	Assess the extent to which HIV health services provided to consumers are consistent with the most recent HHS Guidelines for the treatment of HIV/AIDS and related opportunistic infections.	8.4	Monitor CQM/HAB outcome measures
8.5	Quality Management Plan that includes quality expectations for providers and services, a method to report and track expected outcomes.	8.5	Visit and review providers/sub recipients to monitor compliance with the Quality Management Plan.

Core Services

Outpatient Ambulatory Health Services (OAHS)

Definition:
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a consumer by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where consumers do not stay overnight.

Limitations:
Emergency room, nursing home facilities, 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

Care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Diagnostic Laboratory Testing includes all indicated medical diagnostic testing including all tests considered integral to the treatment of HIV and related complications (e.g. Viral Load, CD4 counts/percentage, and genotype assays). Funded tests must meet the following conditions:

- Tests must be consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations, or organizations.
- Tests must be approved by the FDA, when required under the FDA Medical Devices Act and/or performed in an approval Clinical Laboratory Improvement Amendments of 1988 (CLIA) certified laboratory or State exempt laboratory.
- Tests must be ordered by a registered, certified or licensed medical provider and necessary and appropriated based on established clinical practice standards and professional clinical judgment.

Eligibility:
Consumers shall meet eligibility requirements as defined in the System-Wide Service Standards.

1.0 Treatment Guideline Standards and Performance Measures

The agencies shall ensure compliance with the most current U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Guide for HIV/AIDS Clinical Care – 2014 Edition as cited in the following standards.

1.0 Treatment Guideline Standards and Performance Measures

	STANDARDS		PERFORMANCE MEASURES
1.a	**Medical Evaluation/Assessment**: HIV+ clients accessing primary medical care will have a completed comprehensive medical evaluation/assessment and physical examination that adheres to the current HHS treatment guidelines. ***Source*** Citation: page 61, https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.a.	Written documentation in Consumer's record of the following: Percentage of new clients (newly diagnosed) who have a documented comprehensive assessment/evaluation completed by the MD, NP, CNS, or PA within 3 months of HIV diagnosis in accordance with professional and established HIV practice guidelines. ***(HRSA HAB Measure – Linkage to Care)***
1.b	**Comprehensive HIV related history:** History shall include at a minimum, general medical history, a comprehensive HIV related history and psychosocial history. ***Source***: Page 61-70; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.b	Written documentation on Consumer's record.
1.c	**Physical Examination:** Providers should perform a complete history and physical examination upon entry to care and thereafter at least 1 per year. Objective assessment: • Patient's general appearance • Patient's affect and demeanor in answering questions	1.c	Written documentation on Consumer's record.

	• Body language • Other relevant characteristics • Measure vital signs • Perform physical examination ***Source***: Page 73-77; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf		
1.d	**Initial laboratory tests**, as clinically indicated by licensed provider. ***Source***: Page 79-89; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.d	Written documentation on Consumer's record. Percentage of clients with documented HIV-RNA viral load. ***(HRSA HAB Measure)***
1.e	**Initial Screenings/Assessments:** Screening should include at a minimum: • Quantitative HCV RNA viral load testing • Hepatitis A, B & C screens at initial intake. • Mental health assessment that includes screening for clinical depression • Psychosocial assessment, • Substance use and abuse screening • Alcohol use screening • Patients on ART receive lipid screening annually • Tobacco use screening • Oral health assessment and screening • Cervical Cancer Screen • Tuberculosis (TB) Screening (T-spot or Quantiferon) • Anal Cancer Screen • HLA-B 507 • Genotyping • G-6-P-D • Serum VDRL or RPR	1.e	Written documentation on Consumer's record. Percentage of female clients with a diagnosis of HIV who were screened for cervical cancer in the last three years. ***(HRSA HAB Measure)*** Percentage of clients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for chlamydia within the measurement year. ***(HRSA HAB Measure)*** Percentage of clients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year. ***(HRSA HAB Measure)*** Percentage of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. ***(HRSA HAB Measure)***

	(Syphilis Screening) • Gonorrhea (GC) and Chlamydia (CT) Testing ***Source***: Page 83-89, 127, https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf		Percentage of clients with documented serologic test for syphilis performed. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. ***(HRSA HAB Measure)*** Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV infection. ***(HRSA HAB Measure)*** Percentage of clients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity. ***(HRSA HAB Measure)*** Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV. ***(HRSA HAB Measure)***
1.f	**Immunizations/Antibiotic Treatment:** Patients will be offered vaccinations for the following: • Pneumococcal is recommended for all clients • Completion of hepatitis B (HBV) vaccines series, unless otherwise documented as immune	1.f	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization. ***(HRSA HAB Measure)*** Percentage of patients with a

	• Completion of hepatitis A (HAV) vaccines series, unless otherwise documented as immune. • Varicella-Zoster (VZV) • Zoster vaccine • Meningitis Antibiotic treatment for opportunistic infection will be initiated if active infection has been ruled out and positive for: • Mycobacterium avium complex (MAC) if CD4<50 cells/µL • Toxoplasmosis if CD4<100 cells/µL ***Source***: Page 157-160; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf *HPV vaccine is recommended for females age 9-26 and males age 9-26; ideally given prior to sexual activity with three doses to complete through age 26.		diagnosis of HIV who completed the vaccination series for Hepatitis B. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine. ***(HRSA HAB Measure)***
1.g	**Antiretroviral Therapy and Pneumocystis jiroveci pneumonia (PCP) Prophylaxis:** Antiretroviral therapy will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART. PCP Prophylaxis will be completed adhering to the current HHS Guidelines. ***Source***: (PCP and MAC Prophylaxis) Page 173-179; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-	1.g	Percentages of patients, regardless of age, with a diagnosis of HIV are prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year. ***(HRSA HAB Measure)*** Patients aged 6 weeks or older with a diagnosed of HIV/AIDS, with CD4 counts of less than 200 cells/µL or a CD percentage below 14% will be prescribed PCP prophylaxis. ***(HRSA HAB Measure – amended by OAHS providers in Orange County, Florida EMA)***

	management/2014guide.pdf ***Source***: (ARV) Page 207-220; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf		
1.h	**Drug Resistance Testing:** Drug resistance testing must follow most recent, established resistance testing guidelines, including genotypic testing on all naïve patients. ***Source*:** Page 81; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.h	Percentage of patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year. ***(HRSA HAB Measure)***
1.i	**Health Education/Risk Reduction:** Health education will adhere to the most current HHS guidelines. Providers will provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients. Women of Child-bearing age shall receive preconception counseling. ***Source***: (Smoking Cessation) page 189-196; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf ***Source***: (Patient Education) Page 57-59, 89, 102, 107, 111, 126, 143-154; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.i	Percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year. ***(HRSA HAB Measure)*** Percentage of clients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Written documentation of preconception counseling.
1.j	**Treatment Adherence:** Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines.	1.j	Written documentation on Consumer's record.

	Source: Page 273; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf		
1.k	**Follow-up Visits**: Outpatient Medical Care will adhere to the current HHS guidelines for on-going health care. Reassessment/reevaluation of health history, comprehensive physical examination, and annual laboratory testing should be documented in patient medical record. Patients receiving ARV therapy should have follow- up visits scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence. Patients on ART receive lipid screening annually. ***Source***: (Follow Up/Interim Exams and Labs) Page 79 and 91; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf ***Source:*** (Adverse Outcomes) Page 527; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.k	Written documentation on Consumer's record. Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and who had a fasting lipid panel during the measurement year. ***(HRSA HAB Measure)***
1.l	**Documentation in Patients Charts:** Advance directives in chart or documentation that has been discussed Clinicians will develop/update plan of care at each visit. Problem list documented. Organized and complete medication list including past ART.	1.l	Written documentation on Consumer's record.

	Source: Page77; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf		
1.m	**Documentation of Missed Appointments**/Efforts for Re-engagement ***Source***: Page 1; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	1.m	Written documentation on Consumer's record.

2.0 Scope of Services (These are program specific policies and procedures)

Agencies shall comply with all of the requirements outlined in this Service Standard, unless otherwise specified in their contract.

2.0 Scope of Services

STANDARDS		MEASURES	
2.1	Agencies shall have a written policy for making specialty care referrals in relation to the HIV diagnosis and for tracking such referrals with outcomes included in the consumer record.	2.1	Policies and procedures in place
2.2	Agencies shall ensure that specialty care services are not being provided in an emergency room, hospital, nursing home or any other type of inpatient treatment center.	2.2	Documentation of verification of location in place.
2.3	Agencies shall develop and maintain an appropriate relationship with entities that constitute key points of entry as defined by HRSA.	2.3	Copy of Agreement or documentation of relationship showing key points of entry on file and documented referrals from these points of entry.
2.4	Agencies shall have written policies and procedures for emergency care and treatment and referrals.	2.4	Policies and procedures in place

Local Pharmacy Assistance Program

Definition: Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or sub-recipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

RWHAP Part A or B recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary approved by the local advisory committee/board
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program.

Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

Eligibility: Consumers shall meet eligibility requirements as defined in the System-Wide Standards of Care.

1.0 Agency Policies and Procedures

The agencies shall have Policies and Procedures to ensure that the services are accessible to all eligible consumers. Each agency's policies and procedures shall ensure compliance with the following Standards.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	All agencies shall comply with Florida State Statutes 465.	1.1	Current license(s) are on file at agency.
1.2	All agencies will comply with Section	1.2	License on file at agency

	340B of P.L. 102-585, the Veteran's Health Care Act of 1992.		
1.3	Agencies must ensure that original prescriptions are on file and that all medications are on the current approved formulary.	1.3	Original prescription from a licensed Florida medical provider on file
1.4	Agencies shall ensure that medications are distributed to Ryan White eligible consumers that have been screened for ADAP eligibility with rescreening every six (6) months. •	1.4	Documentation of Ryan White eligibility with ADAP screening and rescreening in Provide Enterprise (PE). •
1.5	Agencies shall ensure that a drug distribution system is in place that provides for: • uniform benefits to all enrolled consumers throughout the EMA a record keeping system for distributed and/or destroyed medications	1.5	Total number of consumers receiving Anti-retroviral (ARV)
1.6	An LPAP does not dispense medications as: • A single occurrence of short duration (an emergency); or • Vouchers to clients on an emergency basis.	1.6	Documentation that the LPAP is not dispensing medications as: • A single occurrence of short duration (an emergency without arrangements for longer term access to medication; or • Vouchers to clients on a single occurrence without arrangements for longer-term access to medications.
1.7	The agency must adhere to the current approved Ryan White Part A formulary established by the local pharmacy work group.	1.7	Documentation that the agency adheres to the current approved Ryan White Part A formulary.
1.8	Agencies shall provide Treatment adherence counseling for all drugs dispensed to consumers.	1.8	Percentage of patients dispensed medication with a viral load less than 200 copies/ml at last HIV viral load test during the measurement year

2.0 Co-pay/Cost Sharing

The purpose of the Share of Cost/Insurance Co-pays standard is ensuring that there are consistent guidelines for determining co-pay and cost sharing.

2.0 Co-pay/Cost Sharing

	STANDARDS		MEASURES
2.1	Agencies must determine share of cost/insurance co-pays based on the following criteria: • consumers who have an income of 200% or less of the federal poverty guideline have zero (0) share of cost; • consumers whose income is between 201% and 400% of the poverty level will receive up to $200 worth of assistance monthly;	2.1	Documentation of applied current federal poverty guidelines and income in consumer file.

3.0 Formulary

3.0 Formulary

	Standards		Measures
3.1	Agency must utilize current approved Ryan White Part A formulary.	3.1	All consumers access only pharmaceuticals listed on the Part A formulary.
3.2	Agencies shall ensure that a representative participates as a member of the Local Pharmacy Work Group.	3.2.	Documentation of participation via minutes

Oral Health

Definition:
Oral health care includes diagnostic, preventive and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.

Eligibility:
Consumers accessing Oral Health Services must meet the eligibility standards as described in the System-Wide Standards of Care.

1.0 Agency Policies and Procedures

The Agencies shall have Policy and Procedures to ensure that the Services are accessible to all eligible consumers. The Agency policy and procedures will ensure compliance with the following Standards.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	Reimbursement will be provided in accordance with the current and up to date Orlando EMA Dental Fee Schedule.	1.1	The agency has a copy of the current and up to date EMA Dental Fee Schedule available to case managers.
1.2	Levels of service shall be in accordance with the established Dental Services Levels.	1.2	Treatment plan in consumer file
1.3	Oral health professionals providing the services shall be approved by the grantee and have appropriate valid licensure and certifications, based on State and local laws.	1.3	Current and approved up to date list of oral health providers available to case managers.
1.4	The case management agency shall develop a policy and procedure for management of waiting lists that prioritizes consumers with existing treatment plans.	1.4	Policy and procedure available for review.
1.5	Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and	1.5	Current and approved up to date list of oral health providers available to case managers.

	auxiliaries and meet current dental care guidelines.		
1.6	The clinical decisions shall be supported by the American Dental Association Dental Practice parameters.	1.6	Copy of the parameters available.

2.0 Responsibility of Case Management Agencies

The Purpose of the Responsibility of Case Management Agencies is to establish the scope of work for the coordinating of oral health services.

2.0 Responsibility of Case Management Agencies

	STANDARDS		MEASURES
2.1	The case management agency shall maintain a list of approved oral health providers in all four counties.	2.1	Up to date list available at agency for review.
2.2	Case Management Agency shall schedule and coordinate all initial oral health appointments and educate consumers about importance of keeping their follow up appointments.	2.2	Documentation in consumer record
2.3	The Case Management Agency is responsible for educating the consumer regarding the missed appointment policy of the assigned provider at their initial contact.	2.3	Documentation of missed appointment policy provided to consumers.
2.4	The Case Management Agency is responsible for educating the consumer regarding the missed appointment policy of the assigned provider at their initial contact.	2.4	Documentation or referral and linkage in consumer record.
2.5	A complete and approved treatment plan shall be maintained by the Case Management Agency to facilitate scheduling of follow up appointments and management of the annual cost cap. A copy of the	2.5	Copy of signed, approved treatment plan in consumer file at case management agency

	approved treatment plan shall be provided to the consumer.		
2.6	Each eligible consumer is permitted two cleanings (oral prophylaxis) per contract year.	2.6	Explanation of Benefits in consumer record and documentation of services
2.7	Oral prophylaxis (cleaning), twice a year are not included in the annual cost cap.	2.7	Explanation of Benefits in consumer record and documentation of services
2.8	Initial appointments for urgent services (medical necessity) shall be given priority scheduling by the Case Management Agency.	2.8	Medical referral, documentation of medical necessity on file (example: client verbalizes pain or abscess
2.9	In the event a waiting list needs to be maintained, the Grantee's Office must be notified. The Case Management Agency shall maintain the waiting list with priority of need based on dentist recommendation.	2.9	Waiting lists

Early Intervention Services

Definition:
Early intervention services (EIS) for Parts A and B include counseling individuals with respect to HIV/AIDS that includes information on measures for prevention of, exposure to, and transmission of HIV/AIDS, hepatitis B, hepatitis C, and other sexually transmitted diseases ; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures. EIS services must include the following four components:

- 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.
    - These testing services must be coordinated 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.
- Referral services to include HIV care and treatment services at key points of entry.
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management and Substance Abuse Care.
- Outreach services and Health Education/Risk Reduction related to HIV diagnosis.

Eligibility:
Consumers recently diagnosed with HIV disease or consumers who know their status but have been out of care for more than six (6) months.

1.0 Agency Policies and Procedures

The Agencies shall have Policies and Procedures to ensure that the services are accessible to all eligible consumers. The Agency policy and procedures will ensure compliance with the following Standards.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	The agency shall maintain information about each EIS Coordinator's case load, which includes, at a minimum: • The assigned EIS coordinator • Number of cases per full-time	1.1	Documentation in agency record

	equivalent (FTE) • The acuity of each consumer.		
1.2	EIS Coordinators shall receive 15 hours of training annually and topics shall include: • Establishing rapport and a professional relationship with the consumer; • Methods of engaging individuals; • Special issues relating to working with the HIV/AIDS affected/infected population; • Confidentiality/HIPAA and professional ethics; • Knowledge of public assistance programs, eligibility requirements, and benefits; and, • The Agency's emergency plan, disaster relief resources, and planning and procedures. Training shall also include, but not be limited to, cultural sensitivity issues, case management issues, bio-psychosocial issues surrounding the HIV disease, and any other training proposed by the Recipient.	1.2	Documentation of the training subject matter, date(s) of attendance, and hours in training shall be in the training record. Training Certificates shall be in the personnel file.
1.3	All EIS Coordinators must meet at least one of the following staff qualifications: • Associate or bachelor level degree in a social science or health discipline and at least one (1) year of case management experience; • An individual with an associate or bachelor degree in disciplines other than health or social science shall have at least one (1) year of direct HIV/AIDS case management experience.	1.3	Appropriate degrees, licensure and/or certification in personnel file

	• With 2 years of verifiable experience case managing individuals with HIV at an established agency can substitute on a year-for-year basis for an Associate degree. Note: Use of this qualification must be preapproved by the recipient.		
1.4	All EIS supervisors must meet the following requirement: • Hold a Master level degree in the fields of mental health, social work, and counseling, nursing with a mental health experience, sociology or psychology. (How much case management experience?) • With case management experience and appropriate credentials, unless otherwise approved by the recipient. **Note: This requirement may be waived by the recipient.**	1.4	Appropriate degrees, licensure and/or certification in personnel file.
1.5	EIS supervisors shall have at least 12 hours of training annually as approved by the Grantee's office. At least six (6) of the twelve (12) hours shall be leadership training; other training topics shall include the following: • The basics of HIV care and treatment; • Appropriate boundaries; • Necessary communication skills relating to specific HIV issues such as principles for treatment and housing, precautions for caregivers and HIV-infected individuals, and pre-and post-test counseling and social and legal aspects relevant to this	1.5	Documentation of the training shall be in the employee training record. Training certificates shall be in the employee file.

	service population.		
1.6	EIS agencies shall demonstrate active collaboration with other agencies to provide referral to the full spectrum of HIV related or other needed services.	1.6	Current Memorandum of Agreements (MOA) on file.
1.7	EIS agencies shall maintain appropriate relationships with Key Points of Entry (KPOE), as defined by HRSA, into the health care system.	1.7	Current MOA(s) on file.
1.8	EIS agencies shall conduct outreach activities for potential consumers to promote the availability of services. Outreach activities shall include but are not limited to: • Participation in health fairs; • Participation in community events; • Collaboration with other providers; and, • Posting of flyers for potential consumers.	1.8	Documentation of outreach activities in PE.
1.9	EIS agencies shall develop an outreach plan and provide evidence of such arrangements to the recipient upon request.	1.9	Outreach plan available upon request.

2.0 Eligibility Assessment

EIS Coordinators shall determine eligibility for services as evidenced by documentation via an eligibility assessment. Verification that the client meets the current eligibility requirements must be obtained prior to payment for services.

2.0 Eligibility Assessment

	STANDARDS		MEASURES
2.1	Eligibility assessment shall ensure all required documents are present and filed in Provide Enterprise (PE) Consumers shall be informed of their	2.1	No later than five (5) workdays from receipt of referral or date of request for service the following shall be complete:

	right to: • Confidentiality in accordance with state and federal laws; • Choice of providers; • Explanation of grievance procedures; and • Consumer Rights and responsibilities.		• Client chart/record face sheet; • Consent to release and exchange information.
2.2	As part of the eligibility and financial assessment, residency and income shall be verified.	2.2	Documentation of residency and income shall be maintained in the consumer record.
2.3	Consumers shall be screened for other funding sources.	2.3	Documentation to indicate that the services provided were not an allowable service under another funding source.

3.0 Consumer Assessment and Care Plan

EIS Coordinators shall complete an Acuity assessment of each consumer to determine their level of need. The assessment shall be documented in Provide Enterprise. A care plan shall be developed, in collaboration with the client that specifies the process of linking the consumer to care.

3.0 Consumer Assessment and Care Plan

	STANDARDS		MEASURES
3.1	An individual care plan shall be developed with the participation of the consumer within 30-days of intake. The care plan shall be based on prioritized identified needs, acuity level, and shall address consumer's cultural needs.	3.1	Care Plan documented in PE.
3.2	A care plan shall be developed that includes: • Goals and objectives specific to the process of linking consumers to care; • Identification of a responsible party for each goal and objective;	3.2	Care plan with all required elements documented in PE.

	• A timeframe for the monitoring and assessment of consumers progress; and, • The signature of the individual providing the service and/or the supervisor.		
3.3	Each consumer shall be assisted in developing time frames for the resolution of any barriers to care identified in the assessment.	3.3	Barriers to care and follow-up services documented in PE as needed but at least monthly.
3.4	Each consumer shall be assisted with establishing expected outcomes within the Care Plan.	3.4	Progress note entries in PE shall document the assistance provided.
3.5	EIS coordinators shall coordinate referrals and track linkages and outcomes of consumers to medical, services, case management, KPOE, partner services and prevention to support access to and retention in care.	3.5	Documentation of referrals in PE.

4.0 Documentation

All EIS providers are required to maintain accurate documentation in order to submit data on EIS activities in the Ryan White Part A Reporting System (Provide Enterprise). The submission requirements are detailed within the contract.

4.0 Documentation

	STANDARDS		MEASURES
4.1	EIS Coordinators shall be assigned within _three (3) days of a request or documentation of a reactive HIV Rapid Test.	4.1	PE shall reflect the name of the assigned Coordinator and date of assignment.
4.2	EIS Coordinators shall obtain documentation of confirmatory test results from PRISM within 15 days of completion of confirmatory test.	4.2	PRISM report documenting date shall be uploaded to PE.
4.3	EIS Coordinators shall obtain Release of Information (ROI) from consumers in order to obtain	4.3	Signed ROI Form and documentation of Test Results uploaded in PE within 15 days of

	documentation of confirmatory test results from the appropriate test sites.		confirmatory test.
4.4	Monitor and document consumer's progress in meeting established goals.	4.3	A progress note shall be completed on a consumer for each contact in PE.
4.5	EIS Coordinators shall document all referrals made on the approved Referral Form and shall include: • Referrals to outpatient/ambulatory health services, and other core and support services; • The date the referral was made; • The consumer's appointment date; and, • The documents that were transmitted as part of the referral.	4.4	Documentation in PE reflects all required elements.
4.6	EIS Coordinators shall successfully link newly diagnosed consumers with Outpatient/Ambulatory Health Services and laboratory services within 30-days of enrollment.	4.5	Successful linkage documented in PE that reflects the date of linkage.
4.7	EIS Coordinators shall provide support and encouragement to consumers for at least six (6) months after enrollment to actively engage them in care and link to case management within this six month period.	4.6	Progress note entries in PE reflect support and encouragement.
4.8	EIS coordinators shall successfully re-link consumers returning to care to a case manager within 6 months.	4.7	Successful linkage documented in PE

5.0 Coordination

Coordination includes communication, information sharing, and collaboration, and occurs regularly between EIS Coordinators and other staff serving the patient within the agency and among other agencies in the community. Coordination activities may

include directly arranging access; reducing barriers to obtaining services; establishing linkages and confirming service acquisition.

5.0 Coordination

	STANDARDS		MEASURES
5.1	EIS Coordinators shall actively participate in team meetings or case conferences for the consumers in order to improve assessment and to sustain retention in care.	5.1	Documentation in PE shall include: • The date of the case conference/meeting; • Names and titles of participants; • Issues and concerns; and/or, • Follow-up plans.
5.2	Assist and reinforce consumer compliance with their respective Treatment Plans as a basis for promoting the practice of health behaviors.	5.2	Documentation in PE reflects reinforcement of respective treatment plans.
5.3	Complement rather than replace the roles of other healthcare and service professionals.	5.3	Progress note entries in PE shall reflect reinforcement of other service professional roles.
5.4	EIS Coordinators shall coordinate and approve transportation services for eligible consumers. Transportation services shall include bus passes and door-to-door services.	5.4	Tracking and accounting of all transportation services shall be documented in PE.
5.5	EIS Coordinators shall coordinate and approve all initial and follow-up oral health appointments for eligible consumers. This includes: • Scheduling appointments; • Providing all necessary authorization forms to dental providers; and, • Providing timely and appropriate follow-up with consumers and dental providers.	5.5	Services related to oral health coordination shall be documented in PE.

6.0 Discharge

Clients who have been successfully linked or are no longer engaged in HIV treatment and care services shall have their cases closed based on the criteria and protocol outlined in the agency's Early Intervention Services Manual.

6.0 Discharge

	STANDARDS		MEASURES
6.1	Upon termination of active early intervention services, a consumer's case shall be closed and the record shall contain a discharge summary documenting the case disposition and offer an exit interview.	6.1	Upon discharge consumers shall receive a transition plan that outlines available resources and instructions for follow-up. Documentation of discharge shall be in PE.
6.2	All attempts to contact the consumer and notification about case closure shall be communicated to the case manager, if applicable.	6.2	Documentation of consumer contacts and notification to the case manager shall be recorded in PE and shall include the reason(s) for closure.
6.3	Cases may be closed when the consumer: • Has achieved the goals listed on the Care Plan; • Has become ineligible for services; • Is deceased; • No longer needs the services; • Decides to discontinue the services; • The service provider is unable to contact the consumer for a determined period of time; or, • Is found to be improperly utilizing the service or is asked to leave the agency.	6.3	Documentation of reason for case closure in PE.
6.4	Supervisor approval is required for all case closures.	6.4	Documentation of supervisor approval in PE.

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Definition:
Health insurance premium and cost-sharing assistance provides financial assistance for eligible consumers living with HIV to maintain continuity of Health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists 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 consumers; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible consumers; and/or
- Paying cost sharing on behalf of the consumer.

Eligibility:
Consumers accessing Health Insurance Premium & Cost Sharing Assistance Service shall meet the eligibility requirements of the Marketplace and have income between 100 and 400 percent FPL.

1.0 Agency Policies and Procedures

The objective of the Policies and Procedures Standard for Health Insurance Premium & Cost-Sharing Assistance is to ensure that Ryan White Part A is the payer of last resort.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	Documentation of Eligibility Determination on file.	1.1	Current Notice of Eligibility and documentation of FPL between 100% and 400% in Provide Enterprise (PE) record.
1.2	Agencies shall be responsible for paying insurance premiums, for approved qualified health and dental plans through the Marketplace.	1.2	Documented proof of insurance and summary of benefits in PE record.

2.0 Scope of Work

The objective of the Scope of Work Standard for Health Insurance Premium & Cost Sharing Assistance is to ensure that Ryan White Part A is the payer of last resort.

2.0 Scope of Work

	STANDARDS		MEASURES
2.1	Agencies shall ensure that only silver plans are selected and full premiums tax credit is taken at the time of enrollment.	2.1	Documented proof of insurance and summary of benefits in PE record.
2.2	Agencies shall pay premiums, deductibles, co-insurance and/or co-pays to consumer's insurance carrier or health care provider.	2.2	Documented proof of premium, deductible, co-insurance and co-payment amount in PE record. (itemized invoice)
2.3	Deductibles, co-insurances and/or co-pays (including co-pays for prescription eyewear) shall be for conditions related to HIV infection.	2.3	Where funds are used to cover deductibles, co-insurance and/or co-payments, documentation shall include a physician's written statement that the condition is related to HIV infection and shall be included in the PE file.
2.4	Agencies shall encourage all consumers receiving Health Insurance Premium services to file income tax returns and appropriate forms each year.	2.4	Progress note indicates discussion of the importance of filing income tax returns. Copies of income tax returns shall be included in the PE file.
2.5	The agency shall establish and maintain a mechanism to assure that upon the consumer's disenrollment, any unused portion of issued premium payments is reimbursed to the program.	2.5	Written procedure and documentation on file.
2.6	Agencies shall ensure that consumers complete and sign the Affordable Care Act (ACA) Client Acknowledgement Form.	2.6	Completed and signed form in PE

Mental Health

Definition:
Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment and counseling services offered to consumers 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.

In Florida, mental health professionals, licensed or authorized include Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Psychiatrists, Psychologists, and Licensed Clinical Social Workers.

This service offers psychological treatment and counseling services, including individuals, group, case consultations, assessments, crisis intervention counseling and psychiatric assessment and treatment provided by state licensed Psychiatrists, mental health professionals and or Master's prepared or Master's level clinical interns directly supervised by a licensed therapist.

Eligibility:
Consumers must meet eligibility as specified in the System-Wide Standard of Care.

1.0 Employment Standards

Agencies providing Mental Health services shall ensure the following employment requirements are met.

1.0 Policies and Procedures

	STANDARDS		MEASURES
1.1	Agencies shall comply with Florida State Statutes 490 and 491	1.1	Current license(s) are on file a provider agency.

2.0 Scope of Service

Agencies providing Mental Health services shall comply with all requirements outlined below.

2.0 Scope of Service

	STANDARDS		MEASURES
2.1	Mental Health services include the following:	2.1	Documentation in consumer clinical record.

	• Biopsychosocial Assessments;
	• Treatment Plan Development;
	• Treatment Plan/ Review;
	• Urine Drug Screening;
	• Psychotherapeutic Treatment to Include:
	  ○ Individual Sessions,
	  ○ Group Sessions, and
	  ○ Case Consultations;
	• Crisis Intervention;
	• Psychiatric Assessment and Treatment; and,
	• Other Services as Deemed Clinically Appropriate.		

2.2	Biopsychosocial assessment should be completed within two visits, but no longer than 30 days. Biopsychosocial assessment will include at a minimum: • Presenting problem • History of the presenting illness or problem • Psychiatric history; • Trauma history; • Medication history; • Alcohol and other drug use history; • Relevant personal and family, medical history; • Mental health status exam; • Cultural influences; • Educational and employment history; • Legal history; • General and HIV related medical history; • Medication adherence; • HIV risk behavior and harm reduction; • Summary of findings; • Diagnostic formulation; • Current risk of danger to self and others;	2.2	Completed assessment, signed and dated in consumer clinical record. If assessment is not completed in 30 days, reason for delay to be documented in progress notes.

	• Social support and functioning, including client strengths/weaknesses, coping mechanisms and self-help strategies; • Domestic violence/abuse history; and, • Treatment recommendations or plan.		
2.3	Biopsychosocial update is ongoing and driven by consumer need, when a consumer's status has changed significantly or when the consumer has left and re-entered treatment, but at a minimum of every six months.	2.3	Progress notes or new assessment demonstrating update in consumer clinical record.
2.4	Assessments and updated assessments completed by unlicensed providers shall be co-signed by licensed clinical supervisor.	2.4	Co-signature on file in consumer clinical record.
2.5	Each consumer shall have an individualized treatment plan that is jointly developed by the consumer and the therapist. The treatment plan must be consumer-centered and consistent with the consumer's identified strengths, abilities, needs and preferences. If the consumer is under the age of 18 years, the consumer's parent, guardian, or legal custodian shall be included in the development of the individualized treatment plan.	2.5	The treatment plan contained in the consumer's clinical record shall reflect the consumer's or his/her legal representative's signature as well as the therapist's signature. If the consumer's age or clinical condition precludes participation in the development of the treatment, an explanation must be provided on the treatment plan. If a treatment plan for a consumer under the age of 18 years does not include the consumer's parent, guardian, or legal custodian's signature by reason of a situation of exception, documentation and justification of the exception must be provided.
2.6	The treatment plan shall contain all of the following components:	2.6	The treatment plan in the consumer's clinical record reflects

	• The consumer's diagnosis code (s) consistent with assessment(s) • Goals that are individualized, strength-based, and appropriate to the consumer's diagnosis, age, culture, strengths, abilities, preferences, and needs, and expressed by the consumer • Measureable objectives with target completion dates that are identified for each goal • A list of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish diagnosis and to gather information for the development of the treatment plan need to be listed) • The amount, frequency, and duration of each service for the six month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use "as needed", "P.R.N" or to state that the consumer will receive a service "x to y times per week".		all required components.
2.7	A formal review of the treatment plan shall be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur and requires the participation of the consumer.	2.7	Consumer clinical record reflects treatment plan review within the appropriate time frame and documents consumer participation.
2.8	Activities, notations of discussions, findings, conclusions, and recommendations shall be documented during the treatment	2.8	Written documentation must be included in the consumer's clinical record upon completion of the treatment plan review activities.

	plan review. Any modifications or additions to the treatment plan must be documented based on the results of the review. The treatment plan review shall contain the following components: • Current diagnosis code(s) and justification for any changes in diagnosis • Consumer's progress toward meeting individualized goals and objectives • Consumer's progress towards meeting individualized discharge criteria • Updates to after care plan • Findings • Recommendations • Dated signature of the consumer • Dated signature of the consumer's parent, guardian, or legal custodian (If consumer is under 18 years of age) • Signatures of the treatment team members who participated in review of the plan • A sign and dated statement by the treating practitioner that services are medically necessary and appropriate to the consumer's diagnosis and needs If the treatment plan review process indicates that the goals and objectives have not been met, documentation shall reflect the treatment team's re-assessment of services and justification if no changes are made.	
2.9	Psychiatric Services include evaluation of the need for	2.9 Written documentation must be included in the consumer's clinical

	medication; evaluation of clinical effectiveness and side effects of medication; prescribing, dispensing, and administering of psychiatric medications; medication education and facilitating informed consent (including discussing side effects, risks, benefits, and alternatives with the consumer or other responsible persons); planning related to service delivery; and evaluating the status of the consumer's community functioning. **Note: Medication management cannot be provided in a group and must be combined with psychotherapy.**		record upon completion of the treatment plan review activities.

3.0 Discharge

Consumers who are no longer engaged in Mental Health services should have their cases closed based on the criteria and protocol outlined in the consumer's treatment plan and the agency's Discharge policy in the Policies and Procedures Manual.

3.0 Discharge

	STANDARDS		MEASURES
3.1	Upon face-to-face discharge, consumers shall receive a discharge plan which has been approved by a qualified supervisor.	3.1	Discharge plan will document reason for closure; outline available resources and instructions for follow up, and are signed by the treating provider and a qualified supervisor.
3.2	Each closed consumer record shall contain a discharge summary and an exit interview, where appropriate. **Note: When the treating provider is not able to conduct an exit interview or discharge summary, the reason must be documented in the record**.	3.2	The discharge summary shall document the recent closure in case disposition and shall be reviewed by the clinical supervisor.
3.3	All discharged consumers shall be offered an exit interview via one of	3.3	The discharge summary shall document an exit interview was

	the following: • Face-to-face visit; • Telephone call; or • Written communication **Note: When the treating provider is not able to conduct an exit interview, reason must be documented in the record.**		offered.
3.4	All discharge summaries shall be documented in Consumer record within 6 months of the last consumer contact.	3.4	Documentation in consumer clinical record

Medical Nutrition Therapy

Definition:
Medical nutrition therapy includes nutrition assessment and screening; dietary/nutrition evaluation; food and/or nutritional supplements per medical provider's recommendation and nutrition education and/or counseling. These services can be provided in individual and/or group settings and outside of an HIV Outpatient/Ambulatory Health Services visit.

All services performed must be pursuant to a medical provider's referral and based on a nutritional plan developed by a registered dietitian or other licensed nutrition professional. . The EMA limits monthly issuance of nutritional supplement per consumer to no more than 2 cans per day per month unless otherwise indicated by the dietitian.

Eligibility:
Consumers must have a referral from a medical provider to a licensed registered dietician who develops and implements a nutrition plan.
Medical Nutrition Therapy providers are expected to comply with the System Wide Standards of Care, as well as these standards.

1.0 Agency Policies and Procedures

The objective of the Policies and Procedures is to ensure the agencies providing medical nutrition therapy services are in compliance with HRSA national standards and monitoring guidelines.

1.0 Agency Policy and Procedures

	STANDARDS		MEASURES
1.1	The dietitian is nationally credentialed by the Commission on Dietetic Registration (CDER) and current on all required trainings.	1.1	CDR license(s) are current and on file at provider agency.

2.0 Determination of Services

The objective of the Determination of Services standards for Medical Nutrition Therapy services is to ensure that service is determined by the needs of each specific consumer, taking into consideration gender, ethnicity and race, co-occurring disorders, and any other psychosocial or economic situations that could impact nutrition status.

2.0 Determination of Services

	STANDARDS		MEASURES
2.1	All consumers receiving Medical Nutrition Therapy will be referred by a primary care physician, nurse practitioners, physician's assistants or dentist to a dietitian.	2.1	Evidence of referral to dietitian by medical provider in consumer record.
2.2	Consumers will have a comprehensive initial intake and assessment by a qualified dietician. The assessment shall include: • Medical considerations; • Food/dietary restrictions, including religions based, allergies, intolerances, interactions between medications, food and complimentary therapies; • Diet history and current nutritional status, including current intake; • Assessment of nutrition intake and estimated need; • Macro- and micro-nutritional supplements; • Actual height and weight, pre-illness body weight, weight trends, goal weight, ideal body weight and % ideal body weight; • Lean body mass and fat; • Waist and hip circumferences; • Food preparation capacity; and • Food preferences and cultural components of food.	2.2	Signed and dated assessment in consumer record
2.3	Ongoing nutritional services will match appropriate level of care as delineated below: • Level 1 – one to two times per year; • Level 2 – two to six times per	2.3	Level of care documented in consumer record

	year; • Level 3 – two to six times per year; and • Level 4 – two to six times per year. In children and adolescents: • CDC Category N & A – one to four times per year; • CDC Category B – four to twelve times per year; and • CDC Category C – six to twelve times per year.		
2.4	Dietician follow up should include at a minimum: • Relevant laboratory data; • Nutrition prescription or desired outcome; • Diagnosis and medical history; • Medications; • Alternative and complementary therapies; • Karnofsky score; • Living situation; and • Any other relevant information that may impact a consumer's ability to care for him or herself.	2.4	Required information provided to distributor and documented in consumer record
2.5	A care plan based on the initial assessment and includes: • Developing and implementing a nutrition care plan; • Providing nutrition counseling and nutrition therapy; • Distributing nutritional supplements, when appropriate; • Providing nutrition and HIV trainings to consumers and their provider; and • Distributing nutrition related education materials to consumers.	2.5	Signed and dated care plan in consumer record.

2.6	Nutrition monitoring and evaluation by the dietitian shall be conducted to determine the degree to which progress is made toward achieving the goals of the care plan.	2.6	Monitoring and evaluation results documented in the consumer record.

3.0 Services to be Provided

The objective of the standards for services to be provided is to ensure that all agencies shall ensure the following services are provided to eligible consumers of the Ryan White Part A EMA.

3.0 Services to be Provided

	STANDARDS		MEASURES
3.1	Providers shall ensure that consumers receive the following services following HRSA Guidelines: • A nutrition assessment; • A nutrition care plan developed and implemented; • Nutrition counseling and nutrition therapy, if appropriate; • Nutritional supplements prescription when appropriate.	3.1	Assessment and treatment plan in consumer record.

4.0 Nutrition Interventions

The objective of the standards for nutrition interventions is to ensure that nutritional supplements deemed medically necessary are provided to eligible Ryan White Part A consumers and adequate records detailing the distribution are kept.

4.0 Nutrition Interventions

	STANDARDS		MEASURES
4.1	Nutritional supplements are issued based on the assessment, prescription and care plan prior to receiving nutritional supplements.	4.1	Progress notes should detail supplement issuance based on assessment, prescription and plan. Assessment, prescription and plan in consumer file.
4.2	Programs shall distribute nutrition	4.2	Materials that promote proper

education materials to consumers.	nutrition and food safety on file at provider agency, along with distribution plan.

5.0 Case Closure

The objective of the standards for case closure is to ensure appropriate case closure.

5.0 Case Closure

	STANDARDS		MEASURES
5.1	Provider shall develop case closure criteria and procedures. Cases may be closed when the consumer: • Is relocating out of the service area; • No longer needs the service/completes care plan; or • Decides to discontinue the service	5.1	Case closure criteria and procedures on file at provider agency. Review of consumer record

Medical Case Management

Definition:
Medical Case Management services (including treatment adherence) is the provision of a range of consumer-centered consumer activities focused on improving health outcomes in support of the HIV Care Continuum. Consumer 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). Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Key activities include:

1. Initial assessment of service needs
2. Development of a comprehensive, individualized service plan
3. Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
4. Continuous consumer monitoring to assess the efficacy of the care plan
5. Re-evaluation of the care plan at least every 6 months with adaptations as necessary
6. Ongoing assessment of the consumer's and other key family members' needs and personal support systems; treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
7. Consumer-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 consumers 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).

Eligibility:
Consumers accessing Medical Case Management shall meet the eligibility standards as described in the System Wide Standards of Care

1.0 Policies and Procedures

Medical Case Management agencies shall have policies and procedures that ensure that the services are accessible to all eligible consumers.

The agency policy and procedures will ensure compliance with the following standards.

1.0 Policies and Procedures

	STANDARDS		MEASURES
1.1	Providers must be certified under Medicaid Project AIDS Care (PAC) Waiver and qualified to provide PAC Case Management services to eligible consumers.	1.1	Certification on file
1.2	The agency shall maintain information about each Medical Case Manager's caseload, which includes, at a minimum: • Assigned Medical Case Manager; • Number of cases per full-time equivalent (FTE); and, • The acuity of each consumer.	1.2	Documentation in agency records
1.3	All Ryan White Medical Case Managers must meet at least one of the following staff qualifications: • Bachelor's degree in a social science or health discipline; • An individual with a bachelor's degree in disciplines other than social science must have at least six (6) months direct case management experience; • Florida licensed registered nurse with at least one year of case management experience; • An individual with a master's degree other than a social science or health can substitute their degree for six (6) months of direct case management experience.	1.3	Appropriate degrees, licensure and/or certification in personnel file
1.4	All Medical Case Management supervisors must meet the following requirement: • Hold a Master's Degree in the fields of mental health, social	1.4	Appropriate degrees, licensure and/or certification in personnel file.

	work, counseling, social science or nursing.		
1.5	Medical Case Management supervisors and Medical Case Managers shall complete: • HIV/AIDS in the News (HIV/AIDS 101) within three (3) months of hire; • HIV/AIDS 501 courses within one (1) year of hire. • The Florida Caribbean AETC Case Manager modules within three (3) months of hire; and • Ryan White Eligibility training within 30 days. ***Note: trainings may be taken on line at:*** **https://fl.train.org**	1.5	Documentation of the following will be in the employee file: • Proficiency certification within one (1) year; AETC certificate within 3 months of hire • Eligibility training certificate within 30 days of hire • HIV/AIDS in the News dated within three (3) months of hire; • 501 certificate dated within one (1) year of hire; • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance and hours in agency training record • Training certificate
1.6	Medical Case Management supervisors shall have 12 hours of training annually as approved by the Recipient's office. At least six (6) of the twelve (12) hours shall be leadership training. other training topics shall include the following: • The basics of HIV care and treatment; • Appropriate boundaries; • Necessary communication skills relating to specific HIV issues such as principles for treatment and housing, precautions for caregivers and HIV-infected individuals, and pre-and post-test counseling and social and legal aspects relevant to this service population.	1.6	Documentation of the training shall be in the employee training record. Training certificates shall be in the employee file.

1.7	Medical Case Managers shall receive 15 hours of training annually. Training shall be approved by the Recipient. Topics shall include: • Establishing rapport and a professional relationship with the consumer; • Methods of engaging individuals; • Special issues relating to working with the HIV/AIDS affected/infected population; • Confidentiality/HIPAA and professional ethics; • Knowledge of public assistance programs, eligibility requirements, and benefits; and, • The Agency's emergency plan, disaster relief resources, and planning and procedures. Training shall also include, but not be limited to, cultural sensitivity issues, case management issues, bio-psychosocial issues surrounding the HIV disease, and any other training proposed by the Recipient.	1.7	Documentation of the training subject matter, date(s) of attendance and hours in training shall be in the training record. Training certificates shall be in the employee file.
1.8	Medical Case Management supervisors and Medical Case Managers shall comply with all training requirements mandated by the Orlando EMA Ryan White Part A Recipient's Office.	1.8	Documentation of all training shall be in the personnel file.
1.9	Medical professionals shall be responsible for maintaining their licensure per Florida State Requirements.	1.9	Copies of licenses will be in personnel file
1.10	Medical Case Managers must be aware of and able to refer and link consumers to providers qualified to provide Project AIDS Care Case Management services to eligible consumers.	1.10	Documentation of all referrals will be noted in PE.

2.0 Eligibility Assessment

Medical Case Managers shall determine eligibility for services as evidenced by documentation via an eligibility assessment. Verification that the consumer meets the current eligibility requirements must be obtained prior to payment for services.

2.0 Eligibility Assessment

	STANDARDS		MEASURES
2.1	Eligibility assessment shall ensure all required documents are in the Provide Enterprise record. Consumers shall be informed of their right to: • Confidentiality in accordance with state and federal laws; • Choice of providers; • Explanation of grievance procedures; and • Consumer Rights and responsibilities. • Information check list	2.1	No later than five (5) workdays from receipt of referral or date of request for service the following shall be complete: • Consumer rights and responsibilities • Consumer chart ; • Information check list; and • Authorization for Release of Confidential or Protected Health Information
2.2	As part of the eligibility assessment, HIV status, residency and income shall be verified. Each consumer shall be recertified every six months or sooner if benefit status, residency or income has changed. Recertification may be done by self-attestation. If self-attestation indicates a change, documentation verifying the change shall be collected at the consumer visit following the report of the change. At least once every 12 months period the recertification procedures shall include the collection of more in-depth supporting documentation, similar to that collected at the initial eligibility determination.	2.2	Documentation of HIV status, residency and income shall be maintained in PE. Notification of self-attestation should also be documented in PE.
2.3	Consumers shall be screened for other funding sources and shall be provided assistance in enrolling in all eligible sources.	2.3	Documentation of ineligibility for other funding sources shall be maintained in PE.

3.0 Consumer Assessment and Care Plan

Medical Case Managers shall conduct a face-to-face assessment of each consumer which shall be documented in the consumer's record in Provide Enterprise (PE); such assessment shall include barriers (perceived and actual) to access and retention in care. A care plan shall be developed, in collaboration with the consumer, based on the results of the assessment.

The care plan shall outline incremental steps in reaching a goal and who is responsible for what activity. The activities shall be measurable with timeframes for the completion of each activity. Outcomes of the care plan activities shall be noted in the Medical Case Management record.

3.0 Consumer Assessment and Care Plan

	STANDARDS		MEASURES
3.1	An initial comprehensive assessment shall be completed for all consumers to include: • Medical; • Behavioral health • Social; • Financial; • Health literacy; • Cultural issues; • Acuity level; and • Other needs.	3.1	A copy of the completed comprehensive assessment shall be maintained in PE.
3.2	An individual care plan shall be developed with the participation of the consumer within 30-days of intake. The care plan shall be based on prioritized identified needs, acuity level, and shall address consumer's cultural needs.	3.2	Care plan shall have consumer's and/or caregiver's signature and shall address prioritized consumer needs identified in the assessment, acuity level and cultural needs.
3.3	Each consumer shall be assisted in developing time frames for the resolution of any barriers to care identified in the assessment and follow-up with the consumer shall be at a minimum of every ninety days to ensure service delivery.	3.3	The Plan of Care and progress notes shall include: • the intervention to resolve the barriers to care; • Achievement dates; and progress notes documenting assistance provided.
3.4	Each consumer shall be assisted with establishing expected outcomes within the Plan of Care.	3.4	Progress notes shall document the assistance provided.

3.5	All completed consumer referral forms shall be maintained in PE.	3.5	All completed consumer referral forms shall be maintained in PE.
3.6	Medical case managers shall conduct periodic re-evaluation and adaptation of the plan at least every 3 months, throughout the consumer's enrollment with MCM services.	3.6	Documentation in consumer record reflects periodic re-evaluation at least every three (3) months.
3.7	The care plan should be signed by the medical case manager and by the consumer. The consumer's signature confirms that the consumer understands and agrees to the care plan. If the consumer does not sign the care plan, the MCM should document and date the reason in the consumer's progress note and/or care plan.	3.7	Care Plan reflects both the MCM and the consumer's signature.
3.8	Medical Case Managers shall ensure that consumers are enrolled in primary medical care.	3.8	Appointment date and time and laboratory (viral load, CD-4) shall be documented in PE record.
3.9	Medical Case Managers shall determine the need for medical transportation and facilitate the appropriate conveyance.	3.9	All bus passes and door-to-door vouchers shall be recorded in Provide Enterprise.
3.10	Medical Case Managers shall facilitate oral health referrals for consumers.	3.10	Oral Health purchase order and treatment plan shall be documented in PE record
3.11	Medical Case Managers shall facilitate distribution of nutritional supplements in accordance with a nutritional plan approved by a licensed dietitian.	3.11	Nutritional plan and services recorded in PE.

4.0 Documentation

All Medical Case Management providers are required to maintain accurate documentation in order to submit data on medical case management activities in the Ryan White Part A Reporting System (Provide Enterprise). The submission requirements are detailed within the contract funding application.

4.0 Documentation

	STANDARDS		MEASURES
4.1	Medical Case Managers shall be assigned within two (2) working days of a request for service or receipt of a referral.	4.1	The record shall reflect the name of the assigned Medical Case Manager and date of assignment.
4.2	An initial intake and assessment shall be initiated within five (5) working days of contact.	4.2	The consumer record shall contain intake and assessment forms dated within five (5) days of referral or date of service request. Intake progress notes shall reflect the date of referral or service requested and date of intake and eligibility assessment.
4.3	Each consumer shall have an acuity level assessment. Individuals with an acuity assessment of 2 as measured by the Ryan White Assessment tool shall be referred to a Medical Case Manager.	4.3	Documentation of the acuity assessment and documentation of any identified difficulties that the consumer may have shall be maintained in the consumer file.
4.4	To receive on-going Medical Case Management services, the consumer must have an acuity level of 2 and be an eligible recipient of Part A funded services. **Note: Use of this qualification must be preapproved by the recipient.**	4.4	Documentation of linkage in PE record
4.5	Medical case managers shall conduct an intake that includes all necessary information to link and retain consumers in care both within Ryan White system of care and	4.5	Documentation of all elements included in PE.

	elsewhere. This includes an initial assessment of needs, consumer strengths, and challenges. An initial plan shall be developed with the consumer based on the level of acuity of needs. Goals set with the consumer should strive to achieve self-empowerment and self- efficacy.		
4.5	Medical Case Managers shall conduct on going care planning, including re-evaluation and updating as evidenced by an ongoing assessment of consumer's medical and psychosocial needs to the extent that the assessment supports access to and retention in care for the consumer. The medical core services assessment with full eligibility, financial and support services assessment shall be conducted every three (3) months.	4.5	Documentation of all elements included in PE.
4.6	Monitor and document consumer's progress in meeting established goals of care.	4.6	A progress note must be completed on a consumer for each contact that includes adherence (medical, medication, care plan), and health outcomes.
4.7	Agencies shall assist consumers in getting basic information about treatment options.	4.7	Documentation of assisting consumers in obtaining information regarding treatment adherence, and prevention shall be maintained in PE.
4.8	All progress note entries shall be electronically signed with the Medical Case Manager's full legal name and title. The entries must also be dated with title and credentials within two (2) days after an interaction with the consumer.	4.8	Progress notes in PE reflect all required elements.

5.0 Coordination of Care

Care Coordination includes communication, information sharing, and collaboration, and occurs regularly between medical case management and other staff serving the patient within the agency and among other agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages and confirming service acquisition.

5.0 Coordination of Care

	STANDARDS		MEASURES
5.1	Medical Case Managers shall coordinate and track linkages and outcomes of consumers referred to other core medical, support services, partner services and prevention to support identification of those unaware of their HIV status.	5.1	Documentation in PE including forms and progress notes
5.2	Medical Case Managers shall actively participate in team meetings or case conferences for the consumers to sustain retention in care and/or to improve the consumer's quality of life.	5.2	Documentation of case conferencing or team meetings in PE.
5.3	Medical Case Managers shall provide benefit/entitlement counseling and referral activities to assist consumers to access other private and public programs (e.g. Medicaid, Medicare, or Insurance Marketplace/Exchange Etc.).	5.3	Progress notes document referral activities regarding accessing other resources.
5.4	Medical Case Managers shall verify that consumers receive medically necessary services and that RW eligibility is current to ensure access to necessary services.	5.4	Progress notes document efforts to coordinate services with other service providers.

6.0 Discharge

Consumers who are no longer engaged in HIV treatment and care services should have their cases closed based on the criteria and protocol outlined in the agency's Medical Case Management Policies and Procedures Manual.

6.0 Discharge

	STANDARDS		MEASURES
6.1	Upon termination of active Medical Case Management services, a consumer's case shall be closed and the record shall contain a discharge summary documenting the case disposition and offer an exit interview.	6.1	Upon discharge consumers will receive a transition plan that outlines available resources and instructions for follow-up
6.2	Each closed consumer record shall contain a face-to-face discharge summary and an exit interview, where appropriate. **Note: When Case Manager is not able to conduct an exit interview or discharge summary, the reason must be documented in the record.**	6.2	The discharge summary shall document the recent foreclosure and case disposition and shall be reviewed by the medical case manager supervisor.
6.3	All discharged consumers shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone; or • Written communication **Note: When the Case Manager is not able to conduct an exit interview, reason must be documented in the record**	6.3	The discharge summary shall document an exit interview was offered.
6.4	All discharge summaries shall be documented in Consumer record within 6 months of the last consumer contact.	6.4	Documentation in PE.

Substance Abuse Services (Outpatient)

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

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

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable Health and Human Services (HHS) guidance, including Health Resources and Services Administration (HRSA) - or the HIV/AIDS Bureau (HAB)-specific guidance.

Eligibility:
Consumers shall meet eligibility requirements as defined in the System-Wide Standards of Care.

1.0 Agency Policies and Procedures

The Agencies shall have Policy and Procedures to ensure that the Services are accessible to all eligible consumers. The Agency's policy and procedures shall ensure compliance with the following Standards.

1.0 Policies and Procedures

	STANDARDS		MEASURES
1.1	Comply with Florida Administrative Code Chapter 65D-30 and Chapter 397 of Florida Statutes.	1.1	Current licensure displayed. Staff resume, license, and certifications on file

2.0 Scope of Service

Agencies shall comply with all of the requirements outlined in this Standard of Care, unless otherwise specified in their contract.

2.0 Scope of Services

	STANDARDS		MEASURES

2.1	Outpatient Substance Abuse services include the following:
	• Biopsychosocial assessments;
	• Treatment plan development;
	• Treatment plan/ review;
	• Urine drug screening;
	• Psychotherapeutic treatment to include:
	  ○ Individual sessions,
	  ○ Group sessions, and
	  ○ Case consultations;
	• Crisis intervention;
	• Referral for psychiatric assessment and treatment; and,
	• Other services as deemed clinically appropriate.
		2.1	Documentation in consumer clinical record

2.2	Biopsychosocial assessment should be completed within two visits, but no longer than 30 days. Biopsychosocial assessment will include at a minimum: • Presenting problem • History of the presenting illness or problem • Psychiatric history; • Trauma history; • Medication history; • Alcohol and other drug use history; • Relevant personal and family, medical history; • Mental health status exam; • Cultural influences;	2.2	Completed assessment, signed and dated in consumer clinical record. If assessment is not completed in 30 days, reason for delay to be documented in progress notes.

	• Educational and employment history; • Legal history; • General and HIV related medical history; • Medication adherence; • HIV risk behavior and harm reduction; • Summary of findings; • Diagnostic formulation; • Current risk of danger to self and others; • Social support and functioning, including client strengths/weaknesses, coping mechanisms and self-help strategies; • Domestic violence/abuse history; and, • Treatment recommendations or plan.		
2.3	A Biopsychosocial update is ongoing and driven by the consumer's needs, when their status has changed significantly, or when the consumer has left and re-entered treatment. A Biopsychosocial update is required to be completed at a minimum of once every six (6) months.	2.3	Progress notes or new assessment demonstrating update in consumer clinical record.
2.4	Assessments and updates completed by unlicensed providers shall be co-signed by licensed clinical supervisor.	2.4	Co-signature on file in consumer clinical record.
2.5	All consumers must have been under the care of a physician within the past twelve (12) months. Consumers out of care must be referred for medical care within 10 business days.	2.5	Documentation in consumer files of receiving medical care in past year or current referral.
2.6	Each consumer shall have an	2.6	The treatment plan contained in

	individualized treatment plan that is jointly developed by the consumer and the therapist. The treatment plan must be consumer-centered and consistent with the consumer's identified strengths, abilities, needs and preferences. If the consumer is under the age of 18 years, the consumer's parent, guardian, or legal custodian shall be included in the development of the individualized treatment plan.		the consumer's clinical record shall reflect the consumer's or his/her legal representative's signature as well as the therapist's signature. If the consumer's age or clinical condition precludes participation in the development of the treatment, an explanation must be provided on the treatment plan. If a treatment plan for a consumer under the age of 18 years does not include the consumer's parent, guardian, or legal custodian's signature by reason of a situation of exception, documentation and justification of the exception must be provided.
2.7	The treatment plan shall contain all of the following components: • The consumer's diagnosis code (s) consistent with assessment(s) • Goals that are individualized, strength-based, and appropriate to the consumer's diagnosis, age, culture, strengths, abilities, preferences, and needs, and expressed by the consumer • Measureable objectives with target completion dates that are identified for each goal • A list of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish diagnosis and to gather information for the development of the treatment plan need to be listed) • The amount, frequency, and duration of each service for the six month duration of the	2.7	The treatment plan in the consumer's clinical record reflects all required components.

	treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use "as needed", "p.r.n" or to state that the consumer will receive a service "x to y times per week"		
2.8	A formal review of the treatment plan shall be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur and requires the participation of the consumer.	2.8	Consumer clinical record reflects treatment plan review within the appropriate time frame and documents consumer participation.
2.9	Activities, notations of discussions, findings, conclusions, and recommendations shall be documented during the treatment plan review. Any modifications or additions to the treatment plan must be documented based on the results of the review. The treatment plan review shall contain the following components: • Current diagnosis code(s) and justification for any changes in diagnosis • Consumer's progress toward meeting individualized goals and objectives • Consumer's progress towards meeting individualized discharge criteria • Updates to after care plan • Findings • Recommendations • Dated signature of the consumer • Dated signature of the consumer's parent, guardian	2.9	Written documentation must be included in the consumer's clinical record upon completion of the treatment plan review activities.

	or legal custodian (If consumer is under 18 years of age) • Signatures of the treatment team members who participated in review of the plan • A sign and dated statement by the treating practitioner that services are medically necessary and appropriate to the consumer's diagnosis and needs If the treatment plan review process indicates that the goals and objectives have not been met, documentation shall reflect the treatment team's re-assessment of services and justification if no changes are made.	

3.0 Discharge

Consumers who are no longer engaged in Outpatient Substance Abuse services should have their cases closed based on the criteria and protocol outlined in the consumer's treatment plan and the agency's Discharge policy in the Policies and Procedures Manual.

3.0 Discharge

	STANDARDS		MEASURES
3.1	Upon face-to-face discharge, consumers shall receive a discharge plan which has been approved by a qualified supervisor	3.1	Discharge plan will document reason for closure; outline available resources and instructions for follow up, and are signed by the treating provider and a qualified supervisor.
3.2	Each closed consumer record shall contain a discharge summary and an exit interview, where appropriate.	3.2	The discharge summary shall document the recent closure in case disposition and shall be reviewed by the clinical supervisor.

	Note: When the treating provider is not able to conduct an exit interview or discharge summary, the reason must be documented in the record.		
3.3	All discharged consumers shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone call; or • Written communication **Note: When the treating provider is not able to conduct an exit interview, reason must be documented in the record**	3.3	The discharge summary shall document an exit interview was offered.
3.4	All discharge summaries shall be documented in Consumer record within 6 months of the last consumer contact.	3.4	Documentation in consumer clinical record

Support Services

Non-Medical Case Management

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

Note: Non-Medical Case Management Services have as their objective providing guidance and assistance in <u>improving access</u> to needed services.

Eligibility:
Consumers accessing Non-Medical Case Management shall meet the eligibility standards as described in the System Wide Standards of Care.

1.0 Policies and Procedures

Non-Medical Case Management agencies shall have policies and procedures that ensure that the services are accessible to all eligible consumers. The agency policy and procedure will ensure compliance with the following standards.

1.0 Policy and Procedures

	STANDARDS		MEASURES
1.1	The agency shall maintain information about each Non-Medical Case Manager's caseload, which includes, at a minimum: • Assigned non-medical case manager; • Number of cases per full time equivalent (FTE); and	1.1	Documentation in agency records

	• The acuity of each consumer.		
1.2	All Non-Medical Case Managers must meet at least one of the following staff qualifications: • An associate's in social science field and at least one (1) year of case management experience or bachelor's degree in social services; or • Individuals with an associate's or bachelor's degree in another field must have at least one year of direct HIV/AIDS case management experience • 2 years of verifiable experience case managing individuals with HIV at an established agency that can substitute on a year-for-year basis for an Associate's degree. **Note: Use of this qualification must be preapproved by the recipient.**	1.2	Appropriate degrees, licensure, and/or certification in personnel file
1.3	Non-Medical Case Management supervisors must meet the following requirement: • Hold a Master's Degree level professional in the fields of mental health, social work, counseling, social science or nursing	1.3	Appropriate degrees, licensure and/or certification in personnel file
1.4	Non-Medical Case Management supervisors and Non-Medical Case Managers shall complete: • HIV/AIDS 101 within three (3) months of hire; • The Florida Caribbean AETC Case Manager modules within six (6) months of hire; and • HIV/AIDS 501 courses within	1.4	Documentation of the following will be in the employee file: • Proficiency certification within one year; • HIV/AIDS 101 dated within three (3) months of hire; • 501 certificate dated within 1 year of hire; • Proof of attendance, certificate or other

	one (1) year of hire.		documentation including training subject matter, date(s) of attendance hour in agency record; • Training certificate
1.5	Non-Medical Case Management supervisors shall have 12 hours of training annually as approved by the Recipient Office. At least six (6) of the twelve (12) hours shall be leadership training.	1.5	Documentation of the training shall be in the employee training record. Training certificates shall be in the employee file.
1.6	Non-Medical Case Managers shall receive 15 hours of training annually. Training shall be approved by the Recipient.	1.6	Documentation of the training subject matter, date(s) of attendance, and hours in training shall be in the training record. Training certificates shall be in the employee file.
1.7	Non-Medical Case Management supervisors and non-medicals case managers shall comply with all training requirements mandated by the Orlando EMA Ryan White Part A Recipient's Office.	1.7	Documentation of all training shall be in the personnel file.
1.8	Non-Medical Case Managers must be aware of and able to refer and link consumers to providers qualified to provide Project AIDS Care Case Management services to eligible consumers.	1.8	Documentation of all referrals will be noted in the consumer's electronic data management system.

2.0 Eligibility Assessment

Non-Medical Case Managers shall determine eligibility for services as evidenced by documentation via an eligibility assessment.

Verification that the consumer meets the current eligibility requirements must be obtained prior to payment for services.

2.0 Eligibility Assessment

STANDARDS		MEASURES	
2.1	Eligibility assessment shall ensure all required documents are present in the Provide Enterprise (PE) record. Consumers shall be informed of their right to: confidentiality in accordance with state and federal laws, choice of providers, explanation of grievance procedures, and Consumer Rights and Responsibilities.	2.1	No later than five (5) working days from receipt of referral or date of request for service the following shall be completed: • Consumer chart; • Authorization of Release of Confidential or Protected Health Information
2.2	As part of the eligibility assessment, HIV status, residency and income shall be verified. Each consumer shall be recertified every 6 months or sooner if benefits status, residency or income has changed.	2.2	Documentation of residency and income shall be maintained in the consumer record per Orlando EMA requirements.
2.3	Consumers shall be screened for other funding sources and should be provided assistance in enrolling ibn all eligible sources.	2.3	Documentation of ineligibility for other funding sources shall be maintained in the consumer record.

3.0 Consumer Assessment and Care Plan

Non-Medical Case Managers shall conduct a face-to-face assessment of each consumer which shall be documented in the consumer's record in Provide Enterprise (PE); such assessment shall include barriers (perceived and actual) to access and retention in care. A care plan shall be developed, in collaboration with the consumer, based on the results of the assessment. The care plan shall outline incremental steps to reaching a goal and who is responsible for what activity. The activities shall be measurable with timeframes for the completion of each activity. Outcomes of the care plan activities shall be noted in the Non-Medical Case Management record.

3.0 Consumer Assessment and Care Plan

STANDARDS		MEASURES	
3.1	An individual care plan shall be developed with the participation of the consumer within 30-days of intake. The care plan shall be based on prioritized identified needs, acuity	3.1	Care plan shall have consumer's and/or caregiver's signature and shall address prioritized consumer needs identified in the assessment, acuity level and

	level, and shall address consumer's cultural needs.		cultural needs.
3.2	Each consumer shall be assisted in developing time frames for the resolution of any barriers to care identified in the assessment and follow-up with the consumer a minimum of every ninety days to ensure service delivery.	3.2	Care plan and progress notes document the intervention to resolve any barriers to care and or services needed.
3.3	Non-medical case managers shall verify that consumers are enrolled in primary medical care.	3.3	Appointment date and time and laboratory (viral load, CD-4) shall be documented in PE record.
3.4	Non-Medical Case Managers shall determine the need for medical transportation and facilitate the appropriate conveyance.	3.4	All bus passes and door-to-door vouchers shall be recorded in Provide Enterprise.
3.5	Non-Medical Case Managers shall facilitate oral health referrals for consumers.	3.5	Oral Health purchase order and treatment plan shall be documented in PE record

4.0 Documentation

All Non-Medical Case Management providers are required to maintain accurate documentation in order to submit data on non- medical case management activities in the Ryan White Part A Reporting System (Provide). The submission requirements are detailed within the contract funding application.

4.0 Documentation

	STANDARDS		MEASURES
4.1	Non-Medical Case Managers shall be assigned within two working days of a request for service or receipt of a referral.	4.1	The record shall reflect the name of the assigned Non-Medical Case Manager and date of assignment.
4.2	An initial intake and assessment shall be initiated within five (5) working days of contact with consumer.	4.2	The consumer record shall contain intake and assessment forms data within five (5) days of contact with consumer regarding referral or

			date of service request. Intake progress notes shall reflect the date of referral or service requested and date of intake and financial eligibility assessment.
4.3	Each consumer must have an acuity level assessment. Individuals with an acuity assessment of 1 as measured by the Ryan White Assessment tool shall be referred to a Non-Medical Case Manager.	4.3	Documentation of the acuity assessment and documentation of any identified difficulties that the consumer may have shall be maintained in the PE record.
4.4	To receive on-going Non-Medical Case Management services, the consumer must have an acuity level of 1 and be an eligible recipient of Part A funded services. **Note: Use of this qualification must be preapproved by the recipient.**	4.4	Documentation of linkage in PE record
4.5	Agency shall assist consumers in getting basic information about treatment options.	4.5	Documentation of assisting consumers in obtaining information treatment adherence and prevention shall be maintained in the consumer record.
4.6	Non-Medical Case Managers shall conduct an intake that includes all necessary information to link and retain consumers in care both within the Ryan White system of care and elsewhere. This includes an initial assessment of needs, consumer strengths and challenges. An initial plan shall be developed with the consumer based on the level of acuity of needs. Goals set with the consumer should strive to achieve self-empowerment and self- efficacy.	4.6	Documentation of all elements included in the consumer's record.

4.7	Non-Medical Case Managers shall conduct on going care planning, including re-evaluation and updating as evidenced by an ongoing assessment of consumer's needs to the extent that the assessment supports access to and retention in care for the consumer. The assessment with full eligibility, financial and support services assessment conducted every six (6) months.	4.7	Documentation of all elements included in the consumer's record.
4.8	Nom-medical Case Managers shall follow up on consumer referrals.	4.8	Documentation of the follow-up included in the consumer records
4.9	Monitor and document consumer's progress in meeting established goals of care.	4.9	A progress note must be done on a consumer for each contact that includes adherence (medical, medication, care plan, etc.), health outcomes, etc.
4.10	All progress note entry must be signed with the Non-Medical Case Manager's full legal name and title. The entry must also be dated with title and credentials within two (2) days after an interaction with the consumer.	4.10	Progress notes in consumer record reflect all required elements.

5.0 Discharge

Consumers who are no longer engaged in HIV treatment and care services should have their cases closed based on the criteria and protocol outlined in the agency's Non-Medical Case Management Policies and Procedures Manual.

5.0 Discharge

	STANDARDS		MEASURES
5.1	Upon face-to-face discharge, consumers shall receive a discharge plan which has been approved by a qualified supervisor.	5.1	Discharge plan will document reason for closure; outline available resources and instructions for follow up, and are signed by the Non-Medical Case

			Manager and a qualified supervisor.
5.2	Each closed consumer record shall contain a discharge summary and an exit interview, where appropriate. **Note: When Case Manager is not able to conduct an exit interview or discharge summary, the reason must be documented in the record.**	5.2	The discharge summary shall document the recent closure in case disposition and shall be reviewed by the Non-Medical Case Manager supervisor.
5.3	All discharged consumers shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone call; or • Written communication **Note: When Case Manager is not able to conduct an exit interview, reason must be documented in the record**	5.3	The discharge summary shall document an exit interview was offered.
5.4	All discharge summaries shall be documented in Consumer record within 6 months of the last consumer contact.	5.4	Documentation in PE record

Emergency Financial Assistance

Definition:
Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the Ryan White HIV/AIDS Program (RWHAP) consumer 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.

Note: Direct cash payments to consumers are not permitted.

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

Note: EFA Services in the Orlando EMA shall include medication services only.

Eligibility:
Consumers accessing Emergency Financial Assistance Services shall meet the eligibility standards as described in the System Wide Standards of Care.

1.0 Scope of Service

EFA requests shall be initiated by Case Managers and shall ensure that consumers do not experience gaps in medications.

1.0 Scope of Service

	STANDARDS		MEASURES
1.1	Consumers requesting EFA services shall be assessed to determine the cause of medication gap.	1.1	Documentation of assessment including the cause of possible medication gap documented in PE
1.2	Case Managers shall ensure that using EFA is the payer of last resort.	1.2	Documentation of the unavailability of other resources in PE notes.
1.3	Case Managers shall complete the RW Part A temporary assistance request form and fax to the Ryan White Part A Pharmacy.	1.3	Completed form uploaded to PE.

1.4	Case Managers shall follow up with consumers to ensure that the barrier(s) to accessing medications through alternative sources have been resolved.	1.4	Documentation in PE notes.
1.5	The Ryan White Part A Pharmacy shall review and approve all EFA requests within 48 business hours.	1.5	Approved form in pharmacy electronic system
1.6	Pharmacy staff shall contact the Case Manager in the event of a denied or pending EFA.	1.6	Documentation of reason of denial or pending status and Case Manager contact in PE
1.7	A separate completed Temporary Assistance Request form shall be completed for each EFA access.	1.7	Separate dated forms in PE.
1.8	EFA services per consumer shall not exceed 6 months unless authorized by the Recipient's Office.	1.8	A dated form in PE does not exceed 6 months without Recipient's Office authorization.

Food Bank/Home Delivered Meals

Definition:
Food bank/home-delivered meals refer 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
- Water filtration/purification systems in communities where issues of water safety exist

Note: The Orlando EMA funds food bank services only. Household appliances, pet foods, and other non-essential products are not allowed.

Eligibility:
Consumers accessing Food Bank/Home Delivered Meals Services shall be at or below 200% of the Federal Poverty Level (FPL).

1.0 Agency Policies and Procedures for Food Pantries

The agencies shall have policy and procedures to ensure that the services are accessible to all eligible consumers. The agency policy and procedures shall ensure compliance with the following standards.

1.0 Agency Policies and Procedures for Food Pantries

	STANDARDS		MEASURES
1.1	Agencies with a food pantry program shall comply with local, state, and federal food safety, sanitization, and safety regulations.	1.1	Policy in place that reflects guidelines
1.2	Agencies with a food pantry shall comply with the USDA Department of Agriculture food handling guidelines.	1.2	USDA guidelines on file and copies of monitoring by regulatory agencies available in agency records
1.3	Agencies with a food pantry shall maintain and show evidence that all required inspections are current, and resulted in acceptable findings.	1.3	Inspection reports available upon request.
1.4	Agencies with a food pantry shall provide adequate space and equipment to store food in a sanitary	1.4	Appropriate space and equipment available upon inspection/observation.

	manner.		
1.5	Agencies with a food pantry shall comply with procedures for purchasing, receiving, sorting, issuing, preparing, and service of safe food and beverage products.	1.5	Procedures and certifications on file.
1.6	All food pantry staff members repackaging bulk foods shall have current and valid food handling permits or license.	1.6	Permits/license on file at provider agency
1.7	All new food pantry staff members shall attend educational seminars regarding food safety within three months of hire and annually thereafter.	1.7	Education certificates on file at provider agency for each staff member

2.0 Food Pantry Scope of Work

The objective of the Scope of Work Standard for Food Bank/Home Delivered Meals is to ensure that Ryan White Part A is the payer of last resort.

2.0 Food Pantry Scope of Work

	STANDARDS		MEASURES
2.1	No food bag shall contain cans that are dented, swollen, showing rust, or missing a label in accordance with FDA Regulations.	2.1	Bag and pantry inspections
2.2	All milk and cheese products shall have the word pasteurized on the label.	2.2	Pantry Inspection
2.3	Fresh food such as bread shall be free of any mold.	2.3	Pantry Inspection
2.4	Fruits and vegetables shall be free from insects and mold.	2.4	Pantry Inspection

2.5	All packaged products shall be labeled properly, and within the expiration period as stated on the product in accordance with FDA Regulations.	2.5	Pantry Inspection
2.6	Frozen foods shall be packaged, kept completely frozen and stored in a proper freezer at 0° Fahrenheit or below.	2.6	Pantry Inspection

3.0 Responsibility of Case Management Agencies

The purpose of the responsibility of case management agencies is to establish the scope of work for the coordination of food bank/home delivered meals.

3.0 Responsibility of Case Management Agencies

	STANDARDS		MEASURES
3.1	Consumers accessing Food Bank/Home Delivered Meals services in Orange County shall be issued a Food Voucher to be used at a contracted Food Pantry. All other eligible consumers shall be issued Supermarket Gift Cards.	3.1	Documentation in PE demonstrates that Food Vouchers are issued to consumers accessing services in Orange County and that gift cards are issued to consumers accessing services in Lake, Osceola and Seminole Counties.
3.2	Agencies shall ensure that consumers have exhausted access through other funding sources prior to issuing a food voucher or gift card.	2.2	Documentation in PE demonstrates Ryan White is the "Payer of Last Resort".
3.3	Agencies distributing supermarket gift cards shall have policies and procedures in place to safely store and track the distribution of gift cards.	3.3	Gift Card distribution policy and procedure reflects safety procedures and tracking mechanisms.
3.4	Agencies distributing gift cards shall ensure that consumer receipts are submitted prior to the distribution of additional gift cards.	3.4	Receipts uploaded into consumer Provide Enterprise (PE) file.

3.5	Agencies distributing gift cards shall ensure that consumer receipts include only allowable items.	3.5	Receipts in PE reflect only allowable items.
3.6	Agencies distributing gift cards and/or Food Vouchers shall ensure that no more than $50/consumer is distributed per month unless pre-approved by the Recipient's Office.	3.6	Gift card and/or Food Voucher tracking mechanism indicate that no more then $50/consumer is distributed monthly without prior approval.
3.7	Gift cards shall be from supermarkets that facilitates the use of gift cards for allowable items only.	3.7	Gift Cards specifies the unallowable items.

4.0 Continuous Quality Improvement

The objective of the Continuous Quality Improvement standards shall be to ensure that all agencies comply with the legislative requirement of maintaining quality management programs.

4.0 Continuous Quality Improvement

	STANDARDS		MEASURES
4.1	Agencies shall ensure that access to the food storage area, in food pantries, is limited, and that it is locked when no food handling or distribution is taking place.	4.1	Observation upon site visit.
4.2	Agencies shall receive consultation from a registered and/or licensed dietitian regarding the nutrition, caloric needs, and other dietary issues of HIV+ persons, and has incorporated that guidance into its food pantry program; and consultation should be done on an annual basis and must be documented.	4.2	Documentation of consultation in agency files.
4.3	Agencies shall ensure that perishable foods are disposed of in accordance with Florida Department of Health guidelines. Nonperishable	4.3	Observation upon site visit and written policy and procedure in place for the disposal of perishable and non-perishable food items.

	foods should be disposed of if there is evidence of spoilage, damage, or package tampering.	

Medical Transportation Services

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

Medical transportation may be provided through:

- Contract with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables consumers to travel to needed medical and support services, but should not in any case exceed the established rates for federal programs
- Purchase or lease of organizational vehicles for consumer transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

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

Eligibility:
Consumers accessing transportation shall be at or below 150% FPL

1.0 Responsibility of Case Management Agencies

The purpose of the responsibility of case management agencies is to establish the scope of work for the coordination of Medical Transportation..

1.0 Responsibility of Case Management Agencies

	STANDARDS		MEASURES
1.1	Ryan White is the Payer of Last Resort and as such transportation services shall be provided only to consumers who can demonstrate that all other non-Ryan White transportation services alternatives	1.1	Documentation that the consumer has exhausted all alternative means of obtaining transportation services. (e.g. denial of Medicaid or Medicare)

	have been exhausted, including Medicaid, Medicare.		
1.2	Agencies shall ensure that consumers receiving door-to-door transportation meet the following criteria: • The income requirement; • Are ineligible or have exhausted benefits under Medicaid, Medicare or Advantage Transportation; • Have one core or support services (including food bank services) within 30 days; and, • Live more than ¾ mile away from a bus route or cannot physically use the bus.	1.2	Documentation in Provide Enterprise (PE) record of eligibility, record of scheduled appointment and/or completed Transportation Checklist form and documentation should reflect the type of medical and/or support service appointment for each authorized trip (bus pass/door-to-door).
1.3	Agencies shall ensure that consumers receiving a 30-day bus pass meet the following criteria: • The income requirement; • Are ineligible or have exhausted benefits under Medicaid, Medicare or Advantage Transportation; • Have two or more core or support services (including food bank services) appointment on different days within 30-day; and, • Live less than ¾ of a mile away from a bus stop.	1.3	Documentation in PE record of eligibility, record of scheduled appointment and/or completed Transportation Checklist form and documentation should reflect the type of medical and/or support service appointment for each authorized trip (bus pass/door-to-door).
1.4	Agencies shall ensure that consumers receiving a 1-day bus pass meet the following criteria: • The income requirement; • Are ineligible or have exhausted benefits under Medicaid, Medicare or Advantage Transportation; • Have one core or support	1.4	Documentation in PE record of eligibility, record of scheduled appointment and/or completed Transportation Checklist form and documentation should reflect the type of medical and/or support service appointment for each authorized trip (bus pass/door-to-door).

	services (including food bank services[1]) appointment on different days within 30-day; and, • Live less than ¾ of a mile away from a bus stop.		
1.5	Agencies shall insure that consumers accessing transportation services are provided a copy of the Ryan White Consumer's Transportation Service guidelines and the Accessing Ryan White Transportation Brochure.	1.5	Signed receipt in consumer file that the consumer has received a copy of the RW guidelines and brochure.

2.0 Employment Requirements

The agency or other selected service providers must ensure the following employment requirements are met.

2.0 Employment Requirements for Transportation Provider

	STANDARDS		MEASURES
2.1	Physical examination must be performed prior to employment and at least annually thereafter.	2.1	Documentation on file of completed satisfactory physical exam by the conveyance or dispatch employee.
2.2	Use of certified approved laboratory facility for pre-employment, random, and post-accident drug urine screenings is required.	2.2	Documentation of testing by certified/approved laboratory screening and results in the employee file.
2.3	Department of Motor Vehicles driver's license check with no more than six (6) points in a three (3) year period checked quarterly. No reckless driving convictions or driving under the influence of drugs or alcohol allowed regardless of the conviction date.	2.3	DMV report in personnel record reflecting that the employee met the criteria outlined in 2.3 for inclusion
2.4	Photocopy of the employee's valid	2.4	Documentation in personnel record

	Florida driver's license		of the employee's driver's license. Random review of drivers to ensure identification is properly displayed.
2.5	Drivers will complete the following training within 90 days of hire: • Passenger Assistance Training (P.A.T.), or equivalent training to ensure staff learns the safe and proper techniques for assisting a consumer in and out of the vehicle, for loading and securing wheelchair-bound consumer, and for assisting visually impaired consumers; • A 4-hour Defensive Driving Training Course (D.D.T.C.) including a road test at the end of class, to ensure staff learns to employ safe defensive driving techniques; • Current C.P.R./A.E.D. and First Aid Basics Training • OSHA and US Public Health Service Guidelines.	2.5	Documentation of training that reflects the minimum requirements in 2.5 in personnel file
2.6	Transportation Service vehicles shall be maintained in working condition and shall contain features that make the vehicle accessible and usable by customers with disabilities. Such features shall include, but not be limited to lifts, ramps, securement devices, signage, and systems or facilitate communication with customers who have visual or hearing impairment. These accessible features shall be maintained in good working condition and promptly repaired if damaged or otherwise out-of-order. In the event that such features are not available to the customers, due to repair or maintenance, the agency shall take reasonable steps to accommodate customers with	2.6	Vehicle inspection.

	impairment until such features are available.		
2.7	The agency shall not permit drivers to transport passengers other than those identified on the Voucher. Only passengers provided for on the Voucher shall be permitted in the vehicle when transporting customers.	2.7	Policy regarding transportation of non-passengers (name on voucher) available for inspection.
2.8	The agency shall maintain confidentiality of all personal information, as identified in Section 501.71, Florida Statutes ("PI").	2.8	Signed Confidentiality Statements available for inspection. Client Satisfaction Survey results will also be used to assess this standard.

3.0 Quality Management

The provider must ensure courteous door-to-door service.

3.0 Quality Management

	STANDARDS		MEASURES
3.1	Drivers shall be scheduled to make pickups at least one (1) hour prior to scheduled appointment. For trips requiring special scheduling, arrangements shall be made by provider based on travel distance and/or special circumstances. Return trips will be scheduled based upon routing priority at completion of appointment. Return pickups shall be made within one (1) hour of call; drivers anticipating longer wait times will need to notify the consumer. Drivers shall attempt to contact consumers to confirm appointments and pickup time at least 24 hours prior to scheduled appointment. Trips requiring special scheduling, arrangements shall be based upon the provider's travel schedule and case-load.	3.1	Documentation of ride including pick up, arrival, and drop off time is annotated in a log and updated daily.

3.2	Drivers shall immediately report any type of incident or unusual occurrence to the Recipient's Office.	3.2	Documentation of incident report on file and faxed copy to Recipient's office at the time the report is made and documented.
3.3	Drivers are not permitted to transport a passenger under the age of 18 years old without adult escort, no exceptions.	3.3	Documentation in trip log of the age of each consumer transported after verification on Driver's License.
3.4	Drivers are only permitted to transport a passenger to the destination noted on his/her voucher unless the Recipient dispatcher grants permission.	3.4	Documentation of transportation voucher that will be provided as part of the monthly report to the Recipient.

Substance Abuse - Residential

Definition:
Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital).

Substance Abuse Services (residential) is permitted only when the consumer has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the Ryan White Program.

Acupuncture therapy may be allowable under this services category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the Ryan White Program.

Note: Ryan White funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

Unit of Service:
A unit is defined as one bed-day.

Eligibility:
Consumers shall meet eligibility requirements as defined in the System-Wide Standards of Care.

1.0 Agency Policies and Procedures

The Agencies shall have Policies and Procedures to ensure that the Services are accessible to all eligible consumers. The Agency's' policies and procedures shall ensure compliance with the following Standards.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	Comply with Florida Administrative Code Chapter 65D-30.007 and	1.1	Current licensure displayed. • Staff resume, license, and

	Chapter 397 of Florida Statutes.		certifications on file
1.2	Providers shall maintain awake, paid staff coverage 24 hours-per-day, 7 days per week.	1.2	Staffing plan demonstrates the required staff coverage.
1.3	No primary counselor shall have a caseload that exceeds 15 currently participating consumers.	1.3	Caseloads reflect the requirement.

2.0 Scope of Service

Agencies shall comply with all of the requirements outlined in this Standard of Care, unless otherwise specified in their contract.

2.0 Scope of Service

	STANDARDS		MEASURES
2.1	There shall be three levels of residential treatment. In each level, treatment shall be structured to serve consumers who need a safe and stable living environment in order to develop sufficient recovery skills for the transition to a less restrictive level of care or reintegration into the general community in accordance with placement criteria. Treatment shall also include a schedule of services provided within a positive environment that reinforce the consumer's recovery, and consumers shall be placed in a level of residential treatment that is based upon their treatment needs and circumstances. • **Level 1** – Therapeutic Communities (TC) or some variation of TC and length of stays (LOS) are shorter in term than level 2. This level is appropriate for persons characterized as having	2.1	Placement criteria reflect the required levels of residential treatment. Assessment and treatment plan reflects the appropriate level of care.

chaotic and often abusive interpersonal relationships, extensive criminal justice histories, and prior treatment episodes in less restrictive levels of care, inconsistent work histories and educational experiences, and anti-social behavior. In addition to clinical services, considerable emphasis shall be placed on services that address the consumer's educational and vocational needs, socially dysfunctional behavior, and need for stable housing upon discharge. It shall also include services that assist the consumer in remaining abstinent upon returning to the community.

- **Level 2 –** Domiciliary Care (DC). LOS is generally longer term than Level 1. This level is appropriate for persons whose cognitive functioning has been severely impaired from the chronic use of substances, either temporarily or permanently. This would include persons with varying degrees of organic brain disorder or brain injury or other problem that require extended care. The emphasis shall be on providing services that work on cognitive problems and activities of daily living, socialization, and specific skills to restore and maintain independent living. The services are typically slower paced, more concrete and repetitive. There shall be considerable emphasis on relapse prevention and reintegration into the

	community. This shall involve considerable use of case management and networking residents into ancillary or wrap-around services such as housing, vocational services, transportation, and self-help meetings. • **Level 3 –** Transitional Care and LOS are generally short-term. This level is appropriate for consumers who have completed levels 1 or 2. This includes consumers who have demonstrated problems in applying recovery skills, a lack of personal responsibility, or a lack of connection to the world of work, education or family life. Although clinical services shall be provided, the main emphasis shall be on services that are low-intensity and typically emphasize a supportive environment. This would include services that focus on recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the world of work, education and family life.	
2.2	Each consumer shall receive services each week. The services shall include a specified number of hours of counseling as provided for below: • Level 1- each client shall receive services in accordance with subsection 65D-30.007(3), F.A.C, including at least 10 hours of counseling;	2.2 Documentation in consumer clinical record reflects the specified services in accordance with the needs of the consumer as identified in the treatment plan.

	• Level 2 - each client shall receive services in accordance with subsection 65D-30.007(3), F.A.C, including at least 4 hours of counseling; and, • Level 3 - each client shall receive services in accordance with subsection 65D-30.007(3), F.A.C, including at least 2 hours of counseling.		
2.3	With the exception of counseling, it is not intended that all services listed below be provided. However, services shall be provided in accordance with the needs of the consumer as identified in the treatment plan as follows: • Individual counseling; • Group counseling; • Counseling with families; • Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle; • Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management; • Non-verbal therapies such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the consumer with alternative means of self-expression and problem resolution;	2.3	Documentation in consumer file clinical record reflects the specified services in accordance with the needs of the consumer as identified in the treatment plan.

	• Training or advising in health and medical issues; employment and educational support services to assist consumers in becoming financially independent; and
	• Mental health services for the purpose of:
	  ○ Managing consumers with disorders who are stabilized;
	  ○ Evaluating consumers' needs for in-depth mental health assessment;
	  ○ Training consumers to manage symptoms; and
	  ○ Timely referral to an appropriate provider for mental health crisis or the emergence of a primary mental health disorder when the provider is not staffed to address primary mental health problems.		

2.4	All consumers must have had a physical exam within the past 6 months. If they have not, one must be provided or coordinated for them.	2.4	Documentation in consumer clinical record of a physical exam
2.5	Each provider shall arrange for or provide transportation services to consumers who are involved in activities or in need of services that are provided at other facilities.	2.5	Documentation of transportation in consumer clinical record.

3.0 Discharge

Consumers who are no longer engaged in Residential Substance Abuse Services

should have their cases closed based on the criteria and protocol outlined in the consumer's treatment plan and the agency's discharge policy in the Policies and Procedures Manual.

3.0 Discharge

	STANDARDS		MEASURES
3.1	Upon face-to-face discharge, consumers shall receive a discharge plan which has been approved by a qualified supervisor.	3.1	Discharge plan will document reason for closure; outline available resources and instructions for follow up, and be signed by the treating provider and a qualified supervisor.
3.2	Each closed consumer record shall contain a discharge summary and an exit interview, where appropriate. **Note: When the treating provider is not able to conduct an exit interview or discharge summary, the reason must be documented in the record.**	3.2	The discharge summary shall document the recent closure in case disposition and shall be reviewed by the clinical supervisor.
3.3	All discharged consumers shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone call; or • Written communication **Note: When the treating provider is not able to conduct an exit interview, reason must be documented in the record**	3.3	The discharge summary shall document an exit interview was offered.
3.4	All discharge summaries shall be documented in Consumer record within 6 months of the last consumer contact.	3.4	Documentation in consumer clinical record

Psychosocial Support Services (Peer Support)

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
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian
- Pastoral care/counseling services.

Note: Psychosocial Support Services in the Orlando EMA shall include Peer Mentoring and Support Group services only.

Eligibility:
Consumers accessing Psychosocial Support Services shall meet the eligibility standards as described in the System Wide Standards of Care.

1.0 Agency Policies and Procedures

The Agencies shall have Policy and Procedures to ensure that the Services are accessible to all eligible consumers. The Agency policy and procedures will ensure compliance with the following Standards.

1.0 Agency Policies and Procedure

	STANDARDS		MEASURES
1.1	Peer mentors shall be self-disclosed HIV+ individuals.	1.1	HIV+ documentation (One of the following) • Western Blot • Confirmatory HIV Test Result • Detectable viral load • Letter from physician
1.2	Peer Mentors shall complete HIV 500 training or the HIV/AIDS in the News (HIV/AIDS 101: Study Guide 2009) DVD training within six months of hire	1.2	Certification of Completion in Personnel file
1.3	Peer Mentors shall complete a Peer Training Program utilizing the Peer Center obtained at	1.3	Certification of Completion in Personnel file

	http://www.careacttarget.org/library/peers/Description-PET-REC-7.pdf, AETC or equivalent source approved by the Grantee's Office		
1.4	The agency shall maintain information about each peer's case load, which includes at a minimum: • Assigned peer mentor • Number of cases per full time equivalent FTE	1.4	Documentation in agency records
1.5	Peer Mentors shall receive 15 hours of training annually and topics shall include: • Establishing rapport and a professional relationship with the consumer; • Methods of engaging individuals and families; • Special issues relating to working with the HIV/AIDS affected/infected Population; • Confidentiality/HIPAA and professional ethics; • Knowledge of public assistance programs, eligibility requirements, and benefits; and • The Agency's emergency plan, disaster relief resources, and planning and procedures. Training shall also include, but not be limited to, cultural sensitivity issues, case management issues, bio-psychosocial issues surrounding the HIV disease, and any other training proposed by the Recipient.	1.5	Documentation of the training subject matter, date(s) of attendance, and hours in training shall be in the training record. Training Certificates shall be in the personnel file.
1.6	Peer Mentor Supervisors shall, at a minimum, meet the following: • Hold a Bachelor's level professional degree in the field of mental health, social work, counseling, social science, or	1.6	Appropriate degree, licensure and/or certification in personnel file.

nursing; (Master's level Degree preferred). **Note: This requirement may be waived by the Recipient.**	

2.0 Responsibility of Peer Mentor Agencies

The purpose of the Responsibility of Peer Mentor agencies is to establish the scope of work for the coordination of psychosocial support

2.0 Responsibility of Peer Mentor Agencies

	STANDARDS		MEASURES
2.1	Peer Mentors shall assess the consumer's knowledge/function and provide guidance in the following areas: • Adherence/compliance • Education • Support • Navigating the system • Advocacy	2.1	Documentation in Provide Enterprise (PE) of the completed Ryan White Quality of Life and Knowledge Assessment.
2.2	Peer Mentor Agencies shall ensure that Peer Mentors receive a copy of the consumer's Case Management Care Plan to facilitate needs and service coordination.	2.2	Copy of Case Management Care plan documented in PE file.
2.3	The Agency shall maintain documentation demonstrating the following: • Regular participation in case conferences; • Determination of goals to be reached with consumer, strategies for resolution, and disposition of each goal; • Review of Case Manager's Assessment and notification of any updates/changes to the consumer's assessment; • Teaching or practicing self-management skills;	2.3	Documentation PE files reflects all required elements.

	• Providing assistance and monitoring progress of consumer's Care Plan developed by their Case Manager or other professional (i.e. Mental Health Provider); • Complementing rather than replacing, the roles of other professionals; • Teaching consumers about safer sex strategies; • Helping consumers understand how HIV medications can help them; • Helping consumers to make decisions about disclosing their HIV status; • Helping consumers to talk openly with their doctors; and • Serving as a critical bridge between consumers and providers.		
2.4	Agencies shall ensure that all PE files provide adequate documentation of the services provided (e.g.) crisis intervention, biopsychosocial assessment, etc.), dates of service, and consistency with the Ryan White Part A Program requirements.	2.4	Documentation in PE file
2.5	Monitor and document consumer's progress in meeting established goals of care.	2.5	A progress note must be done on a consumer for each contact that includes adherence (medical, medication, care plan, etc.), health outcomes, etc.
2.6	All progress note entries shall be signed with the Peer Mentor's full legal name and title. The entry shall also be dated with title and credentials within two (2) days after an interaction with the consumer.	2.6	Progress notes in PE record reflect all requited elements.
2.7	Support/educational group sessions shall be no less than one (1) hour	2.7	Group notes indicate start and ending time of sessions.

	and shall not exceed two (2) hours.		
2.8	Support/educational group sessions shall consist of three (3) or more consumers.	2.8	Sign-in sheet available for inspection
2.9	Providers of support group services shall maintain a sign-in sheet of all participants for each session that is in accordance with HIPAA.	2.9	Documentation of group participation in each consumer's PE file. Sign-in sheet available for review.
2.10	Documentation of each group session and topic shall be maintained in each participant's file.	2.10	Documentation of group participating in consumer PE file.

3.0 Discharge

Consumers who are no longer engaged in psychosocial support services shall have their cases closed based on the criteria and protocol outlined in the agency's Psychosocial Support Policies and Procedures Manual.

3.0 Discharge

	STANDARDS		MEASURES
3.1	All consumers shall be notified of case closures and notification shall include the reason(s) for closure. Whenever possible notification shall be completed in a face-to-face session.	3.1	Documentation of all contact attempts for notification of case closure in PE file.
3.2	Cases may be closed when the consumer: • Has achieved the goals listed on the care plan; • Has become ineligible for service; • Is deceased; • No longer requires the services; • Decides to discontinue the service; • Is found to be improperly utilizing the program; or	3.2	Documentation of reason for case closure in PE file.

	• The service provider is unable to contact the consumer for a determined period of time.		
3.3	Each closed consumer file shall contain a discharge summary and an exit interview, where appropriate. **Note: When the Peer is unable to conduct an exit interview or a face-to-face discharge, the reason shall be documented in the discharge summary.**	3.3	The discharge summary shall document the recent closure and case disposition and shall be reviewed by the Peer Mentor Supervisor.
3.4	All discharged consumers shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone call; or • Written communication. **Note: when the Peer is unable to conduct an exit interview the reason shall be documented in the discharge summary**	3,4	Documentation of completed exit interview in discharge summary in PE file
3.5	Supervisor approval is required for all case closures.	3.5	Supervisor approval documented in PE file.
3.6	All discharge summaries shall be documented in PE record within six (6) months of the last consumer contact.	3.6	Documentation in PE record.