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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Common Standards of Care

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

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Introduction

This document describes the "Common Standards of Care" for all services of HIV Care Program (HCP), a program of the California Department of Public Health, Office of AIDS (OA), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. This document highlights each of the requirements and standards that must be followed by any provider receiving HCP (Ryan White) funding. Common standards addressed here include client eligibility and consent, staffing, cultural and linguistic competency, service management and closure, and quality assurance. These standards must be met or exceeded for all HCP services in all jurisdictions. Users should refer to service category-specific standards for more detailed or additional requirements.

How This Document is Organized

Within this document, the Common Standards of Care are described in terms of (1) Use of HCP Funds, and (2) Requirements.

Use of HCP Funds

1. All clients served by providers funded by HCP shall receive services that:
    - Are accessible to all persons living with HIV who qualify and meet eligibility requirements
    - Include a comprehensive intake process that establishes client eligibility, collects client information, and comprehensively informs them about available services
    - Maintain the highest standards of care, including providing experienced, trained, and (as appropriate) licensed staff
    - Are culturally and linguistically competent
    - Guarantee client confidentiality, protect client autonomy, and protect the rights of persons living with HIV
    - Promote continuity of care, client monitoring, and follow-up
    - Ensure a fair process of grievance review and advocacy
2. Providers must make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients (i.e., Ryan White must be the "payer of last resort").

3. HCP funds are intended to support only the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with HCP funds and the intended client's HIV status.

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4. Affected individuals (partners and family members not living with HIV) may be eligible for HCP services in limited situations, but these services for affected individuals must always directly benefit people living with HIV. For more information see HRSA PCN 16-02 and ARIES Policy Notice C5.

Requirements

All service providers receiving funds to provide HCP services are required to adhere to all standards described in this *Common Standards of Care*. In addition, they must adhere to any service category-specific standards described in the standard of care for that service category. Monitoring is conducted on a yearly basis through desk review and onsite monitoring.

ARIES - AIDS Regional Information & Evaluation System

ARIES is a centralized, secure, online HIV client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by Ryan White-funded service providers throughout California to plan, manage, and report on client data. HCP frequently uses ARIES to conduct monitoring of these Standards of Care.

Intake

Client intake consists of four key steps:

- Eligibility screening
- Consents and notifications
- Client registration
- Screening for service needs / acuity

Eligibility Screening

The certification process verifies that a client's HIV status, residency, income, and insurance status meet eligibility requirements and ensures that HCP is the payer of last resort. Initial eligibility certification includes documentation of the following:

- **Proof of HIV-positive status:** At the first certification, clients must provide proof of HIV-positive status. This must consist of at least one of the following:
    - HIV positive lab results (antibody test, qualitative HIV detection test, or detectable viral load). Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis.

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        - ***NOTE:*** *Rapid linkage to care after diagnosis is a top priority and this is not intended as a barrier; while agencies must have proof of HIV diagnosis and eligibility established before providing HCP-funded services, there is no legislative requirement for a "confirmed" HIV diagnosis prior to care (i.e. initial HIV screening test results is sufficient, though confirmatory testing should be ordered on first visit. See clarifying letter from HRSA on this issue).*
    - Letter from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead with the National Provider Identifier (NPI) number or California license number, and the physician's or a licensed health care provider's signature verifying the client's HIV status.
        - Letters already in client charts that do not meet this standard are grandfathered in; this requirement for letters applies to new intakes conducted after April 1, 2018.
    - Diagnosis Form (CDPH 8440) completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.
- **Proof of Residence:** Individuals eligible for HCP services must reside in the State of California. Acceptable residency verification consists of the client's name and address on one of the following:
    - Current utility bill
    - Current rental or lease agreement
    - Official document, such as a voter registration card, Medi-Cal beneficiary letter, recent school records, property tax receipt, unemployment document, etc.
    - California driver's license or California Identity Card
    - Letter from a shelter, social service agency, or clinic verifying individuals' identity, length of residency, and location designated as their residence. The letter must be on letterhead and signed by a staff person affiliated with the service agency or clinic
    - If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates they are homeless with no connection to any other service provider. In this situation, a referral to assist the client in securing shelter or housing should be a priority. For an example of an affidavit form see the ADAP form CDPH 8727 / CDPH 8727 SP.
- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. HCP financial eligibility matches the financial eligibility defined by ADAP in Health and Safety Code (HSC) § 120960. Currently, HSC § 120960

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defines income eligibility as clients with modified adjusted gross income which does not exceed 500 percent of the federal poverty level per year based on family size and household income. Acceptable income verification includes one of the following:

  - One pay stub from within the last 6 months
  - 1040 Form or W-2 from the previous year
  - Signed and dated letter from a source of earned income, including the client's name, rate, and frequency of pay
  - One bank statement showing income from applicable source(s) (i.e. through direct deposit)
  - Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) letter, or dated screenshots of client benefit program
  - Document confirming other government assistance (e.g., Medi-Cal military/veteran pension benefits, unemployment benefits, child support payments)
  - Investment statement showing interest earned
  - Letter of support signed and dated by an individual providing financial and other living support (food, clothing, and/or shelter) to the client
  - If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates zero income, or attests to earned income not otherwise confirmed by the above. For an example of an affidavit form see the ADAP form CDPH 8441/ CDPH 8441 SP.

- **Insurance Status:** Clients seeking any services through HCP programs must provide documentation of health insurance status. Acceptable verification includes one of the following:
  - Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC) if applicable
  - Dated screenshots of client insurance status verification using an official insurance screening system
  - Denial letter from Medi-Cal
  - Tax statement documenting no insurance, per ACA requirements
  - Statement signed and dated by the client indicating they are not covered by insurance. If client is employed, the statement must include the reason the employer does not provide insurance

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- **Documentation of Need:** In order for providers to pay for services covered or partially covered by Medi-Cal, Denti-Cal, private insurance, or other eligible benefits and retain HCP as the payer of last resort, client charts must include the following:
    - A description of the need for additional medically necessary services, beyond what the client's health care coverage or other benefits provide
    - Documentation indicating that such services are only partially covered or unavailable in a timely fashion through the client's health care coverage or other benefits

  NOTE: *Contractors* and providers *should be aware that HCP funds cannot be used to pay for services provided by a provider not in the client's health care provider network, unless the medically necessary service cannot be obtained through an in-network provider.*

  REMINDER: All HCP providers who provide services that overlap with Medi-Cal or Denti-Cal must be certified to receive Medi-Cal or Denti-Cal payments or are able to document efforts under way to obtain such certifications.

- **Screening for Service Needs / Acuity:** At the time of client intake into any HCP service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance use issues, transportation, and benefits counseling. Screening for services and client acuity can be done using the tools and/or scales of the local jurisdiction, but tools/scales must be standardized within the jurisdiction. Referrals should be made for any services identified as needed but not offered by the screening agency; referrals should be performed utilizing a warm hand off when possible. All referrals must be documented.

Exceptions

In the case of clients with urgent/emergent service needs, it is acceptable to begin providing services having only obtained proof of HIV diagnosis (initial HIV screening test is acceptable per HRSA) and signed consents (see below); in these cases, full eligibility screening and all other requirements must be met within 30 days of service initiation. If this occurs, documentation in the client chart of the circumstances around the need for urgent/emergent services is required.

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Monitoring

Eligibility Screening - Client eligibility, including HIV-positive status, residency, income, and insurance status must be entered into ARIES. Documentation of service needs and acuity must be documented in client chart(s), and made available during site visits.

ARIES Reference

Proof of Diagnosis Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. HIV Letter of Diagnosis 2. Proof of Diagnosis Upload copy of corresponding document *ARIES Policy Notice No. C3*	Residency Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. Picture ID 2. Proof of Residency
Income Eligibility Tab Financial Sub-tab Enter: Household Monthly Income # of People in Household	Insurance Eligibility Tab Insurance Sub-tab Click *New* Enter: Start Date Source Payer *ARIES Policy Notice No. C4*

Consents

Prior to receiving services, clients must sign the following consent forms:

- **Agency Consent for Service:** Clients must sign a consent form indicating they consent to receiving services from the agency
- **ARIES Consent:** Providers must obtain a completed ARIES Consent Form for each client and log the form into the Eligibility Documents screen in ARIES. Clients must indicate whether they want to share their ARIES data with other ARIES-using agencies at which they receive services. Information shared may include demographics, contact information, medical history, and service data. However, data related to mental health, substance use issues, and legal services are never shared between service providers regardless of the client's share choice.
    - The form must be renewed once every three years or whenever clients want to change their data-sharing choice. For more information, refer to ARIES Policy Notice C1 on Client Consent and Share Options.

On an as-needed basis, the following must also be documented via forms signed by the client:

- **Consent to Release Confidential Information (not the same as ARIES Consent Form):** When disclosure of confidential information is requested by the client, or

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required for care coordination or other necessary components of high-quality service provision, the client must be informed of this intent to share information and must provide written consent before the information is shared. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.

- **Authorization to Exchange Confidential Information (not the same as ARIES Consent Form)**: Similar to the consent to release confidential information, when appropriate, clients may also provide consent for regular exchange of information about their case between providers as it helps with care coordination. Again, the client must provide written consent **before the information is shared**. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
    - *NOTE:* Case conferencing between staff of the same organization which takes place on a regular basis and is a standard part of many HCP services does not require additional authorization. However, if staff from outside the organization are needed to conduct thorough case conferencing, prior authorization to exchange information would be required.

All signed consents must be kept in the client's file, and the client must receive a copy.

Monitoring

Agency Consent for Service - Signed consent forms shall either (1) be uploaded to ARIES, or (2) retained in client chart(s) and available for review upon request.

ARIES Consent - ARIES Consent Forms must be logged into ARIES and the Share option must reflect the client's choice as reflected on the form. For more specifics, see ARIES Policy Notice C1.

Authorization to Exchange Confidential Information - Documentation of consent to release or exchange confidential information must be retained in client chart(s) and available for review upon request.

ARIES Reference

ARIES Consent Form
Eligibility Tab
Eligibility Documents Sub-tab
Pick ARIES Consent Form / Enter date

Share Option
Agency Specifics Tab
Agrees to Share Date / Select Yes or No

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Notifications

As a part of HCP services, clients should be notified of the following:

- **Case conferencing** among staff involved in the provision of any of their care occurs regularly as a standard part of HCP services
- **Re-engagement services** are routinely provided by this provider and/or the county health department to ensure that clients have uninterrupted access to care services. This requires sharing of contact information as needed for these services
- **After-hours or weekend options** that are available to clients during an emergency (i.e. an on-call number, answering service, or alternative contacts in other agencies)
- **HIPAA:** Clients must be informed of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) where applicable
- **Client Grievance Procedures:** Clients must be informed of the grievance procedures within their local jurisdiction, and assured that no negative actions will be taken toward them as a client in response to their filing of a grievance
- **Client Rights and Responsibilities**: Clients must receive notice of their rights and responsibilities relative to HCP service provision. This must include the minimum rights and responsibilities outlined later in this Common Standards of Care document.

Clients must receive a written copy of all notifications provided during intake.

Monitoring

Client Notification - Client notification of case conferencing, re-engagement services, and after-hours / weekend emergency options must be documented through submission of agency written policies and procedures and forms related to these notifications.

Client Notification with Signature - Client notification of HIPAA, client grievance procedures, and rights and responsibilities must be documented in client chart(s) and available upon request for review. There must be documentation that the client has received these notifications; documentation shall be through client signature that they have received and acknowledged these notifications.

Client Registration into ARIES

HCP providers must report on the HCP clients they serve using ARIES.

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For new clients, HCP providers must explain the "share" options to the client and obtain a signed ARIES Consent Form (see ARIES Policy Notice C1). Providers shall also collect the client's identifiers to initiate client registration in ARIES. Identifiers include all of the following:

- First Name
- Middle Initial
- Last Name
- Mother's Maiden Name (see **ARIES Policy Notice C2**)
- Date of Birth
- Current Gender

To initiate ARIES registration, the HCP provider enters these identifiers into ARIES. If the client already exists in ARIES as a share client, ARIES will open the existing client record for the provider. If the client is non-share or new to ARIES, ARIES will create a new client record for the provider.

While the client is enrolled in the agency, the HCP provider is required to collect and enter into ARIES certain data elements for the annual Ryan White Services Report (RSR). These data elements are identified with large red asterisks in ARIES. For more details about and provider requirements for the RSR, please visit https://careacttarget.org/category/topics/ryan-white-services-report-rsr.

Timeframe

Intake appointments for new clients should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days from first client referral. A referral can be from another professional or self-referral. Agencies must have a tracking method to record when first contact was made so it can be entered in to ARIES. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours as client missed appointments have been linked to future poor health outcomes. Missed appointments and attempts to reschedule must be documented in the tracking log or the client chart. For appointments made later than 10 days from first client referral, the reason for the delay must be documented in the client chart.

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Monitoring

Timeframe for intake appointments for new clients will be monitored through site visit discussions regarding MOUs with referring agencies and internal processes. For those who do not have an automated system to track new referrals, a log of such referrals must be kept and available for review.

ARIES - data must be recorded for ARIES fields *Referral Date, Agency Enrollment Date,* and *Service Date.* Reasons for any delay in intake appointments beyond 10 days – or any exceptions made for urgent/emergent services per above – must be documented in client chart(s) and available for review upon request.

ARIES Reference

Demographics Tab Agency Specifics Sub-tab	Services Tab Enter date of first service
1. Step One, enter: • Referral Date (date of first contact) • Referral Source • Other 2. Step Two, enter: • Agency Enrollment Date	

Recertification

Eligibility recertification must be repeated at least every six months. At the six-month recertification, a client can self-attest that they continue to meet the established guidelines by signing a form with an appropriate statement. However, complete eligibility documentation is required 12 months after the initial intake or last annual recertification. (for an example of a self-attestation form see the ADAP form CDPH 8723 / CDPH 8723 SP):

- **Proof of Residence:** Continued proof of California residency must be documented. Acceptable residency verification is the same as that required for initial eligibility certification.
- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. Acceptable income verification is the same as that required for initial eligibility certification.
- **Insurance Status:** Clients must provide documentation of health insurance status. Acceptable verification is the same as that required for initial eligibility certification.

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Screening for Service Needs / Acuity: At least every six months, all clients must be re-assessed for service needs and acuity level. Screening can be done using the tools and/or scales of the local jurisdiction, but these tools/scales must be standardized within the jurisdiction and documented in the client chart. Services provided to that client should be adjusted according to any changes in client needs/acuity since the last assessment.

Monitoring

Six-Month Recertification - Eligibility recertification of residency, income, and insurance status must be documented at least every six months. Client self-attestation forms can used for six-month recertification and can be uploaded to ARIES or saved in the client file.

Annual Recertification - Annual recertification of residency, income, and insurance status must be documented in ARIES. Agencies must have updated documentation of these elements in client chart(s), available for review upon request.

ARIES Reference

Step One:	Step Two:
Go to Eligibility Tab Update information on all three sub-tabs as needed (see eligibility section above, HIV Diagnosis does not need to be repeated) Upload self-attestation (optional)	Go to Program Tab, Ryan White sub-tab Enter recertification date and information Note “recertification” in comment field.

Service Access, Management, and Closure

Client Access

Services must be planned and implemented in a way that ensures an accessible environment. Services must:

- Provide adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments
- Not be restricted on the basis of age, gender, sexual orientation, race, ethnicity, disability, past or current health condition, ability to pay fees, residence, or any other discriminatory factors, as applicable, under the California Unruh Civil Rights Act and Disabled Persons Act (except as required for eligibility purposes.)

Service Management

Services must take into account client needs and remove barriers to clients’ ability to meet the requirements of their care/treatment plans, as follows:

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- Services must be managed to achieve:
    - Accessibility
    - Effectiveness
    - Reliability
    - Timeliness
    - Appropriateness to the needs of clients

Monitoring

Accessibility - Existence of adequate physical accommodation(s) for disabilities and/or impairments of clients, will be verified during site visits.

- Services must include activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency, including but not limited to:
    - Access to non-HCP-funded services
    - Resource guides to low-cost/free medical and support services, including those not offered as part of HCP

In addition, services must be transparent and fiscally responsible:

- Services should be planned, managed, and monitored to avoid the need for:
    - Urgent or emergency services
    - Service interruption
    - Needing emergency or unplanned funding to continue services during contract periods.
- Data collection and documentation of all services must be manually entered or imported into ARIES for accounting, reporting, compliance, and evaluation purposes. The optimum goal for entering data into ARIES is in real-time. Some providers may not be able to meet this goal due to staffing levels, lack of computers, or other business practices. Providers that are unable to enter data in real-time have up to two weeks from the service date to enter the data. For more information, please see ARIES Policy Notice E1.
- Program directors and managers shall ensure contract compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.

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- Service providers must have a way to obtain client input and feedback on an annual basis. The ideal method would be a "client advisory board" that consists of representation of the population served and provides input to the delivery of services. In lieu of an advisory board, providers can provide a visible suggestion box which is locked or other similar client input mechanism such as client satisfaction survey.

Monitoring

Client Input – copies of minutes from annual client advisory board meetings, or client suggestions or surveys will be reviewed during site visit.

Case Closure

In some cases (e.g. a client who is incarcerated for longer than 6 months) a client file may be made "inactive," able to easily be returned to "active" status when the client returns to services as expected. A client file may be permanently "closed" under certain conditions. The reason for and circumstances around all closure actions must be documented in the client file or in ARIES. Acceptable reasons for client file closure are:

- The client has requested transfer of services to another agency
- The client has died or moved out of California
    - Providers are strongly encouraged to report clients who have died or moved out of California to the HIV surveillance coordinator at the local public health department. This will allow the coordinator to update the surveillance system and ensure that the county's data accurately reflect who is in care.
    - Providers should attempt to assist the client with identifying a source of care in the jurisdiction they are moving to.
- The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period.
    - Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities.
- The client is no longer eligible or has failed to provide updated documentation of eligibility status

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    - Providers must be proactive in helping clients obtain this information. No client should be discharged before staff have assisted the client with gathering the required documentation.
- The client's actions have put the agency, staff, and/or other clients at risk
- There is evidence of client fraud or deliberate misuse of services
- Additional service-specific circumstances for closing a client file may be found in the Standard of Care for an individual service.

File Closure: Agencies should close a client's file according to the written policies and procedures established by the agency.

- **Prior to closure** (for reasons other than death), the agency must attempt to inform the client of the appeal process and re-entry requirements into the system, make clear to the client the consequences of closing the case, and offer to facilitate transfer of information to a new provider.
- **Prior to forced disenrollment and case closure due to evidence of abusive behavior, client fraud, deliberate misuse of services, or service ineligibility**, the client must:
    - Be given at least 10 days' notice before disenrollment, except in cases of abusive behavior that poses serious physical danger to staff or clients
    - Be sent a letter that verifies the disenrollment date and reason for the action, along with information about the procedure for grievance/appeals. This letter must be legible, signed, and dated, and a copy must be kept in the client record

Record Maintenance: Client files must be retained in a secure place for a minimum of three years, or later as is required by law for your facility type, after a case is closed. After that time period, they must be disposed of securely through confidential means such as cross cut shredding and pulverizing.

Monitoring

File Closure - Appropriateness of file closure will be monitored via chart review during in-person site visits. Agency policies and procedures for file closure, as well as compliance with record maintenance standards, will be monitored through agency submission of applicable written policies and procedures.

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Client Rights and Responsibilities

Information in this section must be included in a client Rights and Responsibilities form. Clients must sign an acknowledgement of having received this information.

All eligible clients have the right to:

- Request and receive approved services consistent with their care/treatment plan
- Receive services that are reliable, timely, respectful, and appropriate to their situation, culture, health status, and level of disability
- Receive accurate and easily understood information about their care plan, health care professionals, and health care facilities
- Participate in decisions about their care and obtain information about treatment options
- Refuse care
- Have their healthcare information be treated confidentially
- Review their client records (including medical records) and request that any inaccurate, irrelevant, or incomplete information be changed as per local policies and procedures.

Clients are responsible for:

- Providing documentation to verify their eligibility for HCP services
- Being involved in their healthcare and adhering to their treatment plan
- Disclosing relevant information
- Clearly communicating their wants and needs
- Treating service providers appropriately and with respect at all times
- Arranging services in a way that avoids emergencies whenever possible
- Maintaining periodic contact with their relevant service provider
- Following provider written policies and procedures and guidelines
- Following written or verbal instructions regarding treatments, activities, safety policies, and utilization of services

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Monitoring

Client Rights and Responsibilities – A copy of the client form outlining Client Rights and Responsibilities must be provided. Review of client acknowledgment will be done via chart reviews.

Staffing Requirements and Qualifications

Education / Experience / Supervision

All staff must hold the appropriate degrees, certification, licenses, permits or other qualifying documentation as required by Federal, State, County, local authorities, or HCP Standards of Care. See each specific service standard for detailed requirements by service.

Monitoring

Staff Education and Experience - Proof of required staff degrees, certification, licenses, permits, or other qualifying documentation must be available for review during site visits.

Staff Orientation and Training

Initial: All staff providing direct services to clients or making decisions about HIV service must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Navigation of the local HIV system of care, including ADAP
- Confidentiality and Security
- Cultural sensitivity, including but not limited to LGBTQ cultural competence, cultural humility, and social determinants of health

Other topics may include:

- Psychosocial issues
- Health maintenance for people living with HIV
- Client service expectations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Confidentiality agreements by staff must be reviewed and re-signed annually.

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Training requirements and updated confidentiality agreements must be clearly documented, and completed trainings must be tracked for monitoring purposes.

Monitoring

Staff Orientation and Training - Agencies must maintain a comprehensive list of staff with hire date, all trainings provided, dates of trainings, and dates of refreshed confidentiality agreements; this list must be available for review during site visits or upon request.

Cultural and Linguistic Competency

According to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), culturally and linguistically competent services are those that "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs." Providers shall provide services that:

- Treat people living with HIV with respect, and are skilled and culturally-appropriate for the communities served
- Reflect the culture of the community served
- Comply with American Disabilities Act (ADA) criteria
- Are in a location and have hours that make it accessible to the community served
- Are provided in the client's primary language. If that language is not English, interpretation must be provided by a staff member or other means
- Are provided in areas with posted and written materials in appropriate languages for the clients served
- Provide interpreters or access to real-time interpreter services (including phone, Skype, etc.) For HIPPA covered services, interpretation services must follow HIPPA requirements; family and friends should not be used for interpretation. For non-HIPPA covered services, family and friends should only provide interpretation as a last resort and with the prior permission of the client.

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Monitoring

Culturally and Linguistic Competency - Compliance with CLAS Standards, including ADA criteria and accessible location/hours of services, will be monitored via direct observation of site setup and function during site visits.

Fiscal Responsibility

Payer of Last Resort

Federal legislation states that Ryan White funds are the payer of last resort. This means that no HCP funds can be used for services that could reasonably be paid for or provided by another funding source. Providers are required to screen all clients for eligibility for other programs such as Medi-Cal, Denti-Cal, private insurance (including Covered California plans), Cal-Fresh (SNAP), etc. While there are limitations on when clients can sign up for Covered California as defined by open enrollment dates, providers should be aware that there are special enrollment periods for certain circumstances (e.g., divorce and loss employment). There are no restrictions when a person can sign up for Medi-Cal or Cal-Fresh as these programs have on-going enrollment. Providing benefits counseling to clients must involve working with eligibility workers from other programs to assist HCP clients with the process of signing up for those programs.

Ryan White legislation also states that other funding sources must be utilized prior to Ryan White funds being used. However there are times that HCP can pay for services covered by other funding. To pay for services covered by Medi-Cal, Denti-Cal, private insurance or other programs, service providers must provide documentation of the need for additional services beyond what the client's health care coverage or other benefits provide or if an exception was made due to no available provider. Funds cannot be used to pay for services from a provider not in the client's health care provider network, unless the medically necessary service cannot be obtained through an in-network provider.

The Department of Veterans Affairs (VA) – HCP service providers may not deny services, including prescription drugs, to a veteran who is otherwise eligible to receive HCP services. Providers may not cite the "payer of last resort" language to compel a veteran living with HIV to obtain services from the VA health care system or refuse to provide services. However, the VA system differs from other payers because of its unique structure as an integrated care system under which the VA may serve as both payer and provider. The VA is not an insurance or entitlement program. Providers should work with the local VA to ensure clients receive all needed core and support services. HCP can pay for services that are unavailable from the VA. For more information see HRSA Policy Notice 16-01.

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Indian Health Services (IHS) programs are exempt from the payer of last resort mandate. For more information see HRSA Policy Notice 07-01.

Quality Assurance

Service Evaluation

Each service provider is responsible for evaluating and reporting its performance relative to care standards, and is subject to client chart, utilization, and other types of audits. Service providers must:

- Collect and examine client satisfaction data, and have a process to act on the information reported
- In response to any findings as part of routine HCP monitoring, develop and implement a Corrective Action Plan (CAP)
- Maintain a grievance procedure which provides for the objective review of client grievances and alleged violations of care and service standards
    - Clients must be routinely informed about and assisted in utilizing this procedure
    - Clients must not be discriminated against for utilizing the grievance procedure
- Have a client complaint procedure which addresses issues not appropriate to the grievance procedure. Complaints will be investigated and responded to in a timely and respectful manner according to local written policies and procedures. Documentation of investigation and response should be maintained in writing and kept separate from the regular client file

Monitoring

Quality Assurance –A copy of the Grievance Policy must be provided to HCP. Oversight of submitted client grievances will occur during site visits. The Grievance Policy may be incorporated into the Client Rights and Responsibility form

Clinical Quality Management - For clinical services, comply with requirements in the California Ryan White Part B Clinical Quality Management Plan

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HIPAA Compliance and Non-HIPAA/HITECH Contractors/Providers

- All providers of HIPAA-covered services will comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All HIPAA regulations must be followed when interacting with or on behalf of a client, and with regards to record maintenance.
- All non-HIPAA covered contractors and providers (including tax preparation professionals, accountants, law firms, etc.) must comply with the Information Privacy and Security Requirements set forth in the HCP/MAI contract.
- All contractors and providers must have their employees and volunteers sign the Agreement by Employee/Contractor to Comply with Confidentiality Requirements (CDPH 8689) upon hire prior to having access to any confidential information and on an annual basis thereafter.

Monitoring

Confidentiality Compliance - Signed agreements to comply with confidentiality requirements (CDPH 8689) must made available during site visits.

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Early Intervention Services (EIS)

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1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Working Draft

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Introduction

This document describes the "Food Bank / Home-Delivered Meals" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Food Bank/Home-Delivered Meals, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Food Bank/Home-Delivered Meals refers to the provision of actual food items, hot meals, or vouchers to purchase food. This also includes the provision of essential non-food items. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service, covered under the Medical Nutrition Therapy standard.

Allowable costs under the Food Bank/Home-Delivered Meals standard include:

- Food items
- Hot meals
- Vouchers used to purchase food
- Nutritional supplements, such as Ensure, may only be used in addition to food and not as the only offering to a client.

Allowable essential non-food items are limited to the following:

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

Unallowable Activities

Unallowable costs under the Food Bank/Home-Delivered Meals standard include:

- Household appliances
- Pet food
- Alcohol, tobacco, or cannabis products

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- Clothing
- Other non-essential products
- Cash payments to clients
- The provision of food is essential to wellbeing and must be based on need. It should not be used as an incentive to motivate clients to attend on-going appointments or take medication

Monitoring

Allowable Costs - Verification that funds are being used only for allowable costs will be conducted via submission of budgets and invoices, and HCP desk audit of services.

Fiscal Management

There are additional requirements when utilizing vouchers or store gift cards.

- Providers must ensure that vouchers or store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services. Some stores may require program vouchers to exclude certain products such as tobacco and alcohol.
- General-use prepaid cards are considered "cash equivalent" and therefore unallowable. Such cards generally bear the logo of a payment network (e.g., Visa, MasterCard, or American Express) and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are co-branded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore not allowed.
- Providers must have systems in place to account for disbursed vouchers. The systems must track the client's name, the staff person who distributed the voucher, the date of the disbursement, and serial number and the voucher dollar amount. These data elements can be tracked on the ARIES Services screen if no other tracking system is available.
- Providers should only buy vouchers in amounts that are reasonable for use in the contract year. In no case should use of vouchers lead to large amounts of Ryan White monies being held over to new contract years.

Monitoring

Fiscal Management - Management of vouchers per the bullet points above will be monitored through agency submission of written policies and procedures for accounting of disbursed vouchers, desk audit of submitted budgets and invoices related to purchase of specific types of vouchers or gift cards, and site visit verification of the use of these products.

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Objective

Food Bank/Home-Delivered Meals provides access to healthy and nutritious food or meals through the distribution of actual food or food vouchers in order to help maintain caloric intake and balanced nutrition in a manner consistent with each client's care plan when applicable.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards. Staff preparing food must be familiar with safe food handling practices and meet any federal, state, or local requirements around food preparation.

Staff Orientation and Training

Initial: All Food Bank/Home Delivered Meals staff must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- Safe food handling procedures
- Confidentiality
- Knowledge of key points of entry for other Ryan White services

Monitoring

Training - Training on safe food handling procedures will be monitored through submission to HCP of evidence of appropriate training, with a date of training prior to the start of service provision.

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

Agency

Any agency providing Food Bank/Home-Delivered Meals must comply with federal, state, and local regulations, including any required licensure or certification for the provision of food bank services and/or home-delivered meals. Where applicable, this also includes adherence to any necessary food handling standards or inspection requirements.

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Monitoring

Regulations - Agencies providing these services will be asked to provide to HCP a copy of their environmental health inspection, as well as any applicable licensure/certification. If these items are not applicable or not available, compliance will be monitored through site visit observation.

Service Characteristics

***Eligibility Screening*:** If the Food Bank/Home-Delivered Meals provider is the client's first contact with HCP, the client must be screened for eligibility as part of a formal intake, as described in the Common Standards of Care.

***Referral*:** Refer clients ineligible for Food Bank/Home-Delivered Meals services through HCP to another community-based organization or link them to another safety net provider as appropriate. Documentation of that referral must be in the client file and available upon request.

Monitoring

Referrals - Processes for referring ineligible clients to other CBOs or service providers will be monitored through discussion of these scenarios during site visits.

Orientation

Each new client enrolled in Food Bank/Home-Delivered Meals must receive an orientation to the services; document this orientation in the client file.

Monitoring

Orientation - Agencies will be asked to submit a policy related to orientation of new clients in this service category; documentation of these orientations will be monitored via site visit observation, discussion, and/or chart review.

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Health Education/Risk Reduction

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1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

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Introduction

This document describes the "Health Education/Risk Reduction" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Health Education/Risk Reduction, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

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

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

Key Activities

Health Education/Risk Reduction may be provided in individual and group settings. These programs should be delivered only to clients; affected individuals (partners and family members not living with HIV) are not eligible unless receiving services concurrently with the client. Health Education/Risk Reduction may NOT be delivered anonymously.

Objective

Health Education/Risk Reduction is intended to reduce HIV transmission by providing clients living with HIV with knowledge of risk factors for HIV transmission and actions they can take to reduce risk of transmission.

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Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards for Health Education/Risk Reduction staff. All Health Education/Risk Reduction staff must be trained and knowledgeable about HIV and familiar with available HIV resources in the area. They should have good communication skills and be culturally competent.

Regardless of education/training, staff should be experienced in all of the following:

- Health education/risk reduction strategies and best practices
- HIV transmission and prevention
- Local HIV service delivery system, especially medical and support services and counseling

Individual supervision and guidance must be available to Health Education/Risk Reduction staff as needed.

Staff Orientation and Training

Initial: All staff providing Health Education/Risk Reduction must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

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

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

Service Characteristics

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

HIV education: Clients should always be provided with HIV risk reduction and prevention education, partner services information, and an overview of the HIV service delivery system including clear information on how to access those services. Clients must also be provided with counseling about how to improve their health status and reduce the risk of HIV transmission to others.

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Monitoring

HIV Education - Adherence to the above standards related to HIV education and counseling content will be monitored through agency submission of materials and counseling protocols used.

Referral / Linkage: Clients should be referred for medical and support services as appropriate; documentation of that referral must be in the client file and available upon request.

Monitoring

Referral / Linkage - Existence and documentation of referrals and linkages for medical and support services will be monitored through discussion and chart review during site visits.

Partner Services: Per HCP Management Memo 15-06, HCP providers funded for Health Education/Risk Reduction must have a process for Partner Services referral and counseling for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Monitoring

Partner Services - Existence of processes for Partner Services counseling and referral will be monitored through agency submission of written policies and procedures related to this topic. Implementation of the policy (i.e. that clients are actually offered and referred to Partner Services) will be monitored through observation, discussion, and/or chart review during site visits.

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Hospice Services

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Introduction

This document describes the "Hospice Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Hospice Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

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

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

Program Guidance

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

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy of six months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under Medi-Cal.

Key Activities

Hospice care is intended to be palliative, rather than curative. Key activities of Hospice Services include:

- Initial assessment of the client's service needs;

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- Mental health counseling, including treatment and counseling provided by mental health professionals licensed or certified in California;
- Nursing care;
- Palliative therapeutics including symptom and pain control;
- Specialized equipment and supplies for in-home hospice care;
- Physician services; and
- Room and board for residential hospice services.

Objective

Hospice Services are designed to promote the highest possible quality of life and function for clients and their families, and help terminally ill clients approach death with dignity and comfort.

Limitations

Hospice services may only be provided to clients with a physician's certification that the client has less than six months to live.

Units of Service

A Unit of Service (UOS) is a single 24-hour day of hospice services.

Requirements

Provider Qualifications

Education/Experience/Supervision

All staff will possess the appropriate and valid licensure or certification as required by the State of California to perform their duties, including:

- Physicians (including Psychiatrists)
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Psychologists
- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Licensed Clinical Social Workers (LCSW)
- Certified Nursing Assistants
- Home Health Attendants

NOTE: *Drugs and biologicals may only be administered by individuals licensed to do so.*

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Individual supervision and guidance must be available to all staff as needed.

Monitoring

Provider qualifications – Availability of clinical supervision for unlicensed providers will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Hospice Services must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Privacy requirements and HIPAA regulations
- Skills to provide end of life care

Ongoing: Staff must also receive ongoing annual training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Programs

Hospice programs require licensure by the California Department of Public Health and certification by Medicare.

Service Characteristics

Hospice Services must be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. They may not be provided in a skilled nursing facility or nursing home.

Intake

To receive hospice services, clients must have received a written certification from their physician stating that they are terminally ill and have a defined life expectancy of six months or less. The hospice staff must ensure that the HCP client intake has been

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performed at the start of service provision, and perform an intake if necessary. Staff should also discuss preparation of advanced medical directives (e.g., living will, durable power of attorney, Do Not Resuscitate order), and assist the client in completing any of these if desired. See the Common Standards of Care for intake requirements.

Orientation

Each new client enrolled in Hospice Services must receive an orientation to the services on admission; document this orientation in the client file.

Initial Assessment

The hospice provider must conduct a comprehensive initial assessment for services. The needs assessment will describe the client's current status and inform the needs and services plan. The assessment should include:

- Age
- Health status and comorbidities
- HIV prevention needs
- Psychological needs
- Spiritual needs
- Need for pain management/palliative care
- Current medications
- Ambulatory status
- Cognitive assessment
- Family composition and status
- Special housing needs
- Level of independence
- Available resources

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, and provision of applicable referrals/linkages, will be monitored via site visit chart review. Primary care provider certification of client's terminal status will be verified via site visit chart review.

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Needs and Services Plan

Frequency: An individualized needs and services plan must be developed upon the client's admission, and re-evaluated at least every six months thereafter, as needed. Written certification from their physician stating that they are terminally ill and have a defined life expectancy of six months or less must be signed again at six months.

Requirements: Hospice providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input – including a client's right to refuse aspects of this service
- Only includes allowable activities
- Includes a statement of the problems or symptoms
- Details expected duration of services
- Ensures coordination of care, through collaboration with the client's service providers (medical provider, case manager, mental health specialist, spiritual advisor, etc.)
- Is signed and dated by the hospice provider, unless documented via the Care Plan in ARIES

Service Provision

Services should be provided utilizing methodologies appropriate for the client's needs. This may include any combination of:

Counseling Services: Counseling services that are consistent with the definition of mental health counseling, including treatment and counseling by psychiatrists, psychologists, or licensed clinical social workers.

Palliative Therapies: Palliative therapeutics for symptom and pain control that are consistent with those allowed by Medi-Cal.

Supportive Services: Hospice programs should provide or coordinate supportive services such as assistance with activities of daily living, medication management, family bereavement counseling, and others as needed.

Referral / Linkage: Programs may provide referral and linkage to the full spectrum of HIV-related services.

Monitoring

Needs and Services Plans – Provision of services consistent with the client's Needs and Services Plan, along with complete documentation, will be monitored via chart review during the site visit.

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Housing Services

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1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

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Introduction

This document describes the "Housing Services" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Housing Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Note: This document pertains to the service category of Housing and does not address the additional requirements for those providing services under the Housing Plus Project.

Service Definition

HRSA Definition

Housing services provide transitional, short-term, or emergency housing assistance (including hotel/motel vouchers) to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and increase stability for clients, allowing them to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated at least every six months, to guide the client's linkage to permanent housing. Housing services also can include housing referral services; assessment, search, placement, and advocacy services; as well as payment of fees associated with these services. Providers must have written policies and procedures that indicate the percentages of a client's monthly rent they can pay through this program.

Key Activities

Allowable activities in this service category include:

- Housing that provides some type of core medical or support services, such as:
    - Residential substance use disorder services
    - Residential mental health services
    - Residential foster care
    - Assisted living residential services

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- Housing that does not provide direct core medical or support services, but is essential for a client or family to initiate or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. This includes paying or supplementing rent. In some cases this can include hotel/motel vouchers, when done on a limited basis as part of an overall plan to transition the client to permanent housing.
- Housing referral services to other (non-HCP) housing programs

NOTE: Utilities, including firewood, may be paid for under the Emergency Financial Assistance service category, but are not allowable in this service category.

Unallowable Activities

Housing services **may not:**

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

Monitoring

Allowable Activities - Appropriateness of HCP-funded housing services (i.e. housing is essential for getting or maintaining HIV care and treatment and/or provides medical or supportive services to people living with HIV) will be monitored through chart review during site visits.

Objective

Housing Services are intended to maintain a client's housing stability, improving their ability to maintain or access medical care.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards for Housing staff. Housing-related referrals must be provided by persons who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs.

Individual supervision and guidance must be available to all staff as needed.

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Staff Orientation and Training

Initial: All staff providing Housing Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Local housing resources including HOPWA
- Privacy requirements
- Navigation of the local HIV system of care including ADAP

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

Monitoring

Provider Qualifications and Training - Agencies must maintain a comprehensive list of staff with hire date, all trainings provided (including those that are housing specific), and dates of trainings; this list must be available for review during site visits. Individual supervision and clinical guidance available to staff will be monitored through direct observation and discussions during site visits.

Service Characteristics

Eligibility Screening: If the Housing Services provider is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Newly Identified Clients: Housing Services providers should work with other HCP providers to ensure that newly-diagnosed clients and clients new to the HCP system are evaluated for and provided with Housing Services as needed.

Appointments: Initial Housing Services appointments should be made as soon as possible to avoid housing disruptions. Appointments must occur no later than 10 calendar days after the first client referral, which can be a self-referral. Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after a request. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and provider attempts at rescheduling must be documented in the file.

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Monitoring

Tracking of Appointments - Evaluation of suitability for Housing Services for clients newly-diagnosed with HIV, as well as timely provision of such services when warranted, will be monitored via discussion and/or chart review during site visits. When housing is not readily available, appointments and follow-up processes must still be in place to ensure suitable shelter is identified. Processes will be reviewed during site visits.

Duration: Services are intended to be temporary in nature. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as lasting up to 24 months. Providers may extend services beyond 24 months if necessary based on individual client assessment, which must include a transition plan to permanent housing with a concrete timeline. The HCP Advisor must be made aware of such an instance.

Documentation: All client contacts, as well as services, referrals, and other assistance provided to clients in order to help them obtain housing must be recorded in the client chart.

- If the client is not placed in housing that also provides some type of core medical or support services, the necessity of housing services to support treatment plan adherence must be documented.
- Documentation must include confirmed appointments to HIV-associated medical care, whether provided through their housing services provider or externally

Monitoring

Duration- Durations of service will be monitored via ARIES

Documentation - Documentation of medical necessity will be monitored through chart review.

Intake

The Housing Services provider must ensure that the client intake has been performed prior to HCP service provision and if not, perform an intake. See the Common Standards of Care for detailed intake requirements. Providers should ensure that any consents specific to housing are completed and in the client's file.

Orientation

Each new client receiving Housing Services must receive an orientation to provided services; document this orientation in the client file.

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Monitoring

Orientation - Agencies will be asked to submit a policy related to orientation of new clients in this service category; documentation of these orientations will be monitored via site visit observation, discussion, and/or chart review.

Housing Plan

Housing Service providers should create an individualized housing plan for each client. The plan must include:

- Assess current housing needs
- Incorporate client input
- Guide the client's linkage to permanent housing
- Include any referrals and linkages to other needed services
- Be signed and dated by staff providing Housing Services

Reassessment

The client's housing plan must be updated at least every six months.

Monitoring

Reassessments - Individualized housing plans, including inclusion of all required content and updating at least once every six months, will be monitored via chart review during site visits.

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Linguistic Services

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1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

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Introduction

This document describes the "Linguistic Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Linguistic Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Linguistic Services provide interpretation and translation services to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of other HCP services.

Program Guidance

Linguistic Services are intended to facilitate effective communication between clients and providers of HCP or other HIV-related services, and to improve service delivery. Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS): https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.

Key Activities

Key activities of Linguistic Services include:

- Oral interpretation of conversations between clients and providers in the client's preferred language, and
- Written translation of documents to the client's preferred language whenever possible, including posted materials relevant to HIV services. When an agency does not have capacity to translate written materials to a language not typically spoken in their jurisdiction, oral translation of these documents may be provided instead.

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Linguistic services may be provided in group or individual settings; funds may also be used to pay for translating printed materials. Interpretation services may be provided by language lines.

Objective

The goal of Linguistic Services is to ensure that clients with a preferred language other than English are able to effectively communicate with providers.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a translator, interpreter, or other provider of Linguistic Services, whether by phone or face-to-face. When Linguistic Services are used during the course of providing other HCP-funded services (such as Medical Case Management), both services should be entered into ARIES. However, if a provider is bilingual and is providing typical services in a preferred language other than English, the service should be billed under the relevant service category, and Linguistic Services may not also be billed.

Requirements

Provider Qualifications

Education / Experience / Supervision

All services must be provided by trained and qualified individuals holding appropriate American Translators Association certification, State of California Court Interpreter certification, or local certification. Providers may utilize commercial interpretation services if existing staff are unable to perform these functions.

Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Provider qualifications – Assurance that all services provided are commensurate with the training, education, and licensure/certification must be kept in personnel files, with hire date for review during site.

Staff supervision – Availability of individual supervision for interpreters and translators will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All staff providing Linguistic Services within an agency funded by HCP must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

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- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including continuing education required locally or by the State of California to maintain certification where applicable. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Service Characteristics

Treatment Provision: Linguistic Services must be provided whenever necessary to ensure effective communication between the provider and the client. Clients should be notified of the availability of translation and interpretation services at intake/orientation and as appropriate. Other best practices include the use of signage explaining the availability of Linguistic Services in multiple languages as appropriate for the site.

Documentation: All client contacts and other information pertinent to services must be recorded in the client chart and documented in ARIES.

Monitoring

Documentation – Provision of linguistic services, including languages available and utilized, will be monitored during site visits via chart review.

Working Draft

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Medical Case Management
(including treatment adherence)

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Working Draft